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From villages to floating islands: A qualitative study exploring maternal experiences of support and isolation in Northern Sri Lanka

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ABSTRACT

Perinatal stress is a well-established risk factor for maternal and child health outcomes. Pregnant women in conflict-affected countries experience unique traumatic stressors, including displacement, material loss, loss of loved ones, and other war-related stressors. This qualitative study examines maternal mental health and parenting practices in Northern Sri Lanka, a region impacted by decades of civil war and displacement. Participants included 34 mothers who were pregnant at the time of the study, have one or more young children, and resided in the Northern Province during the conflict in Sri Lanka. The study explores the interrelationship between early adversity, chronic stressors, and maternal well-being. Qualitative insights highlight themes of unsupported resilience, emotion regulation amidst chronic stressors, and the erosion of traditional community support systems. Mothers reported navigating isolation within nuclear family structures, compounded by societal pressures and diminished communal trust. Despite these challenges, participants emphasized the importance of parenting values rooted in resilience and fostering an appreciation for overcoming hardship as they raise their own children. The study underscores the critical need for culturally sensitive, family-centered interventions that address maternal mental health and support parenting in post-conflict settings. These findings provide a foundation for tailoring maternal and child health policies to the unique needs of war-affected communities in Sri Lanka and beyond.

1. Introduction

Maternal mental health challenges can contribute to risk for less optimal parenting and adverse mental health outcomes for children (e.g., Bryant et al., 2018; Eltanamly et al., 2021; Flanagan et al., 2020; Lambert et al., 2014; Slone and Mann, 2016). Parents living in extreme adversity face additional constraints on their caregiving abilities (Eltanamly et al., 2021). Armed conflict, defined as a prolonged dispute involving violence between parties (UNHCR, 2023), is one such extreme stressor. The resulting instability, displacement, and trauma have profound effects on both caregivers and their children, particularly during the sensitive perinatal period. Pregnant women and new mothers affected by war face a convergence of risks including traumatic histories, ongoing socioeconomic hardship, and gaps in healthcare access that compound mental health vulnerabilities and disrupt parenting quality.

Sri Lanka, a nation that endured a brutal civil war from 1983 to 2009, illustrates these intersecting challenges. Though the war formally ended over a decade ago, its aftermath is still deeply felt particularly in

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the Northern Province, the epicentre of the conflict. Approximately 12,000 individuals remain internally displaced (Internal Displacement Monitoring Centre, 2022), and mental health needs in this region remain underserved. In recent years, these challenges have been compounded by the country's 2022 economic collapse, which downgraded Sri Lanka from middle-income to low-income status (International Crisis Group, 2024). The dual burden of war-related trauma and economic precarity has created a syndemic of adversity, with limited systemic support to address it.

Sri Lanka faces a high burden of mental illness, with mental and substance use disorders accounting for 2,800.2 disability-adjusted life years per 100,000 people (World Health Organization, 2017). A recent systematic review and meta-analysis by Alwis and colleagues (2024), synthesizing data from 33 studies, estimated a pooled point prevalence of depression in Sri Lanka at 19.4 % (95 % CI 14.44–25.54 %), far exceeding global (3.4 %) and regional (3.7 %) averages from the 2019 Global Burden of Disease Study. Mental health problems are especially acute in the Northern Province: Doherty et al. (2019) found major depression rates of 41.1 % (95 % CI, 38.7–44.5) and anxiety disorders at 46.7 % (95 % CI, 41.9–51.5) among post-conflict primary care attendees. Rates are even higher among those exposed to displacement and trauma during the war (Husain et al., 2011; Keraite et al., 2016; Siriwardhana et al., 2015).

Despite this elevated burden, access to mental health services is woefully inadequate. With just 0.6 psychiatrists, 0.03 clinical psychologists, and 0.4 social workers per 100,000 people (World Health Organization, 2022), and a treatment gap exceeding 90 % (Silva et al., 2022), most mental health needs go unmet. Structural barriers such as stigma, provider emigration, and reduced government funding exacerbate this treatment gap particularly in the Northern Province (Siriwardhana et al., 2018). In this context, there is an urgent need for culturally relevant approaches to supporting mental health.

These challenges are particularly concerning for the maternal population in Northern Sri Lanka, who have experienced profound disruptions to caregiving environments due to war, loss of partners, displacement, and long-term socio-economic instability. Evidence from Sri Lanka suggests that trauma-exposed mothers may experience trauma symptoms such as anger, irritability, and emotional dysregulation, which can undermine parenting and increase the risk of harsh discipline or violence against children (Catani, 2010; Sriskandarajah et al., 2015a). Yet research in this area remains limited, with most studies focusing on individual pathology rather than the lived realities of caregiving in post-conflict settings. Exposure to trauma during pregnancy or early motherhood can have profound effects on maternal well-being, fetal development, and later child outcomes (Cook et al., 2018; Erickson et al., 2019; Merrick et al., 2017). For war-affected mothers in Sri Lanka, this means navigating multiple, overlapping stressors: displacement, trauma histories, grief, intimate partner violence, and food insecurity (Alwis et al., 2024; Thomas et al., 2022a; Thomas et al., 2023). War has also restructured family systems, with many women losing their spouses and assuming primary caregiving responsibilities under difficult circumstances (Somasundaram, 2007; Witting et al., 2020). The consequences of these layered stressors on parenting are considerable.

Despite these risks, mothers also play a vital protective role. As early as World War II, caregivers have been recognized as psychological buffers (Freud and Burlingham, 1943), serving as a "protective shield" against trauma for children (Elbedour et al., 1993, p. 811). In Sri Lanka, parental care has been shown to reduce child behavioral problems post-conflict (Sriskandarajah et al., 2015b) and foster children's social connectedness (Hettitantri, 2019). A caring maternal figure was also identified as protective following the 2004 tsunami (Wickrama and Kaspar, 2007). However, the protective potential of parenting is contingent upon the mental health of the caregiver and the surrounding social and institutional context (Masten et al., 2015; Williams, 2010). In Northern Sri Lanka, where mental health resources are minimal, and many mothers remain unsupported in their caregiving roles, this protective potential is deeply threatened.

