

# **Research Report Dossier**

**The Maternal Experience**

**of having a Child**

**with Night-time Sleep Difficulties**

**by**

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## **Abstract**

**Aims:** The main aim of this research was to add depth of understanding and a human voice to existing research on the maternal experience of having a child with night-time sleep difficulties. It was hoped that this increased understanding could be used by counselling psychologists, not only in their own clinical practice but also when supporting physical health practitioners who have direct contact with this client group.

**Method:** Five semi-structured interviews were conducted with mothers who had children over the age of one who were experiencing night-time sleep difficulties. The interviews were transcribed and analysed in accordance with grounded theory methods. A constructivist version of grounded theory was utilised as outlined by Charmaz (2006).

**Analysis:** A central story line of ‘no choice but to function’ emerged. This refers to the place where these mothers found themselves after attempts to solve their child’s sleep problem had proved ineffective, and describes a state of both ‘coping’ and immense struggle. A number of categories were identified which contribute to this central storyline. A process was identified that outlined the stages that all participants moved through as they encountered and adapted to this experience. Personal Conflicts were also identified which described the experience and impact of fatigue, uncertainty and conflicting emotions. Categories of Responsibility and Isolation also emerged and were found to potentially lead to many personal needs not being met

and a lack of engagement with support (including that of health professionals).

Furthermore, a category of Coping highlighted not only the participants' reflections on how they coped but also potential future avenues of support.

**Conclusion:** The aims of this research were met with a deeper understanding of this population being obtained and a human voice being added to the existing research on this subject. Findings from this research offer a theoretical model which highlights not only the physical, emotional and systemic struggles encountered by the participants that were interviewed, but also provides suggestions based on these findings for future research and clinical practice.

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I would like to dedicate this portfolio to my husband Nick and daughter Rose. Without your love, support and patience I would not have been able to have achieved any of this.

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## **Chapter 1: Literature Review**

The search strategy used for this review was conducted using the following search terms: *maternal experience, sleep deprivation, children, mood, sleep disruption, fatigue, maternal fatigue, parental fatigue, wellbeing, mental health, child sleep problems, and, sleep.*

These terms were used to search within the following electronic databases:

PsychARTICLES, PsychINFO, ScienceDirect and Psychology and Behavioural Sciences Collection. This was accompanied by the use of internet search engines including Google Scholar. Articles found were screened for relevance and date of publication. Relevant literature from the reference lists of identified articles were also followed up. Literature was obtained through the University of Wolverhampton's Online Public Access Catalogue (OPAC).

### **1.1 Introduction**

There is increasing recognition of the importance of sleep in relation to physical, emotional and behavioural health. There has also been a growing appreciation of the importance of sleep in relation to physical health conditions, immune function and the stress response (Moller-Levet *et al.*, 2013). With sleep problems recognised as relatively common in infancy and early childhood (Blunden *et al.*, 2004), and the transition into parenthood being recognised as a potentially stressful time for parents (Armstrong, Quinn & Dadds, 1993; Medina, Lederhos & Lillis, 2009), there is surprisingly little research on the parental/maternal/paternal experience of sleep deprivation as a result of having children with sleep difficulties. For the purpose of this review, the focus will be on the maternal experience, as this is where most of the existing research lies. However the lack of research available on the paternal/parental

experience of sleep deprivation will be addressed in recommendations for future research. Areas of research that will be reviewed include: sleep and mental health, the maternal role and night-time care giving, the subjective maternal experience, maternal mood and child sleep problems, more recent research exploring fatigue and the parental experience, and the current approach to treating infant and childhood sleep difficulties. The aim of this review is to integrate this research in order to gain a greater understanding of the maternal experience of having a child with sleep problems and to highlight gaps in the literature.

### 1.2 Relationship between sleep and mental health

The effects of lack of sleep on mood have been well documented with experimental and correlational studies finding sleep deprivation to be related to strong increases in negative mood and corresponding decreases in positive mood. Anger and hostility (Selvi, Gulec, Agargun, & Besiroglu, 2007), irritability (Hou, Huangfu, Zhang, & Miao, 2007) and decreases in self-reported friendliness, elation and positive mood (Acheson, Richards & de Wit, 2007) have all been found to be related to sleep deprivation. Field studies have also supported these findings with decreases in empathic concern and increases in irritability, depressive symptomatology, and depersonalisation being observed following chronic sleep restriction in medical interns (Rosen, Gimotty, Shea, & Bellini, 2006). Furthermore, Zohar, Tzischinsky, Epstein, & Lavie (2005) found that among medical residents, sleep fragmentation and loss were significantly associated with elevated levels of negative affect in response to goal-disruptive events.

