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An exploration of psychological and socio-cultural facets in perinatal distress of Pakistani couples: a triangulated qualitative study

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Abstract

The phenomenon of perinatal distress in terms of depression, anxiety, bipolar, and psychotic disorders is well-explored in the West but barely investigated in South Asia; particularly research evidence highlighting the cultural expression of couples' mental health with respect to Pakistan is rare. The purpose of this research is to focus on the exploration of psycho-socio-cultural expression of couples' perinatal distress and coping strategies used in the Pakistani context in relation to maternal and paternal mental health, with implications for the wellbeing of their unborn or born progeny. The research design focused on qualitative interpretative approaches. In data triangulation, reflexive thematic analysis and interpretative phenomenological analyses were applied on the verbatim of the semi-structured interviews conducted with the mental health professionals ($n=9$) and the couples ($n=8$), screened positive for perinatal distress. Four couples were screened out of 325 perinatal women visiting the gynaecological ward of Aziz Bhatti Shaheed Teaching Hospital, Gujrat. Edinburg Postnatal Depression Scale, Generalized Anxiety Disorder-7 and Washington Early Recognition Center Affectivity and Psychosis Screen are the standardized instruments considered to be used for screening perinatal distress among couples. The Urdu version of WERCAP Screen was developed by a standardized forward-backward translation procedure. The rest of the four couples were purposively selected from the psychiatric ward of the same hospital. The Simplified Negative and Positive Symptoms Interviews were administered to the couples after getting approval for the Urdu version form. All couples were probed with an indigenously developed Structured Clinical Interview Schedule for DSM Disorders based on DSM-5-TR. The triangulation carried out with reflexive thematic analysis and interpretative phenomenological analysis revealed cultural conception of perinatal distress as perceived by the mental health professionals and experienced by the couples during the antenatal and postnatal period of their lives. They were enlightened with a constructive view aimed at promoting transformational change in terms of their mental health care and coping. The implications suggested implementation of a psychotherapeutic intervention for reduction in the level of distress and subsequent enhancement of well-being in couples during the perinatal period.

Keywords Antenatal, Anxiety, Couples, Data Triangulation, Depression, Interpretative Phenomenological Analysis, Thematic analysis, Mania, Postnatal, Psychosis

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Background

Distress in everyday life is experienced to some degree by all of us. Recently, it has been widely explored and studied, especially during the perinatal period. Thus, perinatal distress has been a buzzing term at the international level that served to affect not only parents but also their foetuses and new-born babies. Empirical research evidences showed that both mothers and fathers have suffered from distress during and after pregnancy period. Previous researches emphasized the importance of the influential effect parents have on their children's well-being during the antenatal and postnatal period. Thus, children's mental health is contingent on their parent's mental health, highlighting the significance of exploring distress in perinatal couples [1, 2].

Perinatal period is defined as, "pregnancy and the first year postpartum" (p. 2) [3]. A closely related term, psychological distress is well-thought-out to be the stress reaction in relation to depression, anxiety, interpersonal sensitivity, somatization, obsession-compulsion, phobic anxiety, hostility, paranoid ideation, psychoticism, and posttraumatic stress disorder during antenatal to postnatal period in women (>18 years old) who have been screened for pregnancies at high risk [4]. Therefore, the perinatal period is the most susceptible duration for the onset and/or even exacerbation of psychiatric disorders such as depression, anxiety, and psychosis in women. But fathers cannot be neglected in the exploration of these possibilities.

Diagnostic and Statistical Manual (DSM)-5 TR) [5] has a specifier of peripartum onset with Brief Psychotic Episodes, Bipolar Disorder I, Bipolar Disorder II, and Major Depressive Disorder, yet a review of literature shed light on the presence of perinatal distress with psychosis (schizophrenia), and generalized anxiety disorder during and after pregnancy. The prevalence of depression and anxiety in UK residing fathers during the perinatal period, from conception to 1 year after birth, was 5–10%, and 5–15%, respectively [6]. Similarly, a survey in America yielded, that the prevalence of psychological distress in women during the antenatal period was found to be between 3.9% and 6.4%. In the postpartum period, it was 4.6% (0–2 months) to 6.9% (3–5 months) in women [7]. A systematic review posited the presence of paternal perinatal depression and perinatal anxiety in more than 10% of fathers [8]. It is suggested that husbands have to be screened out during perinatal gynaecological check-ups of the wives [9]. In Pakistan, 45% of women exhibited psychological distress in terms of depression, anxiety, and stress during the antenatal period. The salient causes of distress were lack of spouse support, low income per month, large family size, presence of stressors in life, low self-reliance, issues of domestic abuse, and pregnancy-related concerns [10] and 8.66% of women experienced postpartum disorders such as depression and psychosis. Additional causes indicated young age, no education, previous psychiatric diagnosis of depression or psychosis, women doing household chores, residing in rural residencies, having religious orientation, low socioeconomic status, and lack of husbands' support [11]. The perinatal distress in fathers, for exploration of prevalence in Pakistan has been sporadic. It was found in Karachi that 28.3% of postpartum depression among 20 to 50 years old fathers [12]. A quick glimpse at high prevalence rate of perinatal distress in women (8.7–45%) and men (28.3%) in Pakistan, as compared to women (3.9–6.9) and men (10%) residing in other countries, instigate a curiosity to conduct a study for exploration of psycho-socio-cultural expressions and factors attributable in Pakistan.

Perinatal distress is a widely researched topic in Western countries. Nevertheless in Pakistan, a few determinants of perinatal distress (pertaining to depression or anxiety) in relation to maternity, have been explored. A thorough international perspective exists in qualitative literature on the conception and lived experiences of couples experiencing distress during the antenatal and postnatal period but scarce research is available after gauging this issue in Pakistan. Therefore, the present research aims to explore the essence of conception of perinatal distress as perceived by mental health professionals and as experienced by the high-risk screened couples later diagnosed with a psychiatric disorder in Pakistani socio cultural context.

Based on the review of literature, the primary research questions to be explored in the present study are given below:

1. What is the conception of perinatal distress in psychosocial context of Pakistan?
2. How distress is expressed culturally in the couple during the antenatal and postnatal period?

However, what is attributable for the expression of distress in couples during antenatal and postnatal period? served as a secondary research question. This secondary research question was added as depending on the emerging design in the present qualitative research, fine-tuned additional questions as per emergence of the unexpected themes during the interview process.

Methods

The research design focused on a qualitative interpretative approach and to enhance the quality and credibility of the findings, Patton's recommendation in 1999 [13] for triangulation in perspective and data source is abided by. Therefore, perspective, data source triangulation is done by integration of Reflective Thematic Analysis and Interpretative Phenomenological Analysis for understanding

verbatim obtained by two different data sources such as mental health professionals and screened perinatal couples experiencing distress respectively. According to Campbell, et al. [14], reflexive thematic analysis is a suitable approach in interpretivism when a researcher is committed not to bound to any a priori theory or more precisely theoretical framework and instead focuses on research-related outcomes that emerged from the study. Smith and Osborn (2015) [15] recommended interpretative phenomenological analysis to be a suitable approach for the investigation of lived experiences of people suffering from pain due to physical disorders. Thus, meanings of particular experiences in terms of their personal and social interactions as perceived by the participants produce a better understanding of the phenomenon rather than looking into plausible explanations in a priori theories. The cultural expression of "pain …involving complex psycho-somatic interactions" ([15], p. 41) is displayed for perinatal distress in physical terms (such as headaches, body aches, and weakness) and psychological terms (such as diagnosis of Major Depressive Disorders, Bipolar Disorders, Generalized Anxiety Disorder, and Psychotic Disorders).