War-affected families require tailored interventions beginning prenatally and informed by an understanding of maternal stressors, culturally relevant caregiving norms, and existing mental health management practices (Isosävi et al., 2020; Kirmayer and Pedersen, 2014; Punamäki et al., 2017). To ensure such interventions are culturally informed and actionable, research must actively engage local stakeholders. Taken together, there is an urgent need for contextually grounded research on maternal mental health in post-conflict Sri Lanka, particularly research that centres mothers' perspectives on how trauma, adversity, and chronic stressors shape their parenting. The perinatal period represents a critical window of opportunity for such inquiry, given the implications for maternal and child health across the life course (Erickson et al., 2019). Yet, systematic research exploring how mothers in Northern Sri Lanka make sense of their trauma histories and parenting experiences remains limited. To address this gap, we explored the impact of early life adversity through mothers' constructions and meaning-making of their parenting practices in a post-conflict setting. Guided by a critical realist perspective (Bhaskar, 1975, 1979), which recognizes that knowledge is contextually embedded and shaped by both subjective experience and structural forces, we explored: *How do mothers in Northern Sri Lanka make sense of their experiences of early life adversity, conflict-related trauma, and ongoing stressors, and how do these experiences shape their mental health and parenting practices in a post-conflict context?*

2. Methodology

The study was designed as a convergent mixed-methods design where qualitative and quantitative data were collected and analyzed concurrently. Results discussed here however, focus on qualitative findings.

Ethics approval

Ethics approval was received from the Research Ethics Board (REB) at Toronto Metropolitan University University (TMU) in May 2024 and from the Ethics Review Committee (ERC) at the University of Jaffna (UOJ) in July 2024.

2.1. Research team and social location

This study is the result of a partnership between the first author and collaborators in Sri Lanka. The partnership was initiated in 2015 during the FCT's PhD dissertation work in Sri Lanka (see Thomas et al., 2022a, 2022b). The research team for the current project, consisting of members in Canada, Sri Lanka and the United States, includes professors, clinicians, and research assistants (RAs), and/or as parents. Additionally, nine RAs, local to the Northern Province, were hired to complete data collection, transcription and translation work. RAs were healthcare professionals (i.e., one physiotherapist, one registered nurse, one pharmacy graduate and six pre-internship physicians who successfully completed their MBBS examination) and all have lived experience with the war in Sri Lanka.

2.2. Theoretical standpoint

This study is grounded in a critical realist perspective, acknowledging that participants' accounts are shaped by their social location, language, context, and personal history, while our interpretations are similarly influenced by our own positionalities (Willig, 2013). A social constructionist lens further informed our qualitative approach, highlighting how meaning is co-produced through discourse and shaped by cultural and structural contexts (Burr, 2015). Rather than treating participants' narratives as objective truth, we understood them as situated, interpretive accounts shaped by broader power structures and local

norms. We drew on Ecological Systems Theory (Bronfenbrenner, 1986; Bronfenbrenner and Morris, 2006) to situate maternal mental health within layered systems -individual, family, community, and broader sociopolitical structures - across time, including war, displacement, and post-conflict stressors. This systems-based view aligns with a social determinants of health approach prominent in humanitarian contexts, where trauma-focused care is complemented by holistic psychosocial and public mental health strategies (IASC, 2007; Rasco and Miller, 2004; Silove, 1999, 2013).

The integration of critical realism, social constructionism, and ecological theory enabled a nuanced understanding of how conflict-affected mothers experience and make meaning of mental health. This framing also informed our template analytical approach, which considered how researcher and participant positionalities co-shape knowledge production.

2.3. Setting and participants

Participants were recruited from a community sample in Mullaitivu, Northern Province, Sri Lanka. Mullaitivu was selected in consultation with local partners in Sri Lanka. Mullaitivu was particularly impacted by the conflict and almost the entire population in the district was internally displaced as a result of the conflict (Inter-Agency Standing Committee Sri Lanka, 2008).

Eligibility criteria included women born between 1988 and 1998 who were pregnant at the time of the study, had at least one young child, and were residing in Mullaitivu District. Participants were also required to have lived in one of the five districts of Sri Lanka's Northern Province (Jaffna, Kilinochchi, Mannar, Mullaitivu, or Vavuniya) during the armed conflict. Individuals with language impairments, hearing difficulties, or those unable to provide informed consent were excluded.Participants born between 1988 and 1998 were recruited to ensure they had early memories of the conflict, allowing them to describe these experiences in more depth. The target sample size of 30 was guided by the concept of information power, which is based on a consideration of information *richness* of the data (Malterud et al., 2016), the study's narrow aims, and challenges in recruiting participants due to stringent inclusion criteria, alongside considerations of convenience and accessibility.

2.4. Recruitment

RAs attended antenatal clinics and nongovernmental organizations (NGOs) who serve families to conduct study information sessions. Eligible women were either interviewed immediately upon consent, or for other eligible participants, a mutually convenient interview date, time, and location was arranged. As recruitment was challenging, RAs additionally recruited participants through snowball sampling to ensure a representative sample.

2.5. Measures

2.5.1. Interview guide and semi-structured interviews

The interview guide was developed based on an extensive literature review and consultation with experts in the field of perinatal mental health, post-conflict settings, and child mental health, including knowledge holders in Northern Sri Lanka. It was further revised based on feedback from RAs in Sri Lanka. Interview questions were oriented around four main topics and rooted in ecological systems theory: 1) early childhood experiences of the mother, particularly growing up during the conflict (e.g., "Can you tell me about your family life growing up?"; "What do you remember about the impact of the conflict on your parents/caregivers/family?"); 2) postpartum experiences (e.g., "Can you tell me about the one-year postpartum period for you?", "How were you supported during the postpartum period?"); 3) the experiences of parenting and any unmet needs as a parent (e.g., "When you find it difficult to manage things, how do you cope?", "What do you enjoy most about parenting your children?") and 4) parenting style (e.g., "When you encounter challenging behaviours of your child, how do you typically respond?, "How would you describe your relationship with your children?"). In alignment with ecological models, interview questions were designed in a way to capture maternal experiences relationally as well as chronologically. With regards to the latter and in line with Bronfenbrenner's *chronosystem* (Bronfenbrenner, 1994), we were interested in understanding how historical context (i.e., the war in Northern Sri Lanka) and individual life events (i.e., becoming a mother) impact participants' wellbeing and parenting practices. RAs conducted interviews in Tamil. Interviews lasted approximately 1 h.