In their 2009 review, Medina, Lederhos and Lillis point out what they term to be a ‘methodological caveat’ in relation to the laboratory sleep studies that are able to make the strongest causal claims for consequences of sleep loss. It is suggested that these studies might underestimate the true impact of sleep disruption on new parents as participants were informed that they could withdraw from the study at any time as well as that the study would end within a specified time frame. In contrast, parents cannot ‘opt out’ of their experience and have no certainty about when they may have an opportunity for sufficient sleep. Literature on stress has suggested that such uncontrollability could amplify the mood and physiological consequences of sleep deprivation (Peterson, Maier, & Seligman, 1993).

### 1.3 The maternal role and night-time care giving

In a multi-disciplinary project on parents’ sleep it was found that emotional care for young children at night was largely provided by women with a lack of explicit negotiation between partners about who provides this care (Arber, Hislop & Meadows, 2006). In a national survey in the United States of more than 600 parents of school age children (National Sleep Foundation, 2004) it was found that when children in this survey woke during the night, mothers reported being the primary respondent to the child’s needs (79% of the time).

Hochschild’s (1997) research on couples has suggested that three shifts exist for women: that of daytime work (either paid employment or childcare), evening work (continuing household duties) and emotion work (thinking about the needs of their partner or children whilst undertaking their paid employment or household duties).

Venn, Arber, Meadows and Hislop (2008) propose a *fourth shift* where the initial three shifts are continued at night-time. As a consequence, women were found to be more likely to subjugate their own sleep needs to those of their family. Fathers were found in general to not undertake this fourth night-time shift and those that did were more likely to be fathers of young adult children who were staying out late at night, with the focus of their concern being on the safety of their children.

#### 1.4 The maternal experience

Investigating the maternal experience from a more subjective perspective, in *Maternal Subjectivity*, Joan Raphael-Leff (2011) writes of maternal self-esteem and conceptualisation of parenting:

westernised women often mother in isolation. Alone, having lost both intergenerational support and traditional community network, a new mother is at risk of being overpowered by the impossible expectations and emotional forces inherent in the childbearing/rearing situation

(p. 2).

Raphael-Leff continues to describe the maternal experience:

Each mother's stance is a delicately balanced compromise formation between often irreconcilable pressures of multiple internal figures and external dependants, personal desires and unconscious social forces, with constant awareness of the powerful clash between the seductive/repellent pull/push of the baby's unmet

needs (which have changed little over the millennia), and the complexity and urgency of her own (feminist) expectations

(p.3).

In her large body of work exploring the maternal experience, Raphael-Leff has 'distilled' the spectrum of maternal experience into four basic orientations: Facilitator, Regulator, Reciprocator and Conflicted (Raphael-Leff, 1986) and further large scale studies in different societies have confirmed that the underpinning beliefs and representations can be predictive of both the emotional experience of pregnancy and postnatal maternal mood, anxieties and interactive style (Scher 2001; Sharp & Bramwell 2004; Van Bussell, Spitz, & Demyttenaere, 2008). Facilitators are described as experiencing 'despair over minor lapses of maternal perfection' at times leading mothers in this group to 'anxious over-involvement and guilt-ridden depression' and crying sometimes being experienced as an 'excruciating reprimand'. Regulators are described as sharing a feeling of being exploited through pregnancy and in motherhood and often develop a strict routine that can in effect limit the amount of 'exploitation experienced'. Difficulties can be faced when the regulator does not get the break from the role of mother that she craves. Reciprocators are said to be better able to tolerate uncertainty and mixed emotions while the final group, termed conflicted are torn between maintaining an ideal of maternal perfection and rebellion against it.

Taking all four mothering styles into account, it could be hypothesised that a chronic lack of sleep as a result of having a child with sleep problems could have a profound impact on the experiences of all four groups but in different ways and for different reasons. Scher and Blumberg (1999) found a relationship between care-giving

orientation and the night waking of one year old children, finding that night waking was more frequent among first born babies of facilitators compared with regulators. There has however, to this author's knowledge, been no research looking at the interaction between parenting styles and the experience of having a child who does not sleep. This seems to be a valuable, yet still unexplored area of research.