Table 1 Inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
For Mental Health Professionals	
• Consultant Psychiatrists with at least five years of clinical experience in managing and treating patients with psychiatric illnesses. • Clinical psychologists with at least two years of clinical experience in managing and treating patients with psychiatric illnesses.	• Consultant psychiatrists with less than five years of clinical experience • Psychologists/clinical psychologists with less than two years of experience • Unwilling psychiatrists and clinical psychologists.
For Screened Couples (Husbands and Wives) with Perinatal Distress	
• All women visiting either a gynaecological and/or psychiatric ward for consultation with a medically confirmed pregnancy or have a live child with less than or equal to one year of age or having both antenatal and postnatal conditions. • Women are accompanied by a spouse, and both are willing to participate in the study. • The inclusion criteria hold screened couples with ≥ 11 cut-off score on EPDS, ≥ *10* cut-off score on GAD-7 visiting in gynecological ward. • Eligible couples with > 20 for bipolar disorder, > 13 for psychotic disorder cut-off scores on the WERCAP screen • Spouses also fulfilled the diagnostic criteria via SCID-5TR.	• The willing wives screened positive who were either in unstable physical or mental conditions or were accompanied by a relative other than a spouse, were in the first week of postpartum. • unwilling spouse. • Scores < 11 cut-off on EPDS, < 10 cut-off score on GAD-7. • Scores < 20 cut-offs for bipolar and < 13 cut-offs for psychotic disorder on the WERCAP screen. • Spouse not fulfilling the diagnostic criteria via SCID-5TR.

Participants

The participants of the present study comprised experts and couples screened positive for perinatal distress. In total, nine mental health professionals (5 consultant psychiatrists and 4 clinical psychologists) were contacted for semi-structured interviews in psychiatric wards of Aziz Bhatti Shaheed Teaching Hospital, Doctors Hospital in Gujrat and Benazir Bhutto Hospital, Rawalpindi with purposive sampling technique. For inclusion-exclusion criteria of the experts to be interviewed with the semi-structured approach in the current research, see Table 1. Initially, the plan was to include gynaecologists as an expert in semi-structured interviews for exploration of the phenomenon of perinatal distress among couples. However, while going in the field and interviewing two consultant gynaecologists, it was observed that they were so overwhelmed with routine check-ups of antenatal and postnatal obstetrics and gynaecological issues in women that could not manage time to screen their mental health. Therefore, they were excluded from being consulted as experts in the current research.

In total, eight heterosexual couples were screened positive for perinatal distress with Urdu versions of standardized instruments and were selected with a purposive sampling technique. Out of eight, four couples were selected from the obstetrics and gynaecological ward of Aziz Bhatti Shaheed Teaching Hospital, Gujrat where 325 perinatal women completed the screening procedure. The rest of the four couples were selected from the psychiatric ward of Aziz Bhatti Shaheed Teaching Hospital, Gujrat and a screening procedure was not carried out on all the women visiting the psychiatric ward for consultation. The focus was to select a woman accompanied by her husband either in the antenatal or postnatal period or both and have a previous history of or present diagnosis of severe mental disorders (such as bipolar or psychotic disorders) confirmed by a consultant psychiatrist. For inclusion-exclusion criteria of the selected screened couples for semi-structured interviews in the current study, see Table 1.

The description of the couples and their socio-demographics along with diagnosis are given in Table 2. These couples have been assigned fictitious names to maintain privacy and confidentiality. In present study, only first letters of their assigned fictitious names have been used with their verbal quotes to mask their identity.

Interview schedules

To conduct the interviews, a separate semi-structured interview schedule is prepared based on a review of the literature for experts and couples with perinatal

Table 2 Description of couples, their socio-demographic characteristics, and diagnosis during Perinatal Period

Couples' Description	Socio-demographic Characteristics	Diagnosis
J and A married six years before. They had the death of a daughter, three days after her birth with a C-section, due to pneumonia, two and half years earlier. J took infertility treatment to conceive this baby a second time. Presently, the doctor has identified a low amount of amniotic fluid and prescribed medicines.	J is 28 years old, with six months of pregnancy. A is 30 years of age with approximately PKR. 15,000/- monthly income, residing in a joint family system situated in a rural area. J is a housewife and A is a contractual painter. Both are uneducated. 15 members (Seven adults and eight children) lived in A's home and 11 members (nine adults and two children) lived in J's home.	J and A are diagnosed with Generalized Anxiety Disorder.
L and D married a year ago. This is L's first pregnancy of almost nine months.	L is 21 years old with matriculation. D is 28 years of age with PKR. 50,000/- monthly income, residing in a joint family system situated in an urban area. D has done his master's in computers. L is a housewife and D has a private internet business. 13 members (eleven adults and two children) lived in D's home and 3 members (two adults and a child) lived in L's home.	L and D are diagnosed with Major Depressive Disorder.
T and R married three and a half years ago. This is T's second unplanned pregnancy of two months. In addition, she has an eight-month-old daughter with a caesarean. Once she had a one-and-a-half-month miscarriage due to her sudden bad fall from the stairs.	T is 32 years old with a master's degree. R is 30 years old with PKR. 20,000/- monthly income, residing in a joint family system situated in a rural area. R has completed his education up to class eighth. T is a housewife and R paints the houses. 6 members (five adults and one child) lived in R's home and 4 adults lived in T's home.	T is diagnosed with Major Depressive Disorder. R is diagnosed with Generalized Anxiety Disorder.
Y and S married twelve years ago. Y has an unplanned five months of pregnancy. In addition, she has a twelve-month-old daughter. One of her sons died fifteen minutes after birth due to incomplete formations of the lungs.	Y is 35 years old with intermediate qualifications. S is also 35 years old with PKR. 30,000/- monthly income, residing in a nuclear family system situated in a rural area. S has completed his education up to class eighth. Y is a housewife and S works in a shoe factory. The couple along with a daughter lived together where as the parents lived in Y's home.	Y is diagnosed with Generalized Anxiety Disorder. S is diagnosed with Major Depressive Disorder.
B and E married thirteen years ago. In addition, she has a six-month-old son. One of her sons died sixty minutes after birth due to pneumonia. She had a five-month miscarriage of another son due to unknown reasons.	B is 32 years old and E is 40 years old with PKR. 16,000/- monthly income, residing in a nuclear family system situated in a rural area. B is uneducated but E has attained education up to matriculation level. B is a housewife while E is a labourer. E's home is occupied by his wife and four children. 8 adults and 13 children lived in B's home.	B is diagnosed with a Psychotic Disorder (Schizophrenia) with peripartum onset specifier. E is diagnosed with Major Depressive Disorder with anxious distress.
N and M married three years ago. They have a twelve-month-old son and a three-month-old daughter. One of her sons died after birth due to unknown reasons.	N is 20 years old and M is 32 years old with PKR. 20,000/- monthly income, residing in a nuclear family system situated in a rural area. Both are uneducated. N is a housewife while M is a driver. M's home is occupied by his wife and two children. 4 adults lived in N's home.	N is diagnosed with Bipolar Disorder I. M is diagnosed with Generalized Anxiety Disorder.
Z and I married a year ago. Z has an unplanned pregnancy of two months.	Z is 25 years old and I is 30 years old with PKR. 20,000/- monthly income, residing in a nuclear family system situated in an urban area. Z has completed education up to the intermediate level while I has completed matriculation. Z is a housewife while I is a salesman. I's home is occupied with his wife only and 7 adults lived in Z's home.	Z is diagnosed with Bipolar Disorder II. I is diagnosed with Generalized Anxiety Disorder.
H and K married four years ago. They have a twenty-four-month-old son. H currently has a four-month unplanned pregnancy and her first delivery was a caesarean.	H is 32 years old and K is 35 years old with PKR. 15,000/- monthly income, residing in a joint family system situated in a rural area. Both are uneducated. H is a housewife while K is a labourer. 7 members (6 adults and one child) lived in K's home and 7 members (five adults and two children) lived in H's home.	H is diagnosed with a Psychotic Disorder (Schizophrenia). K is diagnosed with Major Depressive Disorder with anxious distress.