2.6. Data collection

Data collection took place from July to August 2024. Prior to commencing data collection, RAs in Sri Lanka received training in interview techniques, ethical research practices, data management, and addressing challenging situations with participants through a hybrid (i.e., virtual and in-person attendance) workshop held in May and June 2024. RAs were also introduced to Bronfenbrenner's theoretical framework and were encouraged to consider the experience of participants across the lifespan and how participant interaction with multiple systems (e.g., family, community) may impact their well-being. Training was provided by TMU researchers and led by the Principal Investigator (PI) of the study (FCT). Following training, a pilot study was conducted in the Jaffna district with four participants. The purpose of the pilot study was to identify and address emerging challenges, revise the interview guide, and allow RAs to familiarize themselves with the interview process.

2.7. Safety protocol

To ensure the ethical and safe conduct of the study, a comprehensive safety protocol was developed and implemented. RAs received remote training from FCT on conducting interviews with vulnerable populations, recognizing self and participant distress, and initiating appropriate referrals. Training included role plays and behavioral rehearsal (Beidas et al., 2014), emphasizing skills for addressing safety-related concerns such as suicide, intimate partner violence, and abuse. The safety protocol was co-developed with healthcare professionals in Northern Sri Lanka, and detailed a locally grounded, step-by-step procedure for risk assessment and referral. Sample safety-related interview questions were collaboratively designed with local partners and incorporated into a training manual designed for the RAs. Regular supervision was provided by FCT through virtual check-ins and daily availability via secure messaging platforms.

During interviews, if emotional distress or imminent safety concerns (e.g., risk of self-harm or suicide) arose, RAs followed a structured response protocol, including contacting an on-call psychiatrist, remaining with the participant until professional care was secured, and providing access to formal mental health services. A core team, comprising the PI (clinical psychologist) and co-investigators (Sri Lanka-based psychiatrist and two North American-based clinical psychologists), reviewed all high-risk incidents, ensured tailored follow-up, and continually revised the protocol as needed. This team also maintained a clear communication and debriefing process to support RA well-being and ensure responsive, ethical research practices.

2.8. Interview procedure

The interview procedure was designed to ensure data integrity and both participant and RA safety. Two RAs were assigned to conduct each interview: one as the interviewer and the other as a notetaker. This dual role structure allowed for more nuanced and contextual notes while enabling the interviewer RA to focus entirely on conducting the interview. With consent, each interview was audio-recorded to maintain the

fidelity of responses at the transcription stage. RAs completed a field diary after each interview which included their personal reflections on the interview process and dynamics. These diaries were a valuable tool as part of ongoing group reflection and discussion during supervision and helped with identifying any safety concerns. RAs securely uploaded the audio recordings to a shared, encrypted folder at the end of the data collection session. A designated TMU RA verified the recordings and made a backup copy. Original files were deleted from the audio recorder. Completed consent forms and paper questionnaires were scanned and securely uploaded to the shared drive, with the original stored in a secure location with a co-investigator in Sri Lanka.

Interviews were first transcribed verbatim in Tamil and then translated to English. English transcripts were further verified against the Tamil version by two bilingual RAs, based in Toronto, Canada. Both Tamil and English transcripts were retained for the current project and future secondary analysis to increase access to primary language data.

3. Analysis

3.1. Quantitative data analysis

Descriptive statistics were computed to describe the sample's socio-demographic information. The analyses were conducted using the R software (R Core Team, 2023).

3.2. Qualitative data analysis

Codebook thematic analysis, specifically Template Analysis, was conducted on transcripts translated to English (Brooks et al., 2014; King, 1998, 2012). Analysis was grounded in a social constructionist theoretical stance, with the primary goal of exploring how mothers experience and make meaning of parenting, in light of early adversity and the current post-conflict context. We were interested in both patterns across participants and unique, low-frequency elements that are significant in how they relate to or differ from emerging themes (Creswell and Creswell, 2018).

As a first step, an analysis team was established comprising the PI (FCT) and four RAs based at TMU University (BG, KM, ONHK, and PKP). These RAs were located in Ontario and were not involved in data collection. Efforts were made to include the RAs based in Sri Lanka in the analysis phase; however, they were unavailable during this stage of the study. Next, BG and ONHK organized and prepared the data for analysis. This involved reviewing the transcripts for completion, updating the master database with relevant details (i.e., participant ID, length of interview, location of interview, demographic details) and preparing the data for analysis in Dedoose, a mixed-method software management program (Dedoose, 2024, Version 9.2.22). BG, ONHK, and FCT reviewed all transcripts as they were translated to English and clarified ambiguities in the transcripts with the transcriptionists in Sri Lanka and Ontario. This process also enabled us to gain familiarity with the data, repeatedly reading transcripts and noting down initial patterns and ideas. At this stage, we highlighted text, made memos, and took notes that contributed to our broader understanding of participant experiences.

Step two of Template Analysis entailed preliminary coding of the data. In Template Analysis, *a priori* themes are permissible, although used tentatively in developing a template codebook (Brooks et al., 2014). The codebook from the PI's previous work in Sri Lanka (2022b) was used as a conceptual guide. However, inductive analysis allowed for the coding team to produce novel descriptors from the data (Creswell and Creswell, 2018). Based on familiarity with the dataset from step one, several themes from FCT's previous codebook were eliminated as they did not apply in this study (e.g., themes related to coping mechanisms).

Using the remaining *a priori* defined themes, BG, ONHK, and FCT reviewed a set of six transcripts in-depth. The three coders independently applied the *a priori* themes where relevant and independently generated a provisional set of codes based on analysis of the six transcripts. They discussed how their coding diverged or aligned, as well as the meaning of certain codes. Step three involved organizing codes into meaningful clusters (Brooks et al., 2014; King, 2012). Emphasis was placed on the *significance* and interrelationships between codes, rather than the *frequency* of codes (Creswell and Creswell, 2018). Following a Template Analysis approach, descriptive and interpretive codes were generated (King, 2004). We discussed our initial impressions, drawing from an inductive approach grounded in the transcripts, as well as from our theoretical stance as articulated previously, the scholarly literature, and personal experiences (Frohard-Dourlent et al., 2020). In step four, a preliminary template codebook was developed based on coding team discussions, including definitions for each code, along with examples of exemplar quotes from coded transcripts. By the end of this process, the only codes retained from the *a priori* codebook (Thomas et al., 2022b) was related to daily stressors. These were later subsumed under the broader code of "cumulative adverse events", which better captured the experiences of participants in the current study.