### 1.5 Maternal mental health and child sleep problems

Problems with normal childhood sleep behaviour are very common and create significant distress for parents (Armstrong et al, 1993). When there is a sleep problem, it has been found to have a relationship with maternal mood, significant marital disharmony (Medina et al, 2009) and to predispose to child abuse (Owens, 2005) and child injury (Owens, Fernando, & McGuinn, 2005).

There have been several field investigations that have examined the link between maternal mental health and child sleep problems, with Hiscock and Wake (2001) finding that maternal report of infant sleep problems predicted depressive symptoms. Furthermore, in a community survey, Bayer, Hiscock, Hampton and Wake (2007) found that infant sleep problems were strongly associated with poorer maternal mental health. Interestingly, research looking at mothers of chronically ill older children found that depression was entirely mediated by sleep quality with no linkage between child health status and depression once maternal sleep quality was taken into account (Meltzer & Mindell, 2006). Furthermore, marital satisfaction of new parents has also been found to be at risk when parental insomnia is experienced (Meijer & van den Wittenboer, 2007). Additional studies have found strong relationships between postpartum depression and maternal sleep disturbance (Armstrong, Van Haeringen, Dadds & Cash, 1998; Dennis & Ross, 2005) with Ross,

Murray and Steiner (2005) suggesting that ‘reduction of sleep deprivation during the perinatal period may offer a cost-effective method for the prevention, and potentially treatment, of postpartum depression and psychosis’ (p.247).

In a pilot study that they identified as ‘one of the first to examine the relationship between children’s sleep quality, maternal sleep quality, and maternal daytime functioning in families with typically developing healthy children’ (p.71), Meltzer and Mindell (2007) had 47 mothers complete measures of sleep, depression, parenting stress, fatigue, and sleepiness. Significant differences in maternal mood and parenting stress were found between mothers of children with and without significant sleep disturbances. It was found that the quality of the children’s sleep significantly predicted the quality of maternal sleep and maternal sleep quality was found to be a significant predictor of maternal mood, stress, and fatigue. In their article they describe how results from the pilot study support the need for future research examining the relationship between child sleep disturbances and maternal daytime functioning. Meltzer and Mindell (2007) also highlight the importance of screening for and treating paediatric sleep disruptions, identifying that ‘most sleep disturbances in children are treatable’. However there is no mention of support (besides ‘treatment’ of the sleep problem) that should or could be offered to the mothers who experience low mood, stress and fatigue as a result of these sleep disturbances.

### 1.6 Parental fatigue

More recently there has been a developing research interest in parental fatigue with fatigue being characterised by a lack of physical and mental energy, increased rest requirements, lethargy and difficulty concentrating (Rychnovsky, 2004). In their

2012 study of 1276 parents of young children (aged from birth to five years), Cooklin and colleagues found factors such as poor sleep quality, limited engagement in self care behaviours, poor nutrition and exercise, inadequate social support and ineffective coping behaviours such as self-blame or avoidance to be associated with high levels of fatigue. Additionally they found fatigue to be associated with increased depression, low parental self-efficacy, anxiety and stress symptoms.

### 1.7 The parental *experience* of fatigue

The only known qualitative study, that investigates the experience of having children with sleep difficulties, focuses exclusively on the experience of fatigue (Giallo, Rose, Cooklin & McCormack, 2013). Within this study thematic analysis was used to analyse semi-structured focus group interviews of parents with children age from birth to six years. The parents who were interviewed for this study described unrelenting physical and cognitive symptoms of fatigue and its impact on daily functioning, well-being and parenting. While both mothers and fathers saw sleep deprivation as contributing to fatigue, mothers also emphasised that daily demands and limited opportunities for a break contributed to their fatigue. With regards to managing the fatigue, parents identified taking time out for self, exercise and social support as helpful, with fathers also describing work as a source of respite and having realistic expectations as important.

Giallo and colleagues' 2013 study addresses a large gap in the literature by offering a qualitative study that provides some insight into the experiences of fatigue and its impact on the lives of a group of parents. However by addressing fatigue in isolation, it fails to address the possible relationship between fatigue and other factors that have been identified as part of the experience of having a child with night-time sleep

difficulties including issues of self-blame, low parental self-efficacy and anxiety. Furthermore, while it provides a human voice and depth to illustrate the experience of parental fatigue, it remains descriptive rather than addressing the psychological factors and processes that might lie beneath the experience.