disorders. The questions of the semi-structured interview schedules were approved by a committee of three expert health professionals (a consultant psychiatrist, a clinical psychologist and a gynaecologist). The questions related to perinatal distress symptomology in couples focused on schizophrenia and other psychotic conditions, bipolar disorder, major depressive disorder, and generalized anxiety disorder for experts. For couples with perinatal distress, the indirect questions focused on general information, precipitating and perpetuating issues for the diagnosed categories of schizophrenia and other psychotic conditions, bipolar disorder, major depressive disorder, and generalized anxiety disorder. Overall, the semi-structured interview schedule focused on questions designed to elicit cultural expressions, as recommended [16] in the mentioned spectrum of mental disorders in the couples during perinatal period. Structured Clinical Interview for DSM Disorders based on DSM-5-TR (SCID-5TR) [5] was constructed by following four steps for the forward-backwards translation procedure [17].

Procedure

A semi-structured interview via a semi-structured interview schedule was conducted with 5 consultant psychiatrists and 4 clinical psychologists in their hospital work setting after getting permission. In total eight couples (4 couples from the gynaecological ward and 4 couples from the psychiatric ward) were screened (see Table 2) by the standardized instruments for the presence of perinatal distress. Edinburg Postnatal Depression Scale (EPDS, [18], Urdu version [19], and Generalized Anxiety Disorder-7 (GAD-7, [20], Urdu version [21] were used for screening of perinatal depression and perinatal anxiety. Washington Early Recognition Center Affectivity and Psychosis Screen (WERCAP Screen, [22]) was used for screening of mania and psychosis in the couples during perinatal period. The Urdu version of the WERCAP Screen was constructed by following four steps for a standardized forward-backwards translation procedure [17]. Moreover, the semi-structured interview schedule, the SNAPSI [23] was translated into Urdu by following standardized procedures and getting approval [24].

Risky couples screened positive by EPDS, GAD-7 and WERCAP screen were probed with indigenously developed Structured Clinical Interview Schedule for DSM Disorders based on DSM-5-TR with informed consent. The written informed consent form was sorted and it highlighted the exploration of general issues related to the perinatal period for the provision of better services at the hospital. The assessment of mental health was not mentioned because there is no practice of screening perinatal women in gynaecological wards of hospitals in Pakistan. Therefore, they were unaware and unaccustomed to such kind of examination. Moreover, it was hidden to rule out the possibility of social desirability effect and resentment while responding to screening instruments and to gauge the genuine responses of the participants. Educated couples signed the informed consent but uneducated couples or any spouse gave their thumb impressions or verbal consent. They were verbally debriefed that this study aimed at the exploration of mental health and identification of psychiatric disorders in couples during the perinatal period to investigate precipitating, perpetuating and protective issues around disorders. The steps of interpretative phenomenological analysis are applied to the verbatim obtained while exploring the lived experiences of couples with perinatal distress [25]. They were interviewed with a semi-structured interview schedule together in a single session of 45 to 60 min duration. The semi-structured interviews were recorded and transcribed in Urdu for four couples (2 antenatal couples and 2 postnatal couples) each screened positive and diagnosed with SCID, having a wife with Major Depressive Disorder and Generalized Anxiety Disorder visiting the gynaecological ward of Aziz Bhatti Shaheed Teaching Hospital, Gujrat for routine check-ups. Their husbands were screened positive and either diagnosed with SCID for Major Depressive Disorder or Generalized Anxiety Disorder or comorbidity of both.

However, four couples (2 antenatal couples and 2 postnatal couples) visiting the psychiatric ward of Aziz Bhatti Shaheed Teaching Hospital, Gujrat for consultation were purposively selected without screening all patients visiting the psychiatric ward. In addition to SCID, the Urdu version of SNAPSI [23] was administered to the couples. They were interviewed in a single session of 45 to 60 min duration separately one after another because either wife or husband tried to dominate the session and inhibited the expressive viewpoints of their spouse. Their semi-structured interviews were not recorded because the wives of the couples were hesitant and unwilling to participate in the recording of their interviews. Instead written notes were taken on the spot while interviewing the couples. Wives were diagnosed with Bipolar Disorder and Psychotic disorder. Their husbands were either diagnosed with Major Depressive Disorder or Generalized Anxiety Disorder or comorbidity of both. The critical interview method was applied with the experts and high risk for distress in the couples during the perinatal period [26]. It provides the flexibility of inclusion of questions in emerging design in response to following and probing the flow of the one-to-one face-to-face interactive interviews. The research has not been planned in detail at the beginning and is shaped according to the revelation of the themes and subthemes within the process [27].

While reflecting on the procedure of data collection, it was observed that research conduction is a difficult task particularly in Pakistan as research culture is not a norm and people are not accustomed to it. Therefore, initial verbal instruction (before written informed consent) such as "this research intends to understand the phenomenon of couple perinatal distress" does not stem motivation for any couple to show willingness to participate in the research. That's why out of 325 perinatal women screened for perinatal distress in the gynaecological ward, 5 women screened positive refused to be in the study. Changing initial verbal instructions such as "this research intends to teach coping strategies for the couple perinatal distress to enhance the wellbeing of their children" motivated 24 screened-positive women visiting the gynaecological ward to participate in the study. Out of them, four were retained in the study as described earlier and twenty were excluded because of any of the mentioned reasons which are unwillingness of either wives or husbands to participate, having an expatriate spouse, not accompanied by a spouse or accompanied by an unwilling spouse. The semi-structured interviews proceeded with psychoeducation and counselling with perinatal couples for improvement of their parenting skills and

coping strategies in daily life. They were given contact number for further consultation if required. Those who contacted were given the therapeutic services later on.