As is typical in Template Analysis, this preliminary version of the template codebook was developed based on analysis of a subset of the data; it was revised and modified as the initial template codebook was applied to the remaining dataset in step five (Brooks et al., 2014; King, 2012). Specifically, the larger analysis team (BG, KM, ONHK, PKP, and FCT) coded an additional five transcripts using the preliminary template codebook (one transcript each). The template codebook was finalized using these 11 transcripts (six from round 1 of coding and five from round 2). The coding team used this final template codebook to code remaining transcripts in Dedoose. The template codebook thus served as a tool to guide data coding (Braun and Clarke, 2022). The template codebook was adjusted as needed during analysis meetings, with the recognition that the codebook remains *provisional* even once analysis is complete (Braun and Clarke, 2022). Once all transcripts were coded, BG categorized excerpts from each transcript under their respective code. The analysis team reviewed these excerpts and sorted codes into relevant themes. Discrepancies were resolved through discussions to ensure consistency and previously-coded transcripts were re-coded accordingly. This process deepened our understanding of the themes, their interconnections, and the overarching narrative presented below. While initial themes were collaboratively identified with the analysis team, FCT conducted further iterative review of the data to refine, define, and name the final themes. Final theme names and content were subsequently reviewed and adjusted in collaboration with co-authors to ensure contextual relevance and resonance.

With regard to the theoretical lens, RAs were familiar with ecological systems theory (Bronfenbrenner, 1986; Bronfenbrenner and Morris, 2006) and discussions and reflections on codes often centered on their relation to the various systems and networks (e.g., family, community, broader society) that impact on maternal well-being.

Throughout the analysis process, the coding team engaged in a reflexive process, documenting individual reflections during transcript review and collaboratively discussing these insights in weekly meetings. This process also involved discussing the relation between codes, life history of participants, as well as how our social location and identities influenced the selection of codes. This approach was integral to acknowledging the contextual and situated nature of meaning-making, as well as the inherent subjectivity informed by our respective social locations. Inherently, our approach was grounded in an ecological systems approach to analysis by way of factoring in various systems and the interaction between them.

4. Results

4.1. Sample

Thirty-four women were recruited, with a mean age of 31 years old (see Table 1). All participants reported receiving some level of formal

education, ranging from grade 1 to postsecondary education, with the majority completing their General Certificate of Ordinary Levels (41.2 %). The majority of the sample was unemployed (76.5 %) and all were married (see Table 2).

We identified four main themes to capture participants' experiences of early life adversity and how those experiences impact their current parenting practices. The first, *guided by roots*, exemplifies intergenerational values, respect for parental figures, and the transmission of parenting lessons. This theme was prominent and serves as the foundational lens through which parenting is interpreted. The second theme, *the uneven village: parenting with and without* support, explored the spectrum of support experienced by mothers, from large, multifaceted support systems to experiences of deep isolation. The third theme, *parenting on display*, focuses on the distinction between safety-driven parenting and performance-driven parenting. The final theme, e*nduring struggles, intentional parenting*, emphasizes the interplay between cumulative and enduring stressors, emotional self-regulation, and parenting intentions.

4.1.1. *Guided by roots: parenting values across generations*

Participants expressed a strong desire to emulate their parents in parenting, often highlighting their appreciation for what their parents taught them and endured to protect them during the conflict. Many mothers noted their appreciation for their own mothers grew with age, especially after becoming parents themselves: "We don't realize what our mothers do for us when we are with them. It's only after we become mothers ourselves that we understand we should do these things and raise our children in the same way" (24 years old, mother of one child).

As participants reflected on their own upbringing, several interviewees shared the challenges they encountered in childhood and discussed the importance of teaching their children about adversity. For some participants who continue to encounter chronic stressors, such as financial strain, they described the value of being able to teach their children life lessons about navigating difficult circumstances learned from their own parents. As one participant noted,

> We face a lot of challenges while raising our child, for example, we struggle to provide good food. During a nice festival … it is difficult to buy new clothes for our son. But we borrow money from others to buy clothes. I am raising my child by showing the difficulties of life like how my mother raised me. I have not raised my child in such a way that he throws a tantrum to get what he wants. I am happy that my child can understand the difficulties of life because in his future, he can understand the value of us. Same way, he will also raise his children … I give him the available food, and tell him that we should eat for hunger, not for taste … We are able to understand life's conditions because we have been through so much in our childhood. Similarly, we too endeavour to raise our child. (35 years old, mother of one child)

Another participant shared,

> If we made any mistakes, they [parents] didn't punish us; instead, they corrected us with love and taught us. They showed us their struggle to earn money because giving a child too much money can lead them down a bad path. By demonstrating their struggles and explaining that they couldn't always afford things, they provided us with valuable life lessons … Because we were raised in financial difficulty, we know how to raise our child. (34 years old, mother of one child)

This theme captures how mothers draw on their own upbringing to guide their parenting, often expressing a deepened appreciation for their parents' sacrifices. Although most participants described a desire to carry forward these values, their experiences of social support in doing so were more variable.

Table 1
Participant demographic.

	Mean	SD	Min	Max
Age	31.00	3.77	24	39
Monthly household income (LKR)	38352.94 (131.73 USD)	10425.60 (35.81 USD)	15000 (51.52 USD)	100000 (343.47 USD)
Months of pregnancy	6.62	2.12	2	9
Number of children	1.35	0.49	1	2

Table 2
Participant education and employment.

Variable	Categories	n	Percent
Education	Not had formal school education	0	0.0
	From grade 1 to grade 5	1	2.9
	From grade 6 to O/Ls	7	20.6
	Passed O/Ls	14	41.2
	Up to A/Ls or passed A/L	8	23.5
	University or higher	3	8.8
	Prefer not to Specify	0	0.0
	NA	1	2.9
Employment status	unemployed	26	76.5
	employed	6	17.6
	NA	2	5.9

4.1.2. *The uneven village: parenting with and without support*

Similar to findings from Thomas and colleagues (2022b), participants in this sample described changes to their family systems. In the current study, a dichotomous pattern was identified, such that participants described either having access to multiple sources of support or being significantly isolated.