An additional limitation of the study relates to the themes found around managing fatigue. While participant suggestions such as ‘change your expectations’ and ‘absolve yourself of guilt’ would undeniably be helpful in battling fatigue for this population, they could, for many, be very difficult psychological tasks to undertake. With recent quantitative research identifying the links between fatigue and self-blame, poor coping techniques and lack of self-care, it seems that perhaps an opportunity was missed within this research to gain understanding into the possible barriers to the positive behavioural and psychological changes that are recommended.

### 1.8 The treatment of infant and childhood sleep difficulties

The majority of childhood and infant sleep difficulties (including difficulty initiating and maintaining sleep with frequent night waking) are considered to be behavioural in nature and are categorised as such in The International Classification of Sleep Disorders as Behavioural Insomnia of Childhood (American Academy of Sleep Medicine, 2005). As a result, the treatments are behavioural in approach, with parents being encouraged to change their response to the sleep difficulty (Bouton, 2004). This can involve changing bedtime routines, and usually involves some form of ‘sleep training’ method. Common sleep training methods for parents include leaving a child to initiate sleep alone while ignoring their protests (often referred to

as the ‘cry-it-out method’), ‘controlled crying/comforting’ where the parent checks their child with minimal interaction at increasingly longer intervals, and the method known as ‘camping out’ which involves parents staying with the child in their room and gradually withdrawing their presence (Mindell et al, 2006). While these methods are commonly used and successful (Mindell et al, 2006), it has been suggested that they can be difficult to adhere to (Long, 2001; St James- Roberts *et al.*, 2006). All methods, including the more gentle and interactive method of ‘camping out’, require parents to ignore their child’s protests and cries with an expectation that the parent will not comfort their child if distressed. This requires parents to withstand their child’s crying and perceived distress and to override their emotional and instinctive drives which can result in the experience being highly distressing for the parents (Mindell et al., 2006; Scher & Blumberg, 1999). In response to the difficulties experienced with traditional sleep training, Blunden (2011) presents preliminary findings from a behavioural sleep treatment programme that does not expect a parent to ignore their child’s cries. This method is similar to the camping out method but allows parents to follow their instincts and to interact with their child as they choose, so long as the interaction is gradually reduced. Results of this pilot study indicated significant improvement in sleep duration, negative sleep associations and co-sleeping in the majority of families who took part. Furthermore, all parents reported a high level of satisfaction and a preference for this method compared to previous approaches that they had tried. Further investigation into this method is recommended by Blunden due to the preliminary nature of this study. However, results indicate a possible alternative method that could be offered to parents who struggle with ignoring extended bouts of crying which often accompanies more traditional methods of sleep training.

### 1.9 Clinical implications and directions for future research

In their study, Meltzer and Mindell cite that ‘sleep disturbances in children are prevalent, with over 25% of all children having some type of sleep problem during childhood, including behavioural insomnia of childhood and obstructive sleep apnea (Blunden *et al.*, 2004). If these children are not receiving ‘treatment’ where does this leave the parents who are caring for them? The primary goal guiding this review is to shine light on a significant and common experience that has been found to lead to stress and depression but seems to have been relatively ignored by therapeutic based research.

The majority of research found on the maternal/paternal/parental experience of having an infant or child with sleep problems is quantitative in approach with only one piece of qualitative research available to illustrate this significant experience from an experiential perspective. Further qualitative research exploring this experience and the meanings that parents attach to it would be recommended in order to add depth and a human voice to the existing research.

Despite the potential impacts of fatigue on both mothers and fathers, Glazener and colleagues (1995) reported that parents rarely seek support for tiredness and fatigue. Furthermore, findings suggest that chronic sleep problems in Australian children are significantly under-reported by parents during general practice consultations despite a relatively high frequency across all age groups (Blunden *et al.* 2004). In the same study, researchers also found that medical practitioners may under-report sleep problems in children even when the issue has been raised by parents. As health practitioners have regular contact with new parents and are likely to be the first to be approached by parents of children who do not sleep through the night, it seems

relevant for them to have an awareness of the importance of assessing for sleep problems, of what this experience could be like for the parents caring for the child, and to be able to recognise signs and significance if parents are having difficulty coping psychologically. Furthermore, it seems relevant to Counselling Psychology to gain an understanding into the psychological processes that might act as barriers to parents seeking help when experiencing what have been identified as significant physical and emotional effects of fatigue.