Data analysis

The steps of reflexive thematic analysis [28] are applied for the interpretation of the verbatim obtained by a semi-structured interview with experts in the mental health profession. In addition, the procedure of interpretative phenomenological analysis [25] for analysis of lived experiences of perinatal couples (after seeking informed consent) screened out for Psychotic Disorders, Bipolar Disorders, Major Depressive Disorder, and Generalized Anxiety Disorder through standardized instruments and diagnosed with indigenously constructed SCID-5TR.

Results

Participants

The sample comprised nine mental health professionals (five consultant psychiatrists and four clinical psychologists) and eight perinatal couples (eight wives and their eight husbands) with ages ranging between 20 and 40 years. The majority belonged to the lower middle class with education levels ranging between no qualifications to intermediate.

Findings

The reflexive thematic analysis and interpretative phenomenological analysis of semi-structured interviews with the mental health professionals and perinatal distressed couple respectively, revealed 14 subthemes, classified under three major themes and sub-themes (Table 3).

Table 3 Themes and subthemes

Themes	Psychological Screening Assessment	Cultural Articulation	Cultural Aetiology
Subthemes	Generalized Anxiety Disorder	Emotive-somatic expression	Gender roles
	Major Depressive Disorder	Maladaptive emotive-behavioural expression	Stressful and traumatic events
	Mania/Bipolar	Religious and supernatural cognitive expression	Mental health stigma
	Psychotic Disorders		Mental health illiteracy
			Family support
			Perinatal cognitions
			Bonding and emotional attachment with foetus and infants

Theme 1: Psychological screening assessment

All experts, experienced clinical psychologists and consultant psychiatrists narrated the diagnostic features and criteria of DSM-5-TR [5] and ICD-11 [29] respectively for psychotic disorders, generalized anxiety disorder, major depressive disorder and bipolar disorders.

> *"...their (for the psychotic disorders, generalized anxiety disorder, major depressive disorder and bipolar disorders) symptoms are well written in DSM" (Clinical Psychologist).*

Moreover, the contents of the symptomology sometimes become specific to the perinatal condition that a mother is experiencing at the given moment.

> *"I will never be a good mother" (Clinical Psychologist).*

These specific contents pertaining to the antenatal and postnatal period are well described and interpreted in the subtheme of Perinatal Cognitions. Anyhow, when diagnostic criteria of DSM were explored in the perinatal couples with major depressive disorder and generalized anxiety disorder, they were able to identify the symptomology but were unaware of the recognition of these signs as an indication of the presence of a psychiatric disorder. The perinatal couples diagnosed with psychotic disorders and bipolar disorders in the mother were aware of the disease because of the previous occurrence of episodes and their visit to psychiatric wards for treatment with medication. However, they were not aware of particular information pertaining to the diagnosis.

> *"It's been a long time since they are taking medicines but they are not aware of the diagnosis of the disorder" (Clinical Psychologist).*

Theme 2: Cultural articulation

The theme of cultural articulation is manifested in the following subthemes. Emotions, somatization, and maladaptive coping are classified as proximal factors whereas religious and supernatural cognitions are classified as distal factors.

Emotive-somatic expression

In couples with perinatal distress, *"Anger"*, *"Sadness"*, and *"Shame"* have been observed and reported by psychiatrists and clinical psychologists though clients are unaware of these sentiments. In addition, gender

differences are explicit in the expression and the understanding of emotions.

"Generally speaking men express their emotions less as compared to women. Women are ahead of men in emotional exhibition and seeking help" (Psychiatrist).

Husbands could not understand what was happening with their wives during pregnancy and postpartum because of the patriarchal mindset of the upbringing of men.

"We train our sons for physical contact (sex) in marriages but do not train men for understanding woman's emotions and sentiments" (Psychiatrist).

The somatic component is obvious in the findings of the present study such as.

"Headaches" "Bodily weakness" "Tiredness" (Psychiatrist).
"Fastening of heartbeat" (Clinical Psychologist).

Here, the expert pointed out that the clients' heartbeat races unconsciously without known reason.

The expression for bodily ailments and aches is vivid in the heart (Dil) as a primary recipient organ of stressors in Pakistani culture.

"Dil na lagna" (lack of interest) (Clinical Psychologist).
Dil kharab huta hai (Translation: The heart feels anxious).
"Dil pay buch hai (Translation: The heart is burdened with tension)" (B).

Maladaptive emotive-behavioural coping

The individuals suffering from psychiatric illnesses expressed the following emotional and behavioural coping strategies that have been interpreted as dysfunctional and adaptive, but they were unaware of them. The dysfunctional coping skills as narrated by the mental health professionals are validated by the lived experiences of the perinatal couples with distress.

"Quarrelsome" "cry on pity matters" (Psychiatrist).
"She fights and doubts me" (K).
"Become silent" (Psychiatrist).
"I become silent and do not talk (Dil nai karta baat karnay ko)" (K).

The children become a source of displacement of anger and frustration felt by the mothers.

"do not behave properly with children" (Psychiatrist).

House chores are not properly managed.

"Do not do household chores" (Psychiatrist).
"So that a woman does not do any household work" (S).

Refrain from enjoyable activities and become stubborn and rebellious.

"She does not eat" (E).
"Do not listen to anybody" (B).

Usually, wives insist on repeated check-ups with a gynaecologist for reassurance of good physical health of a foetus or infant but husbands refrain from unnecessary visits to the hospitals.

"My husband insists that when a doctor gives an appointment, only then we have to visit him" (Z).

However, lack of interest in sexual activity during pregnancy and after the lochial period is expressed by mental health professionals only. Pakistani couples are too shy to talk about such issues during a conversation. These issues were not probed in the interview to avoid embarrassment and maintain the privacy of the couples.

"Women have a mindset to refrain from sex with their husband during pregnancy because they think it to be better for themselves but for men, it is difficult to bear the urge"(Clinical Psychologist).

Religious and supernatural cognitive expression

The common cultural practices found in the present study are given below.

"People primarily take them to Peer-o-Faqeer (Faith Healers/Traditional Religious Healers). When they are not healed by Dum-o-Darood, they come to us" (Psychiatrist).

Pakistani perinatal couples think that they are affected by someone's evil eye.

"…somebody has cast a spell or is envious or is under the influence of a shadow" (Clinical Psychologist).
"I think evil eye makes things worse" (L).

It is not always the case that faith healers retain clients to themselves for treatment purposes. Some learned traditional healers have insight into mental disorders and they refer clients to mental health professionals in addition to dum (recitation of Quranic verses) upon them.

"…Peers (Faith Healers/Traditional Religious Healers) refer patients to us. They understand psychiatric disorders" (Psychiatrist).

But unqualified quack traditional healers use psychiatric medications and injections to treat mentally ill people and they have faith in the success of the treatment.

"This peer (traditional religious healers/faith healers) has treated the jinn" (Psychiatrist).

Jinn is an invisible creature made of fire by God who inhabited Earth along with human beings and animals.

Participants try to use amulets or do some home remedies. Dum is the practice of recitation of Quranic verses for healing purposes for a sick person. Except for dum (recitation of Quranic verses for healing purposes), the rest are cultural practises such as burning chillies and throwing sugar.