4.1.2.1. Anchored in support. Some participants shared that they felt well-supported and had sufficient help from loved ones, such as their parents, in-laws, and/or husbands. One participant described the support she received during both the postpartum period and her current circumstances:

> My mother, elder brother, and my husband; all of them provided support … No one allowed me to do any work [laughs]. My mother-in-law and husband did everything … My mother is with me, which is very helpful as she does almost all the work. I only need to do the remaining tasks. My husband also helps with household chores like sweeping and washing the baby's clothes. If I am ill, he will do everything. (31 years old, mother of one child)

Several mentioned their husbands assisting with domestic tasks like cooking and laundry. As noted by one participant:

> More than anyone else, my husband cares for me. My mother, my sister … they go to
>
> work right? It's not that they don't take care of me … they do … but, my husband is the one
>
> who washed my clothes and cooked for me. (25 years old, mother of one child)

Another mother shared, "We both actively participate in parenting our child. My husband bathes her because I am pregnant. I dress her and take her to school, then come home to cook". 25 years old, mother of one child).

4.1.2.2. Alone in the modern family

> On the other hand, several participants lamented the loss of extended family and larger systems of support, often as a result of relocating

after marriage. Mothers shared how family structures have changed between generations:

I grew up in an extended family, so if my parents scolded me, my grandmother would

protect and take care of me. But nowadays, it's totally different. We're living in a nuclear

family, so it's difficult for a mother to manage everything on her own. That's something I

miss.(31 years old, mother of one child)

These mothers not only suffered from the lack of extended family support, but were unable to obtain support from their husbands or others in the community. One mother's words exemplified this difficult experience. This participant was raised by adoptive parents. She also experienced adversity in several other ways, including displacement in childhood, and loss of her first child shortly after delivery:

… he [husband] doesn't comfort me in that way … I don't have any friends. All of them

are married and settled in various areas … No one was there to help. It was just me. I felt like I had to do it all myself … I don't have any brothers or sisters to support me. The people who raised me were not my relatives (voice trembling) … There wasn't much help from their [husband's] side either … Yes, I do expect it [help], but I don't get it … I think that since he also works hard during the day, he's tired like me … He is working as a daily wager, which is hard to manage.(29 years old, mother of two children)

This participant's experience highlights the significant isolation some mothers encounter and the adversity that continues into the parenting dynamic between generations.

As emphasized by another participant:

Raising children wasn't considered too difficult back then. Now, it's different; we constantly have to keep an eye on the children. Back then, everyone lived together as a joint family. My mother raised nine children, but I'm not sure if it felt like a big struggle. If she could provide food, that was enough. Clothes for the children and managing things were part of it. Now, raising even one child feels challenging. We're struggling. (29 years old, mother of two children)

The strain was amplified for those with multiple children and in the workforce:

With the second child, it was even harder because I was at home by myself, so I had to do all the work, go to my job, and take care of the children. I don't have the time to talk that much with neighbours. Since I'm alone at home, I have to cook after I come back from work. Besides that, she [my daughter] is in grade 2, so I need to spend time teaching her. Also, food - I need to give food to the two of them and hand-feed them … I also need to cook for him. After doing all that, again the next morning, the same challenge. Getting them ready for school, showering them, doing everything, and giving them food.I also pack my lunch and need to go to work. (31 years old, mother of two children)

The increased caregiving burden on mothers has resulted in reduced time to connect with neighbours, especially when moving to new neighborhoods.

I don't have much interaction with neighbours. We moved here after I delivered my first baby, so it was difficult to visit the neighbours' houses with my child. As a result, I didn't go anywhere. I only visited a neighbour's aunt's house a few times, mainly to ask for advice if my son was ill during his early years. Other than that, I didn't have many contacts. However, after I enrolled my son in nursery school, I got to know some people. Before that, I didn't really know anyone at all. (31 years old, mother of one child)

Another participant shared how this would be different if they still lived as an extended family:

I don't have relatives or known people as neighbours to ask for help. If I were in my

village, my siblings or at least someone I know would be nearby. If it were difficult for

me to pick up my son, I could ask my relatives, and they would help. But the situation

here is different. I have to go myself, whether I can or not. (34 years old, mother of one

child)

4.2. Compounding loss and vulnerability

Finally, a subset of participants in our sample were particularly impacted by early life experiences, current chronic stressors, and isolation. These were women who lost their own parents at a young age, were forcibly recruited to fight with the armed forces, and/or experienced pregnancy loss, loss of their infant, or had children with disabilities. In the face of such significant early life trauma and profound current stressors, participants described a severe lack of support.

The mother quoted below is an individual who lost her own mother at a young age. She shared that she joined the armed forces as an adolescent because of difficulties in her childhood home. Currently, she experiences several stressors including caregiving burden, interpersonal violence, and raising two children with disabilities:

Oh, yes [I went to work soon after my children were born] ….I brought them [my children] with me. If there was someone at my workplace, I would get help from them to take care of my child while I worked. If no one was available, I would keep my child under a tree while I worked … I don't have enough time to spend with my child, which is my most challenging problem. At the same time, I need to work to pay off a lot of loans. My husband also continues to drink. Sometimes he seems okay, but other times he gets drunk and fights with me. (35 years old, mother of two children)

Another mother described the difficulties of infant loss and feeling unsupported following that tragic experience: "My child passed away 4 days after birth due to a heart problem. After that, there was no one to take care of me. Then, my adoptive parents came … (crying)" (29 years old, mother of two children).

4.2.1. Parenting on display: Guarded communities and social pressures

Isolation is compounded by fragmented trust in the community. Parenting behaviours were influenced by safety concerns, especially for daughters, and social pressures particularly related to educational accomplishments.

4.2.1.1. Protective parenting in an age of eroded trust. Safety concerns were often cited as a reason for minimizing interactions with community members. One participant shared: "When we were young, our mother didn't come to school with us … we would walk to school. From grade one, we walked there … But now, it's not like that. We go everywhere with the children" (29 years old, mother of two children).