With studies focusing on the maternal experience, very little is known about the paternal experience of having a child who does not sleep, beyond that which affects the parental relationship. However a 2010 meta-analysis (Paulson & Bazemore) did find that roughly 10% of fathers experience depression after their children are born, with sleep deprivation, strained marital relations and isolation from friends being listed as contributing causes. However the extent to which sleep deprivation plays a role in these cases remains unknown and thus this seems to be another area in need of further research.

In their 2012 study, Giallo and colleagues further highlighted the paternal experience of fatigue, finding fathers to specifically mention the impact of fatigue on their paid employment and its interference with family life. Within this study fathers also described fatigue impacting on their well-being and experience of parenting. These studies highlight the relevance in further exploring this experience from a paternal perspective.

To this author's knowledge there are also very few studies investigating the effects of having a healthy child with chronic and ongoing sleep problems. Most research seems to focus on the first six months or year of a child's life, an experience that

while difficult, is generally accepted to be relatively 'normal'. Little is known about the long-term, ongoing effects of having a child over the age of one year who does not sleep through the night. However emerging evidence suggests that fatigue is also a difficulty that is faced by parents of children during the toddler and pre-school years, with parenting stress and low parental self-efficacy being identified (Cooklin et al., 2012; Giallo, Rose, & Vittorino, 2011; Giallo *et al.*, 2012).

In their 2012 investigation into parental fatigue, Giallo and colleagues suggest that understanding the impact of fatigue on parents beyond the postnatal period and into the pre-school years is particularly important as this is a period when mothers often resume employment and may be at heightened risk of fatigue when establishing and negotiating the demands of employment, unpaid labour and childcare responsibilities. It could further be hypothesised that due to sleep difficulties being more commonly associated with infants, the added unknown and seemingly 'abnormal' nature of this (not only up to pre-school age but also beyond) could increase the uncertainty and stress experienced by parents.

Much of the above mentioned research relating to the effects of lack of sleep on maternal mood has been published in medical journals and followed a medical model approach, looking at 'fixing' the problem rather than the meanings given by those who experience it. It is therefore proposed that this focus on fixing the problem could have possibly resulted in the actual experience and its effects being ignored. While this research has found that there are certain approaches that can help get an infant or young child with chronic sleep difficulties to sleep better, it has also found that these approaches may only be effective for a proportion of cases (Armstrong et al, 1998) and that not all parents feel comfortable with the techniques that are offered to them

(Blundell, 2011). This therefore raises questions about the experience of a parent who does not feel that there is a solution or possibly even an end in sight for their child's sleep difficulties.

With regard to practice, the existing research details the importance in identifying potential support for parents experiencing this phenomenon. Following their numerous investigations into parental fatigue, Giallo and colleagues have begun to address this gap in the literature through exploration of the risk and protective factors associated with parental fatigue (Cooklin et al., 2012; Giallo, Rose, & Vittorino, 2011). Furthermore, they have developed a psychoeducational intervention called Wide Awake Parenting (WAP) (Giallo *et al.*, 2012) which was found in an initial pilot study to support parents with some of the factors that are associated with fatigue. This seems a positive step towards supporting parents within this population. However, as discussed, further exploration of the barriers to engaging in some of the protective factors that have been identified remains an area in need of further research. Alongside this, further exploration of therapeutic techniques that can support individuals with implementing positive change while facing adversity would be advantageous. With therapeutic approaches such as motivational interviewing and acceptance and commitment therapy both evidenced as being effective in supporting individuals with issues such as adjustment, change and acceptance (Rollnich & Mille, 2002; Hayes, Strosahl & Wilson, 2004; Ruiz, 2010) they could potentially offer useful interventions. This seems another area of research worth pursuing.

With much quantitative research demonstrating the impact that lack of sleep can have on maternal mood (including stress, fatigue, depression and a decrease in marital satisfaction) it seems relevant to the field of counselling psychology to

investigate the phenomenological understanding of this experience for the person who lives it. Research has identified that maternal mood can improve with ‘treatment’ of the child’s sleep problem (Hiscock & Wake, 2002). However ‘treatment’ is not always offered, does not always work, and can be resisted by some parents (Mindell et al., 2006; Blunden, 2011). It is therefore imperative to find ways of providing psychological support, if needed, to mothers who are experiencing this phenomenon and to enhance the awareness and sensitivity of practitioners when working with this client group.