"…here (in Pakistan) the trend of majority is towards taweez dahgay (amulets)" (Clinical Psychologist).
"Throw sugar after spiralling around the victim of the evil eye. To do dum and To burn red chillis" (L).

Theme 3: Cultural aetiology

It comprised of the subtheme clusters of the following factors.

Precipitating determinants

Precipitating factors in the present study that triggered the onset of the disorder are gender roles and stressful or traumatic events.

Gender roles

Since Pakistan is a patriarchal society, the preference for sons due to their dominant role and being bread earners is prominent in the verbatim of the participants. The social construct of discriminating perspectives about men and women has pressurized pregnant women to long for the birth of a son instead of a daughter.

"Men earn. He is security for the future" (Clinical Psychologist).
"When I gave birth to a baby girl…they were talking earlier that she will have a daughter and when she was born, no one took my care" (T).

Right after marriage, the couple is forced by the significant relatives to share information about their parenthood without any delay or intervals taken.

"Immediately after marriage she is pressurized to give a good news (to become pregnant) and then to deliver a baby boy because a boy moves the race forward" (Clinical Psychologist).

In some families, the desire for the birth of a baby boy in family members is so strong that might cause divorce to the bride if she fails to fulfil their dreams.

"Sometimes a woman is divorced immediately after giving birth to a girl within a few months" (Psychiatrist).

Beliefs in traditional gender roles, refrain men from expressing their emotions and concerns openly in our society. Similarly, women are confined to the boundaries of the home and are expected to take care of children and family members.

"It is a common phrase here (in Pakistan) to be a man. It means that do not express hopelessness and anxiety. A man is a man when he bears hardships" (Psychiatrist).
"Whole of the house environment is dependent on the mother. Mother has to maintain the house environment…if a mother becomes sick then the functioning of the house gets disorganized" (E).
"Father earns to bear the expenditures. Mother should spend within the limited budget" (I).

Stressful or traumatic events

The present study has identified the following stresses and traumatic experiences.

The prime factor is financial glitches. These pressurize women to refrain from taking supplements if the doctor recommends them for the better health of the mother and foetus.

"…my family members cannot afford expansive medicines (nutrition supplements) for me (during pregnancy)" (Clinical Psychologist).
"I breastfeed my daughter but when I ask him to bring a milk bottle, he says she is short of money" (N).

Husbands' Stressful workload on the job and an obligation to earn, result in negligence of their wives.

"I deal with a hundred people per day. I remain engaged on the phone. If the internet link gets down then it is a tension" (D).

Husbands cannot understand the mental and physical condition of their wives and take action for divorce. Or else the wives are unaware of their psychological miseries and demand divorce (*khula*).

"He thinks of divorcing his wife because he has no awareness of what is happening" (Clinical Psychologist).
Still others struggle with the sorrows of child loss either during pregnancy or after delivery.
"I had a miscarriage due to a fall" (T).
"Anxiety is due to the death of a baby girl" (A) who died after three days after her birth due to pneumonia.

Perpetuating determinants

Perpetuating factors that contribute to the maintenance of the problem are mental health stigma, mental health illiteracy, and family support. However, perpetuating proximal factors included mental health stigma and family support (with or without empathy), whereas perpetuating distal factors included mental health illiteracy.

Mental health stigma

The way general people view and picture mentally unstable persons is stigmatized as unanimously expressed by mental health professionals and perinatal couples.

"...he became insane and no one liked to be called crazy" (Psychiatrist).

Due to taboos surrounding mental illnesses, family members do not talk about the psychiatric issues their brides or grooms have and give consent for their marriages which in turn leads to a high divorce rate.

"Her family has not informed me (before marriage) that she is sick" (M).
"Others ask me to divorce her but I do not want to do so" (K).

The biological basis of psychiatric illnesses is a naïve concept among perinatal couples and these behaviours are interpreted as attention-seeking intentional outbursts.

"Nobody can understand. They say that I behave like this intentionally" (E).
"My brother's wife says that she is only doing a drama and she is not sick" (M).

Mental health illiteracy

In Pakistan, people have been found to lack knowledge and awareness about mental disorders in general and have mild to no understanding of the vulnerability of women to psychiatric disorders during the perinatal period.

"If a woman expresses anxiety, majority of the people do not entertain her" (Psychiatrist).
"People use Dum and Home Remedies (totkay) and only visit the doctor when physical symptoms worsen" (Psychiatrist).

Some families are aware of the mental health issues and take care of pregnant women.

"If the husband is qualified and educated, his family knows about the mental problems, (they say) we should seek the psychological help" (Clinical Psychologist).

However, the knowledge and understanding they have about the disorder is superficial.

"Depression happens when the situation is anxious. Anxious person becomes depressed. .all kind of good and bad thoughts go through the mind. One thinks what will happen next. It is a kind of fear" (T).
"I just know that it is a dangerous mental illness" (H).

High education and qualification are key to the handling of psychological problems in the perinatal period.

"If we see men of rural areas, they cannot control their aggression and they might beat their pregnant wife" (Clinical psychologist).
Others openly acknowledge their naivetés in this issue and instigate the researcher to inform them.
"I do not know that it is related to the brain" (Z).
"You tell us" (S).

People misbehave, misunderstand their problems and bully them.

Family support

In Pakistan, the majority of people prefer to live in a joint family system. In this way of living, they tend to save money and provide emotional support to each other in times of happiness or hardships. The joint family system still provides some support in the maternal aspects of chores as compared to the nuclear family system.

"Mostly, in practice, either mother-in-law or another woman in the house brings pregnant women…she could be mother-in-law, sister-in-law or woman's family (biological mother or sister) members" (Clinical Psychologist).

Usually, husbands provide less support to their wives in the nuclear family system during the perinatal period.

"To be very honest, I have observed a few husbands accompanied their pregnant wives…" (Clinical Psychologist).

The birth of a child adds to the responsibilities of the father and symbolizes his eternal bonding with the mother and the baby. They consider their earning responsibilities primary and rearing responsibilities secondary thus neglecting the pregnant and nurturing mothers.

"I work the whole day and he (husband) does not give me any time" (T).
"My husband takes care more of his brothers and sisters" (N).

Some pregnant women face domestic violence and they decide to abort the baby and portray it as a naturally occurring miscarriage partly due to religious and social restrictions in abortion matters.

"My sister has convinced me that I should not take tension. It influences the children badly…If we fight then it will have a bad impact on the children" (Y).

Here tension refers to the psychological or mental strain, an individual feels in the presence of the stressors.

Moreover, they are taunted by their mother-in-laws who compare their condition with theirs and show an unsympathetic attitude towards their mental and physical needs.

"They (mother-in-laws) say that we have not taken supplements, and you should not take them" (Clinical Psychologist).
"We raised four kids and you cannot rear one child" (Psychiatrist).

The husband's families hold high expectations from the pregnant and peripartum women as they expect them to work and participate in all household chores like everybody else, neglecting her need for rest and bonding with a child.

"she has to cook food…do household chores and take care of children…puerperium period is a beautiful concept in our culture…it is for rest, for recovery of weakness…for creating a bond with the infant" (Clinical Psychologist).
"… My sister-in-law will take care for one day. Second day she will say we are not responsible for you and your children" (Y).