Another mother shared a similar sentiment:

When we were children, my husband and I played with children in our neighbours' houses. But now everyone only lets their children play inside their houses … In the current situation, parents won't let anyone go out. The children only get to meet their friends at school

> … If the child is a girl … even I don't let her go out. 'Sit with me, play with me, okay? I will come with you' That's what I tell her. Letting her go out by herself makes me scared. Back then, we didn't play like the kids do today; we wandered around freely. Nowadays … we don't allow our children the same freedom … we can't trust anyone, so we need to keep our children with us while they are playing. In our house, my eldest son, it started at that time. We don't let him go out [because I am]scared. Some people say that others might capture our child, some say if it is a girl there's a different type of problem so we can't trust and let them go out. So with us, we tell him to "play here, play here" alone. They're growing up alone. That is something impacting this generation of children. (29 years old, mother of three children (one deceased)).

Concerns were particularly high for protecting daughters: "As I am a working lady, it is difficult to reserve time for my daughter … because it's important nowadays to teach her the facts of this society like sexual abuse. I need to save my daughter from such things" (28 years old, mother of one child).

4.2.1.2. Society's parenting lens. Parenting behaviours were shaped, in many cases, by social pressures. Some mothers described the emphasis on teaching resilience, and the influence of community perceptions on parenting approaches. This was described as particularly important for those who identified as facing financial challenges:

> You should be disciplined. As we were raised in difficult times, we were shown it growing up and were told that we should be disciplined. In a poor family, if a mistake happens, it can quickly spread throughout society. However, if the same mistake occurs in a wealthy family, it often stays hidden. That's why we need to be careful. We may face financial difficulties, but we must remain disciplined and not allow others to speak poorly of us. (34 years old, mother of one child)

A commonly cited example regarding the weight of perception was related to education. Several participants described the repeated interruptions to their education as a result of the conflict and displacement. Subsequently, they placed emphasis on educational opportunities as a means of ensuring their child's future success. As one participant noted, "Due to the war we weren't able to study and make our life better. My children have to study well, then only they can be stable in financial aspects" (32 years old, mother of one child). Stated by another participant, "I want my child to be a good person in society, to eventually learn a skill and get a good job. These days, the main focus is on how to educate the child, and that's the priority" (29 years old, mother of two children).

The emphasis on education created other pressures on parents:

> It's not a competition between a child and a child, but rather a competition between a mother and a mother. Before, my parents came to my school and checked only my report card, not any other child's report. Now, they get their children's book and their neighbour's child's book as well. Why do they care about the other child's mistakes? (29 years old, mother of two children)

4.3. Intentional parenting through silent struggles

Participants described navigating a complex web of early life and ongoing stressors, including caregiving challenges, safety concerns, material hardship, and health-concerns (of self and family). These cumulative stressors shaped their parenting in both subtle and profound ways, yet a prevailing theme was one of resilience and a commitment to breaking cycles of adversity.

Many mothers conveyed a forward-focused determination to shield their children from the burdens they themselves carried. One participant reflected:

> I have faced multiple challenges, including my children not having anyone else [other family members] to help them. And, our financial difficulties are also something that affects me deeply. But, I won't show that feeling to my child. I have made the decision that our experiences, no matter how bad they are, shouldn't be passed on to the kids … the hard times should end with us. (35 years old, mother of one child)

Although some mothers openly acknowledged the weight of their past and present experiences, others downplayed their hardship, suggesting a normalization of adversity. As one participant stated, "We saw people die from the shell bomb attacks, which caused some fear, but other than that, nothing much" (35 years old, mother of two children). Another noted, "My husband and I were separated for 2 years … after that, my husband returned to us … it was fine and not that difficult [when we were separated]" (32 years old, mother of two children).

Despite these hardships, mothers consistently emphasized their parenting values and the emotional regulation required to uphold them. Most expressed a preference for nurturing, supportive approaches over physical discipline. One mother shared, "Even if I get angry, I will control that and I will lift him up, make him sit on my lap and advise him not to do that" (31 years old, mother of one child). Another emphasized the importance of raising children with love and autonomy: "We can raise children with love, but excessive control can hinder their development … if we frequently hit our children for minor mistakes, they may feel discouraged. It is better to raise children without physical punishment" (25 years old, mother of one child).

However, the emotional toll of unaddressed stress and limited support often surfaced in moments of parenting conflict. Several mothers described feeling overwhelmed and reactive, especially when lacking familial or community support. As shared by one participant,

> I feel irritable and get angry easily … My son is still quite young, and when I scold him, he will sit alone, feeling upset with me … Since my mother and family live far away, I've learned to handle things on my own. (31 years old, mother of one child)

The same participant described relying on silence or fear to manage misbehaviour:

> I often feel angry because he [son] doesn't listen to me … I'll talk about my unborn child and say that I'll go alone with the baby, leaving him with his father. I tell him that if he wants his mother, he shouldn't behave this way.

Another participant shared:

> I feel angry [when my daughter misbehaves]. But, if she is stubborn, I won't talk to her for a while … She knows that I'm angry so she doesn't talk … It is difficult, but I won't speak. After that, she will come and say sorry.(29 years old, mother of one child)

Taken together, these narratives reveal the emotional complexity of parenting under pressure where enduring hardship, emotional regulation, and the desire to raise well-adjusted children coexist in a dynamic and often difficult balancing act.

5. Discussion

The aim of this study was to explore the relationship between early adverse experiences, maternal mental health, and perceived impacts on parenting for women who are now mothers in Northern Sri Lanka. Findings from this study highlight the long history of early adversity and its impact on maternal mental health in this post-conflict context. The following themes were prominent in the qualitative analysis: the importance of parenting values across generations, shifting family systems and increased caregiver burden for mothers facing isolation, and parenting styles influenced by social pressures and safety concerns. The data include poignant testimonies of adversity and resilience in

parenting in post-conflict Northern Sri Lanka.

In line with other ecological models (Miller and Rasco, 2004; Miller and Rasmussen, 2024; Murphy et al., 2023), our findings show that multilayered stressors affect maternal mental health and caregiving in post-conflict settings. Participants described several cumulative adversities, including displacement, loss and educational disruptions. While these have been explored in previous studies (e.g., Jayawickreme et al., 2017, Thomas et al., 2022a,b), the current study focused on the impact of early adversity and chronic stressors on parenting.