## **Chapter 2: Introduction and rationale for research**

A review of the current literature indicates how problems with infant and childhood sleep behaviour are both common (Meltzer & Mindell, 2007; Blunden et al., 2004) and known to cause significant distress for parents (Armstrong, Quinn & Dadds, 1993). Along with the physical implications of insufficient sleep including a decreased immune system and metabolism (Moller-Levet *et al.*, 2013), research indicates that sleep deprivation can be related to decreases in positive mood and increases in anger and hostility (Selvi et al, 2007). Furthermore, with specific reference to infant and child sleep problems, research has found sleep deprivation to lead to parenting stress (Meltzer & Mindell, 2007), depressive mood (Hiscock & Wake, 2001) and relationship disharmony (Medina et al, 2009). Additionally, parental fatigue specifically has been found to be associated with limited engagement in self care behaviours, inadequate social support, ineffective coping behaviours, and low parental self-efficacy (Cooklin et al, 2012).

While evidence suggests that infant and child sleep difficulties have significant implications for both mothers and fathers (Giallo *et al.*, 2012), research indicates that mothers are the main night-time care givers to children who wake at night (Arber et al, 2006; National Sleep Foundation, 2004). Reflecting on current research, this appears to be a population at risk of mental health difficulties and yet, despite having a central focus of improving the lived experience of the individuals that make up our social context (Strawbridge & Woolfe, 2003), Counselling Psychology has produced little to no research on this topic. The majority of research to date is from a quantitative perspective and with the exception of Giallo and colleagues' 2013 study exploring the experience of parental fatigue, there appears to be no literature

exploring the meanings, beliefs, contexts and processes that are constructed as part of this experience, all of which are highly significant to Counselling Psychology.

Counselling Psychologists are able to work in a plethora of different settings with individuals and families. The underpinning philosophy of the Humanistic Approach (Rogers, 1961) coupled with many different psychotherapeutic approaches, such as Psychodynamic (Freud, 1895), Gestalt (Perls, 1976), and Cognitive Behavioural Therapy (Beck, 1979) makes Counselling Psychology well placed to be able to deal with both behavioural and relational issues by looking at the impact a situation has upon a person. This research will be beneficial to Counselling Psychologists as it is likely that they will encounter individuals who are affected by the issues raised in this research. The maternal experience of having a child who has night time sleep difficulties may likely impact not only upon the mother's self-concept, but also on family dynamics and relationships. When dealing with an individual's set of beliefs it is essential that the person feels supported and not judged. This is an environment that Counselling Psychologists are able to provide during therapeutic work.

Counselling Psychologists are also well placed to train other allied health professionals. In this role they would be able to highlight potential issues to health professionals who provide psychosocial care, thus positively impacting upon the support the mother receives.

Chronic child sleep problems have been found to be significantly under-reported to health professionals in Australia despite a high frequency across all age groups (Blunden *et al.*, 2004). Furthermore, research has identified that the current interventions that are suggested to parents by health professionals are not only for some difficult to adhere to (Long, 2001) but can also be highly distressing for parents (Mindell *et al.*, 2006). These findings could indicate that the current physical health

approach to childhood sleep difficulties could benefit from psychological insight in order to improve support for this population.

The accompanying literature review has identified several gaps within this area of research, including a lack of qualitative and therapeutically based research on the subject. With literature indicating that mothers of children with sleep difficulties are vulnerable to psychological distress, it is relevant to counselling psychology to gain a deeper understanding of the processes involved in order to find ways of better supporting both these mothers and the health professionals who are tasked with advising and supporting them throughout this experience.

### 2.1 Research aims:

The aim of this research is to add depth of understanding and a human voice to existing research on the maternal experience of having a child with night-time sleep difficulties. Furthermore, this research hopes to identify the needs of this population and potential implications for counselling psychologists when working with this group.

It is hoped that an explanatory hypothesis will be developed that illustrates the meanings and processes that are involved in this common experience. This understanding could then potentially be used by counselling psychologists, not only in their own clinical practice but also when supporting physical health practitioners who have direct contact with this client group.

### **Chapter 3: Methodology**

This research was developed within a qualitative paradigm and constructivist framework. Grounded Theory (GT) methods were found to be the most appropriate for meeting the research aims. This choice of methodology was guided firstly by the research aims and the lack of previous literature available in the area. However it was also informed by my own approach to the nature and production of knowledge, which has been significantly influenced by the humanistic underpinnings of Counselling Psychology.