There are a few husbands who serve as a pillar to support the necessities and requirements of their wives during the antenatal and postnatal periods.

"I support her. I do not let anybody blame her for anything" (D).

Present determinants

Present factors that are functioning during the experience of distress in the current research are perinatal cognitions, bonding and emotional attachment with the foetus and infant. The perinatal cognitions and emotional attachment with the foetus and infant are present proximal factors and bonding with the foetus-infant is included in the present distal factor.

Perinatal cognitions

The salient features of thoughts coming into the mind of pregnant or postpartum women are centred on concerns for baby and maternal health and rearing practices in addition to financial issues.

"I will never be a good mother"(Clinical Psychologist).
"I long to eat fruits or take juices but what can I do" (J).
"I am anxious for my foetus that the future does not hold any bad events for him or her" (J).

However, in general, it is observed that low-income families have a high number of children as compared to high-income families in Pakistan.

"I have observed men reproducing children, even a hawker will give birth to the children irrespective of having food in the home or not" (Clinical psychologist).

The gender of the baby is also a prime thought during the perinatal period.

"Do not know how my in-laws will behave at the birth of a baby girl" (Clinical Psychologist).

Fears of miscarriage, harming a baby and exchanging possibilities in hospitals are also prominent.

"Mother is not taking care of a child" (Clinical Psychologist).

In the West, pregnant women undergo screening tests regarding the identification of abnormalities in the foetus and may subsequently go for abortion to avoid misshapen. Here, in Pakistan, this facility is rarely availed because abortion is prohibited in Islam except for certain extreme risks concerning the well-being of a mother.

"go for screening autism risk in pregnancy"(Clinical Psychologist).

Prenatal genetic tests are available in metropolitan cities of Pakistan such as Islamabad, Lahore, and Karachi. Unlike freedom of choice for termination of pregnancy with the detection of neurodevelopmental disorders in the West, couples do not abort their foetuses when and manage to rear the child with abnormalities throughout life. According to Islam, abortion is allowed when a threat to the mother's or baby's life is present and the physicians recommend termination due to medical reasons. However, the couple has to pay fidiya (charity) for the aborted foetus. In addition, they could recite "Indeed my Lord is, over all things, Guardian" (The Quran) for the protection of the foetus from any infliction during pregnancy with no termination decision.

Bonding and emotional attachment with fetus and infant

For some participants, it is easy to establish a bond with their fetus and talk about them.

"You have a bond with a baby during pregnancy" (Clinical Psychologist).
"Nowadays I take out baby's clothes…watch them… and set them back" (L).

For others, it is not too concerning of an issue as they consider bonding to emerge after the birth of a child.

"Puerperium period is a beautiful concept in our culture…it is for rest, for recovery of weakness…for creating a bond with the infant" (Clinical Psychologist).

Yet, a minority thinks that small children and infants are not affected by the attachment of the mother and father because they are not mature enough.

"Three small kids are not affected by her condition but the eldest daughter does get affected" (E).

Therefore, the bonding issues of parents with the foetus and infant are not mature indicating a dominant "authoritarian style of parenting" (see [30]) used to rear the children in Pakistan.

Discussion

Cultural exploration of psychopathology conception is helpful in contributing to a contextual interpretation of assessment outcomes and give insight into devising of appropriate interventional strategies [31]. The present study has tried to capture the essence of perinatal distress as experienced by couples and viewed by mental health professionals in Pakistan. The three major findings that emerged in the current research are (1) Psychological Screening Assessment for Perinatal Distress, (2) Cultural Articulation of Perinatal Distress, and (3) Cultural Aetiology of Perinatal Distress. In an exploration of the "cultural concept of distress" ([5], p. 17), the two aspects in the findings are (i) Cultural Idiom of Distress that pertains to the behaviours or way of expressing symptoms or problems among individuals having similar socio-cultural backgrounds. And (ii) Cultural Explanation or perceived Cause of distress that is relevant to attribution, or aetiology within the given socio-cultural context. These affect the clinical presentation of presenting complaints, help-seeking behaviour, prospects of treatment, and treatment mode [5].

The first domain, psychological screening assessment, yield the conception of perinatal distress in psychosocial context of Pakistan as perceived by the professional experts and experienced by the high risk screened and diagnosed couples for distress, answering the first primary research question. The psychosocial and cultural exploration of the concept of perinatal distress in Pakistan yield symptomatic presentation of depression, anxiety, mania, and psychosis as perceived by the health care professionals and diagnosed couples. The symptomatic presentation is clustered together to develop theme of psychological screening assessment. It was found that professional psychologists and psychiatrists adhered to the DSM-5-TR and ICD-11 respectively for elaboration of the symptoms of depression, anxiety, mania, and psychosis to be identified in Pakistan. On the other hand diagnosed couples were found to have little or no insight into their distressing experiences. The couples usually explained their psychological distress in somatic physical symptoms that comprised the cultural articulation of perinatal distress.

Psychological screening assessment refers to the gathered information for evaluation of the individual's abilities, behaviours, and other characteristics to detect the disorders and recommend the relevant treatments. DSM-5-TR has defined the categories of perinatal distress such as psychotic disorder, generalized anxiety disorder, major depressive disorder and mania-major depressive disorder (collectively known as Bipolar Disorder). Psychotic

disorders are defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behaviour (including catatonia), and negative symptoms. The essential feature of generalized anxiety disorder is excessive anxiety and worry (apprehensive expectation) about some events or activities. A manic or hypomanic episode is an abnormally, persistently elevated, expansive, or irritable mood and persistently increased activity or energy that is present. Major Depressive Disorder is either a depressed mood or the loss of interest or pleasure in all or nearly all activities for most of the day nearly every day [5]. However, only Major Depressive Disorder has a specifier of postpartum depression. However, in ICD-11 [29], the specification of mental disorders such as depression, mania, anxiety, and psychosis during pregnancy and after childbirth is mentioned. Systematic reviews showed that psychological screening assessment is carried out by several researchers on women and men during their perinatal period worldwide [32, 33]. The findings of the present study confirmed the culture free utility of symptomatic criteria of psychopathology given in DSM-5TR and ICD-11 however, professionals must be cautionary for the patients complaints overwhelmed with somatic expression in Pakistan.

The second domain of the present research finding is termed "cultural articulation". It exhibits the cultural expression of distress in the couple during the antenatal and postnatal period, answering the second primary question. Cultural articulation is defined as the cultural forms and practices considered appropriate for the expression of thoughts, emotions, and behaviours for mental disorders. This definition differed from the articulation concept presented by Middleton (1990) [34] who elucidated those cultural elements play a crucial role in socioeconomic formation. In Pakistan, the cultural articulation for perinatal distress is wrapped in emotional and somatic symptoms along with maladaptive coping capabilities. The problem is seemed to be aggravated by the firm beliefs in supernatural and magical attributable. Emotions are complicated drives with neurophysiological universal expression. These emotions are presented in ten universal forms such as interest, joy, sadness, fear, anger, disgust, contempt, surprise, shame and guilt [35]. Emotions when not regularized properly are expressed in the form of over-reactive bodily patterns in somatic expressions [36]. Somatic expressions are general exhibitions of somatic problems with a psychological component explainable in terms of hypochondriasis and anxiety about health [37]. Somatic symptomology for mental disorders is comprised of symptoms that have physical causes and not psychological ones [38]. Keeping in view, "In some cultural contexts, somatic symptoms predominate in the expression of the disorder, whereas in other cultural contexts, cognitive symptoms tend to predominate" (5], p.254), the present research confirmed the domination of physical and somatic expression of the psychological disorders in Pakistan. Thus, emotive-somatic expression is a term that is comprised of complex emotional expressions in the form of bodily symptoms.