Exemplifying the interconnection between *societal*, *interpersonal*, and *individual* layers of socio-ecological frameworks (e.g., Murphy et al., 2023), participants described the juxtaposition between honouring tradition and striving for change. In particular, mothers expressed a strong desire to break cycles of punitive parenting, reflecting shifting norms toward more nurturing, authoritative approaches. Mothers described a clear preference for parenting strategies that were both nurturing and firm, which they saw as important for raising children who are confident and of "good heart." This perspective aligns with attachment theory, particularly the concept of parents serving as a secure base (Bowlby, 1988; Imran and Jackson, 2022). Their parenting values were often informed by both admiration for their own parents and a desire to improve upon the punitive experiences of their childhood. This dual orientation illustrates a complex and emotionally nuanced commitment to uphold generational values while moving toward more emotionally responsive parenting.

However, this ideal was difficult to sustain in practice. Under stress, mothers described resorting to harsher discipline strategies such as yelling, silencing interactions, or threatening abandonment, actions that were often contrary to their stated values. This mismatch, or discrepant discipline (Rhoades et al., 2017), illustrates how heightened emotional arousal, particularly anger and irritability, can narrow attentional focus and reduce a caregiver's ability to attune to their child and respond with consistency (Dix, 1991). In these moments, caregiving decisions appeared driven more by efforts to regulate maternal distress (i.e., negative urgency; Cyders et al., 2014) than by long-term parenting goals. This pattern is not unique to Sri Lanka. Research in conflict-affected contexts, such as among Syrian parents displaced to Lebanon, has found increased reliance on harsh discipline and a reduction in positive parent-child interactions in the face of situational stress (Sim et al., 2018).

Explosive anger has been identified as a common and persistent psychological reaction among survivors of mass conflict and is particularly relevant in post-conflict caregiving contexts. In Timor-Leste, longitudinal research by Silove and colleagues (2017) found that 50 % of individuals who reported explosive anger at baseline continued to experience it six years later, and one-third who had not initially reported it went on to develop it. This trajectory was more likely among women, younger individuals, and those with high trauma exposure, and was strongly associated with a cumulative sense of injustice. Notably, explosive anger was linked to impairment in daily functioning and increased conflict within intimate and family relationships highlighting its potential to disrupt caregiving. Complementary findings from a separate study with pregnant and postpartum women in Timor-Leste (Silove et al., 2015) revealed similarly high levels of explosive anger (nearly 50 %), particularly among those facing ongoing adversity, intimate partner violence (IPV), unemployment, and lower education. The frequency of anger episodes was associated with greater functional impairment.

Taken together, these findings echo the experiences of mothers in the current study, who, though not always naming anger explicitly, often described overwhelming irritability and emotional intensity in parenting. These reactions likely reflect the emotional aftermath of prolonged trauma, gendered burdens, and a profound sense of injustice along with a range of chronic stressors, underscoring the need for parenting and mental health interventions that acknowledge and address explosive anger as a long-term consequence of conflict.

As several socio-ecological frameworks (Miller and Rasco, 2004; Miller and Rasmussen, 2024; Murphy et al., 2023) emphasize, societal-level drivers, such as entrenched gender norms, economic marginalization, and the shifting expectations of motherhood, exert a powerful influence on parenting. Participants' narratives reflected this tension: while they aspired to parent with warmth and stability, their daily lives were shaped by systemic constraints that limited their emotional and practical resources. These findings highlight the importance of supporting mothers not only at the individual level but through structural and societal interventions that address the broader context of caregiving (Bond and Guzder, 2023).

At the community level, mothers described the collapse of traditional social and caregiving networks that had once been foundational to emotional well-being and practical support. Extended family members and neighbours had historically played an integral role in raising children and buffering the burdens of caregiving, but post-conflict transformations have altered these relational landscapes. The shift toward nuclear family structures in Northern Sri Lanka has coincided with a broader erosion of community cohesion, amplifying maternal isolation and parenting stress.

Participants shared that they often struggled to connect with neighbours, citing time constraints, daily survival pressures, and, notably, heightened vigilance, particularly regarding the safety of their daughters. Protective parenting was frequently framed not only as a personal instinct but as a response to broader social threats. Several mothers spoke of teaching their daughters to be cautious around others, reflecting a fear of sexual violence that has been shaped by past trauma and present insecurity. These fears are not unfounded: 13 % of the Sri Lankan population experienced sexual assault during the war (Traunmüller et al., 2019), with Tamil women disproportionately affected (UN HRC, 2015; Wood, 2006). As in other conflict-affected settings, the breakdown of institutional and social protections has been linked to increased exposure to sexual violence (Plümper and Neumeyer, 2006).

Murphy et al.'s (2023) Socio-Ecological Framework for Drivers of Conflict and Post-Conflict Violence Against Women and Girls (VAWG) offers a particularly relevant lens through which to understand these accounts. The framework conceptualizes violence as shaped by multiple, interacting forces across global, societal, institutional, community, interpersonal, and individual levels. Critically, it draws attention to both longstanding structural conditions - such as entrenched gender norms, economic marginalization, and institutional neglect as well as conflict-exacerbated or emergent factors, including militarization, displacement, and the erosion of social cohesion.

The stories shared by mothers in this study align closely with these dynamics, especially at the *community level,* where the collapse of trust and social networks contributes to heightened parenting stress and protective behaviors. Participants' concerns for their daughters' safety, shaped by lived experience and collective memory, exemplify how conflict reshapes social environments in ways that intensify gendered vulnerability and redefine caregiving roles. In this way, the framework not only helps situate individual narratives within a broader sociopolitical ecology but also underscores the importance of addressing multiple, intersecting drivers of violence and distress in post-conflict parenting interventions.

In this context, community loss extends beyond logistical challenges to a more profound sense of social fragmentation and distrust. For many mothers, the emotional and practical support once provided by extended family and community is now diminished or absent. While some participants expressed a strong desire to replicate the nurturing parenting styles of their own parents, this aspiration was often at odds with their present reality, marked by the weight of solo caregiving, diminished communal reciprocity, and intensified protective instincts.

In our findings, the erosion of community cohesion and the loss of collective efficacy - the shared belief in a community's ability to act together for common goals - were particularly salient. As community

cohesion diminishes in the aftermath of conflict, mothers experienced heightened isolation, which compounded their parenting stress. This aligns with the concept of collective efficacy, which, according to Somasundaram and Sivayokan (2013), plays a protective role in mitigating the negative effects of daily stressors.