Maladaptive emotional-behavioural coping is the second subtheme that emerged under the domain of cultural articulation. This refers to the use of ineffective emotional and behavioural strategies to deal with the distress in the present study. This research study has filled in the gap identified, "symptoms commonly associated with depression across cultural contexts, not listed in the DSM criteria, include social isolation or loneliness, anger, crying, and diffuse pain. A wide range of other somatic complaints are common and vary by cultural context. Understanding the significance of these symptoms requires exploring their meaning in local social contexts" ([5], p. 190). One of the key findings in maladaptive coping is an exploration of the precepts and behavioral activities related to sex in couples. According to the mental health professional, women experienced low sexual desire and low intercourse gratification during pregnancy in Pakistan. "Low levels of sexual desire have been reported by some ethnoracial and migrant groups. and … reflect less interest in sex" ([5], p. 493). Asian women tend to suppress sexual desires as compared to European women in general [39], and in the perinatal period serve as a cultural norm to avoid having sex with their husbands. The presence of orgasmic difficulty affected sexual and relationship factors more in Pakistani women than in U.S. women [40]. Anxiety and depression commonly occur during pregnancy in Pakistani women, and 42% of women were physically and/or sexually abused who have unemployed spouses and lower household income [41].

Unanimous response attributed causes of the perinatal distress to be religious and supernatural, encompassing the religious and supernatural cognitive expression of the perinatal distress. The present study has found that mental health professionals consensually adhere to the features of the diagnostic criteria recommended in DSM-5-TR [5] and ICD-11 [29] for their routine psychiatric assessments even in perinatal couples. Yet, the reflexive thematic analysis and interpretative phenomenological analysis revealed that perinatal couples are not aware of the diagnostic criteria as per DSM-5-TR and ICD-11. They comprehend their symptomology in the physical forms and visit the physicians, local quack, or even traditional healers (spiritual healers) for diagnosis and treatment of any kind of perceived physical disease. Thus, somatic expression is a viable clinical presentation in their case. The reason people visit local quacks instead of qualified physicians or mental health professionals is attributable to low fees charges and easily accessible

psychopharmacological medicines from the pharmacy in Pakistan [42]. The subtheme of religious and supernatural cultural cognitions refers to the cultural beliefs based on either interpretation or misinterpretation of religion. The valid elucidation of the Quran and Hadees would comprise religious cognitions whereas invalid clarification of the Quran and Hadees prevalent in Pakistani culture is referred to as supernatural cognitions.

The majority of mental health professionals and general physicians are reluctant to discuss spiritual aspects of disorders with patients because either they lack time or are deficient in knowledge to devote to discussion on spirituality beyond the bio-medical model though patients are interested in pondering upon such issues [43]. The findings in the present study yielded that some of the traditional religious-spiritual faith healers are aware of mental disorders and psychiatric treatment. They play a crucial role in directing the patients to visit the mental health professionals in addition to dua from Hadees (prayers), and Quranic verses given to them for recitation. Moreover, perinatal couples use home remedies to soothe their symptoms of distress. They visit the physician only when symptoms worsen and the disorder becomes severe. In Pakistanis [44], illnesses considered to be minor are not trended to be treated by the consultation of qualified doctors. The majority of people use herbal medicines, do self-medication or visit faith healers in Pakistan.

The findings of the present study have uncovered that *Nazar-e-Bad* (Evil Eye), Jadoo (Magic), and *Jinn* (Genie) are the triggering factors for causing distress in perinatal couples. "culturally specific coping behaviours such as accessing faith, spiritual, or traditional healers or other variations in illness management that are acceptable within cultural contexts and represent an attempt to help heal the medical condition. These local practices may complement rather than obstruct evidence-based interventions" ([5], p. 367). Yet, if symptoms persist, it is strongly recommended to visit qualified mental health professionals instead of visiting traditional healers who deceive people and rob their wealth. Home remedy for Pakistanis to avoid quack faith healers is the following prayers

> *Bismillah Hi Allah Humma Azhab Har Raha Wa Bardaha Wa Wasabaha.*
> *Translation: In the name of Allah. O Allah, remove its (nazr) heat, its cold, and its pain [45].*

Surah Al-Falaq and Surah An-Nas collectively called Mauzatain (Quran), are recited for breaking the effects of the spell. Hadees explained the context of recitation of these Surahs for betterment of people.

A worldwide survey was conducted on 39 Islamic countries with 38,000 face-to-face interviews with Muslims. The median percentage of South Asian Muslims for their beliefs in magic (35%), evil eye (45%), jinn (77%), use of talismans (26%), and visiting traditional religious healers (55%) for cure is either low or equal to Pakistanis beliefs median percentages 50%, 61%, 77%, 41%, and 55% respectively [46]. Pakistani patients reported magic-religious-oriented mental health beliefs frequently to explain the causes of their ailments [47]. That is why Dein and Illaiee [48] recommended, "collaborative working relationships between Islamic religious professionals and mental health professionals" (p. 290) to diagnose and treat mental disorders in Islamic countries. Contemplations in the cultural assessment of psychotic disorders are cautionary because "ideas that appear to be delusional in one cultural context (e.g., evil eye, causing illness through curses, influences of spirits) may be commonly held in others" (5], p119) and "accepted in others" ([5], p. 907).

So far the phenomenon of possession or influence of Jinns on human beings is concerned; two opinions exist among Islamic scholars. One assents to the likelihood of Jinn's possession of human bodies. The others differ and proclaim that Jinns influence human beings but cannot possess a human body by entering and invading it [48]. The latter view of Jinns manipulating human beings is appropriate because Jinns can influence thoughts going through the human mind. The acceptance, acting upon and possessions of these thoughts that are stimulated by jinn, is an option available for the humans to choose. Yet, the empirical evidences for assessment of such influences are awaited with future procession and development in science and technology.

The third domain of cultural aetiology served to answer the secondary research question for identifications of the attributable for the expression of distress in couples during antenatal and postnatal period. Cultural aetiology refers to cultural factors that play a role in the onset and maintenance of the mental disorder. Racine, et al. [49] have defined three categories of these factors. (i) Precipitating Determinants are specific events that led to the onset of the current problem. (ii) Perpetuating Determinants maintain the problem once it has occurred. (iii) Present Determinants are operative during the experience of the distress. Further, these antecedents are bifurcated into proximal directly affecting outcome variable factors and distal indirectly affecting outcome variable factors [50].

Precipitating determinants are interwoven into the elusive web of gender roles as perceived in Pakistani society. Traumatic events such as miscarriage, death of an infant after birth, temporary infertility, and financial burden served as major stressors encountered in the lives of perinatal couples. Further, family support in terms of the availability of husbands, and backing up by the significant members of in-laws (such as mother-in-law, and

sister-in-law) perpetuate the problems when found detrimental and truculent. Moreover, high mental health illiteracy and high mental health stigma deteriorate the health-seeking behaviour in couples for better well-being of their children yet to born or alive infant. Thus, former perpetuating determinants can aggravate present negative perinatal cognitions related to foetus and infant in mothers primarily and impact the foetus-infant bonding with their parents (present facet).

Previous researches conducted in Pakistan found that men are considered bread earners and there is a tendency for preference in the birth of a boy child in the majority of the household families in Pakistan [51]. Pakistanis continue to engage in reproduction just to have either a son or to have more than one son. There is concealed evidence for an increasing trend of sex-selective abortion of girls [52]. Stressors and traumatic experiences are uncontrollable, unwanted circumstances [53] that affect perinatal distress in couples. Husbands and other relatives can serve either as a support or as a stressor [54]. Thus mothers and their husbands can be preoccupied by the dysfunctional thoughts in the antenatal and postnatal period due to transitional changes in their roles as parents [55]. A systematic review posited that Pakistanis have exhibited a low level of education and awareness regarding psychiatric illnesses and therefore prefer to visit faith healers for their treatment [56]. These cultural beliefs are surrounded by stigmatized practices held against mentally ill people [57]. Thus, they serve as a barrier to seeking treatment from mental health professionals.

Shafiq [58] constructed an indigenous perinatal distress model based on the reflective thematic analysis of the experts' interview verbatim and interpretative phenomenological analysis of the lived experiences of screened high-risk couples for perinatal distress. She has empirically confirmed the model via statistical regression analysis after measurement of perinatal distress via an indigenously constructed perinatal distress inventory. While fulfilling the quality criteria [59] of substantial model construction and empirical validation, the researcher's reflexivity narrated the absence of children and naivety of personal experience of pregnancy, childbirth, perinatal experiences of distress, and child-rearing practices served to provide firm grounds to withhold biased preconceptions and assumptions. Thus, the qualitative data is interpreted as objectively as possible in the context of the Pakistani socio-cultural scenario via triangulation and respondent validation of written notes at the end of the interviews. In addition, the written verbal statements of the participants were re-confirmed by them for retention of the meanings and interpretation.

Strengths and limitations

Ortiz and Lella posited, "Psychologists should also seek to develop the qualifications required for conducting competent cross-cultural assessment" ([60], p. 139) and they emphasized the importance of the applicability of DSM-5-TR and ICD-11 diagnostic criteria in one's culture. In Pakistan, psychologists, and clinical psychologists are inclined towards DSM and psychiatrists persuaded ICD for assessment of the mental health of individuals. Therefore, the emerged themes and subthemes served as a hallmark for the development of a culturally fitted indigenous model of perinatal distress and indigenous screening tool for the assessment of psychiatric distress, with the ultimate aim of providing a therapeutic intervention program for high-risk distressed couples during the perinatal period.

The numbers of subjects were few and may not be representative of a larger population. Therefore, a qualitative research project with represented sample extraction from various areas of Punjab for deep exploration of perinatal distress is recommendable in future. The subject selection process of high-risk distressed couples and the exclusive use of mental health professionals have resulted in the study focusing on psychiatric disorders (common and severe) and missed the more usual mild to moderate peripartum depression, anxiety, mania, and psychosis. Future research could cater for this drawback by representation and inclusion of mild to moderate levels of psychological distress during the perinatal period and their challenges. The inclusion criteria for the participants of the present research are not confined to the restriction of previous traumatic experiences faced by the couples in the form of miscarriages and infant death within one year after birth. Future studies would focus exclusively on gauging their experiences in terms of posttraumatic stress disorder and posttraumatic growth trajectory practices carried by the couples during the perinatal period. It is beyond the scope of the aims and research questions of the present study to elaborate findings of the counselling and guidance provided to the diagnosed couples. Future research could focus on provision findings related with one-to-one based couple therapeutic sessions to the diagnosed distressed individuals.

Clinical and research implications

Exploration of cultural concepts of distress is essential to psychiatric screening and diagnosis for expediting the identification of individuals' concerns and psychopathology, in user-friendly terminology rather than with jargon. It elicits definite factors that play in symptom development, cultural risk factors, and coping responses [7]. Distinguishing cultural idioms of distress in terms of the usage of the heart as an organ for the expression of bodily symptomology in the present research opens avenues

for further scientific evidence gained by the researchers. Thus, with reference to Pakistan, there is a dire need to carry out couples' screening assessment for major depressive disorder, generalized anxiety disorder, bipolar disorder, and psychotic disorders during the perinatal period as per criteria of DSM-5-TR [5] and ICD-11 [29], unanimously recommended by the mental health professionals. Moreover, with the use of indigenous screening tool during routine gynaecological check-ups in the hospitals, appropriate referrals might be made for provision of the counselling or psychotherapeutic services as per requirement of the case in the professional consultancy.

Conclusions

The present triangulation of reflexive thematic analysis and interpretative phenomenological analysis on the verbatim of mental health professionals and couples experiencing perinatal distress has revealed the cultural conception of distress in Pakistan. Though psychiatrists and clinical psychologists stick to ICD-11 and DSM-5-TR diagnostic criteria for screening and assessing distress in wives and husbands during the antenatal and postnatal period, the general public is found to be unaware of the symptomology and explains it in terms of bodily ailments (emotive-somatic expression) primarily attributable to lack of social media campaigns to dissipate the information concerning maternal and paternal mental health and impact on their progeny. Unlike Western predominate cause of substance abuse in psychiatric disorders, the aetiology in Pakistan found stressors or traumatic experiences, gender role expectations, family support, perinatal concerns around foetus, infant, and mother, mental health illiteracy and high stigmatization and unawareness of bonding-attachments as contributable to parenting styles later on. The findings have implications for the development of an indigenous scale to capture the essence of these cultural expressions and to provide psychotherapeutic intervention services (preferably evidence-based cognitive behaviour therapy) at gynaecological wards in the hospitals of Pakistan for timely screening and management of these distress for better paternal, maternal, and progeny wellbeing in long run.

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S. S. wrote the main manuscript text, collected data, prepared tables, and reviewed the manuscript.

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Data availability
The datasets used and/or analyzed during the current study available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
Ethical approval was taken for the unfunded research project titled, "Cognitive-Behavioural Couple Therapy for Perinatal Distress: A Mixed Methods Study" by Institutional Review Board (IRB), University of Gujrat, letter no: UOG/ORIC/2022/393 dated 22nd December, 2022. This manuscript has been extracted from the above cited study, letter no: UOG/ORIC/2023/234 dated 22nd June, 2023. All methods were carried out in accordance with relevant guidelines. Written informed consent forms were filled by the participants taking part in the present study.

Consent for publication
Informed consent has been taken from all subjects for use of identifying information/images in an online open-access publication. It is further consented that they will be assigned fictitious names and only first letter of their fictitious names will be used in research publication to mask their identity.

Competing interests
The authors declare no competing interests.

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