This loss of communal infrastructure undermines a critical protective factor in childrearing. Social support has been shown to play a vital role in promoting caregiver emotional regulation, buffering the effects of stress, and reducing the risk of harsh or neglectful parenting (Tracy et al., 2018; Tucker and Rodriguez, 2014). In the absence of these protective community networks, the psychological and emotional load borne by mothers increases, further straining their ability to parent in alignment with their values.

These findings underscore the urgency of strengthening collective systems of support as part of any intervention. In post-conflict settings like Northern Sri Lanka, where social trust and networks have been eroded, community-based programs must not only address individual mental health but also rebuild the social fabric that supports caregiving. Protective parenting should be understood within this broader ecology - one that is marked by historical trauma, insecurity, and shifting norms around family and community life.

5.1. Limitations

Biases in data collection may exist. We used snowball sampling because of challenges with recruitment. Snowball sampling may result in sampling bias, as participants may have shared views with others in their social networks (Kirchherr and Charles, 2018). To circumvent biases inherent in snowball sampling approaches, RAs recruited participants more broadly from antenatal clinics and NGOs who serve families. Relatedly, all interviews were conducted at a single time point, which may not have allowed sufficient opportunity to build rapport and foster the level of trust needed for participants to openly share aspects of their daily lives.

Relatedly, it is important to acknowledge the concept of a *culture of silence*, a learned defense mechanism wherein individuals withhold their true feelings or experiences out of fear of stigma, reprisal, or social disruption (Crotty, 1998; Taussig, 1984). In Sri Lanka, this tendency has been documented in post-conflict settings, particularly in relation to trauma, political violence, and family matters (Thomas et al., 2022b). This was evident during interviews, as some participants appeared to share only what felt safe or socially acceptable, a pattern that aligns with observations from clinical work in the Northern Province (Sivayokan and Somasundaram, 2014).

However, the dynamic was not uniform. Although IPV and gender-based violence (GBV) were not a focus of the current study, the topics were frequently mentioned in broader conversations during field visits by RA2, including meetings with NGO staff, clinicians, and community members. Yet, only one participant in our sample explicitly disclosed experiences of IPV. Instead, several participants in our sample described their husbands as highly supportive and as taking on roles of caregiving and as a substitute for the lost community. This discrepancy raises the possibility that individuals may have felt more comfortable disclosing certain experiences to an outsider (e.g., RA2) rather than to local RAs who were from the Northern Province. In this sense, while the culture of silence may inhibit openness, the presence of a perceived outsider might have created a relational space where certain truths could be more safely expressed.

This highlights a critical methodological consideration: while working with local RAs is invaluable for culturally grounded engagement, language fluency, and trust-building, it may also inadvertently constrain disclosure particularly when discussing stigmatized topics. Future research with similarly vulnerable or conflict-affected populations should carefully weigh these dynamics, striving to create a relational space that both honours local knowledge and allows for the safe expression of difficult truths. Mixed research teams, reflexive interviewer training, and thoughtful interviewer-participant matching may help navigate this complex terrain.

Another important limitation of this study is that we did not explicitly ask participants about their socio-cultural context or previous roles (e.g., involvement in conflict or loss of children), which could have provided deeper insight into the ways these factors might influence psychological outcomes and social relationships. While some participants spontaneously shared such experiences, we did not conduct a systematic analysis of these past roles. Future research should consider explicitly exploring the impact of these factors on mothers' mental health and parenting in post-conflict settings.

Lastly, a limitation of this study is the use of Template Analysis, which carries a risk of analytic foreclosure due to the use of *a priori* codes and themes developed early in the process (Braun and Clarke, 2022). To mitigate this, the research team remained open to new patterns by iteratively refining the template codebook throughout the analysis. Additionally, all researchers involved in the analysis process engaged in critical self-reflection, which was further discussed in research team meetings. This enabled us to remain open to participant narratives, while checking in with our own perceptions and social location to examine how our vantage points might influence the analysis (e.g., overly empathic stance for some; limited contextual knowledge for others). Although Template Analysis may limit full inductive discovery, it offers a practical and structured entry point for an applied research team with varied levels of qualitative research experience.

6. Conclusion

Despite these limitations, the current study offers a strong foundation for understanding maternal mental health and parenting within a post-conflict context. By focusing on the experiences of mothers in Northern Sri Lanka, this research contributes to an underexplored area of study, offering valuable insights into the unique challenges faced by mothers who have endured histories of adversity. The findings underscore the importance of country-specific programming and policies that offer tailored, culturally sensitive interventions starting prenatally and informed by an assessment of maternal risk.

Aligned with Creswell's approach to qualitative research, which emphasizes in-depth, contextualized exploration of a central phenomenon (Creswell, 2005), this study was designed to provide a richer understanding of the experiences of mothers living in post-conflict Northern Sri Lanka. This research has illuminated the generational impacts of trauma and the ways in which these experiences shape maternal mental health and parenting in Northern Sri Lanka. As such, the study contributes to the growing body of literature that applies socio-ecological frameworks to post-conflict situations, demonstrating strong resonances between participant stories and existing research in this field.

CRediT authorship contribution statement

Fiona C. Thomas: Writing – review & editing, Writing – original draft, Validation, Supervision, Software, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization. **Katherine McGuire:** Writing – review & editing, Writing – original draft, Project administration, Formal analysis. **Ophélie Ng Ha Kwong:** Writing – review & editing, Writing – original draft, Project administration, Formal analysis. **Puneet K. Parmar:** Writing – review & editing, Writing – original draft, Project administration, Formal analysis. **Bee Goldgruber:** Writing – review & editing, Project administration, Formal analysis. **Shannon Doherty:** Writing – review & editing, Supervision, Formal analysis, Conceptualization. **Nuwan Jayawickreme:** Writing – review & editing, Project administration, Methodology, Conceptualization. **Karen Milligan:** Writing – review & editing, Writing – original draft, Methodology, Investigation, Conceptualization. **Giselle Dass:** Writing – review & editing, Project

administration, Data curation, Conceptualization. **Sambasivamoorthy Sivayokan:** Writing – review & editing, Supervision, Resources, Project administration, Methodology, Investigation, Data curation, Conceptualization. **Rajendra Surenthirakumaran:** Writing – review & editing, Supervision, Resources, Project administration, Investigation, Conceptualization.

Declaration of competing interest

None.

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