#### **3.1 A qualitative approach**

Following an extensive literature review, there is seemingly currently only one piece of qualitative research that attempts to explore the experience of having a child with night-time sleep difficulties. However this study by Giallo and colleagues (2013) was focused specifically at exploring the experience of parental fatigue. In contrast, as identified in the introduction to this report, there is considerable quantitative research which illustrates the significant impact that child sleep difficulties can have on maternal mental health. Therefore, it seems relevant, particularly to the subject of Counselling Psychology, which places emphasis on the individual experience, to gain further insight into what this experience is like for those who live it. A qualitative approach has been deemed as best placed to do this, providing methods through which meaning and the individual experience can be explored (Willig, 2001). Additionally, Lincoln and Guba (1985) argue that qualitative approaches allow the researcher to be more sensitive to the various interpretations that individuals may make of experiences in an attempt to gain understanding. Furthermore, while a quantitative approach might enable causal relationships to be investigated, a qualitative approach enables relationships to be described and

explained (Mack et al, 2005) which may provide a deeper understanding of participants' experiences.

### 3.2 Choice of methodology

As discussed, the development of this research was led by a desire to create a forum to explore this phenomenon and to provide a form of 'explanatory hypothesis' (Peirce, 1955, p.67). As a result of these factors, the lack of available research, and the researchers' approach to the nature and production of knowledge, GT was chosen as the methodology for this study.

Given the centrality of the 'lived experience' to the aims for this study, other qualitative methods were also considered. In particular, Interpretative Phenomenological Analysis (IPA) was explored in depth and was in fact initially chosen as the methodology for this research as a result of its focus on the 'lived experience' and ability to produce rich descriptive accounts of the phenomena under investigation. However, the interpretations that emerge through IPA are ultimately used to compare to existing theory (Willig, 2008). In contrast, the current research is aimed at providing new information which could be expanded upon to add new theory, generated from participant experiences (Urquhart, 2013; Fassinger, 2005). This research aim of generating new theory was found to be consistent with the epistemology of GT and therefore the methodology for this study was changed from IPA to GT.

Glaser and Strauss (1967), who first described GT methodology, defined the method as 'the discovery of theory from data- systematically obtained and analysed in social research'. While various versions of GT have since been developed, the main characteristics of the method are summarised by Barnett (2012; p.48) as:

- Concurrent processes of data collection and analysis;
- An inductive approach leading to conceptual understanding of the data;
- Pursuit of core themes early in the data analysis;
- Sampling procedures driven by constant comparative analysis; and
- The integration of categories into theoretical frameworks

It is hoped that through the use of GT, this research will add a depth of understanding and a human voice to existing research as well as enhance practitioners' awareness and sensitivity when working with this client group.

### 3.3 A constructivist approach

Having explored several approaches to GT, Charmaz's (2006) constructivist approach to GT was found to be most suited to both the research aims and to my philosophical approaches to both the development of knowledge and clinical work. While Glaser and Strauss (1967) emphasised generality and objectivity, Charmaz proposes the importance of relativity and reflexivity, a focus which is in keeping with the ethos of reflection and transparency that is encouraged within counselling psychology as a profession.

While adhering to the structured analytical approach and constant comparison methods outlined in earlier versions, Charmaz's version of GT (2006) is based on constructivist assumptions and abductive reasoning. Constructivist GT lies within the interpretive tradition and places priority on the phenomena of study, seeing both data and analysis as created from shared experiences and relationships with participants and other sources of data (Charmaz, 1990). Characteristics of this approach include the emphasis on how, when and to what extent the studied experience is rooted in

larger and often hidden systems. Working to this approach, the emphasis is placed on how and why participants construct meanings and actions in specific situations. There is an acknowledgement within this approach that while the researcher will try to get as close to the participant's experience as possible, the resulting theory is subjective and an interpretation, depending on the researcher's own views and assumptions. As a result of this, reflexivity is vital to this form of GT, with it being imperative that researchers consider how their theories evolve and acknowledge that what they see in their analysis may be impacted by their own values and experiences. Thus working from a constructivist approach it is important as a researcher to be aware of one's own presuppositions and to explore how they affect the research. This was particularly relevant for the current study, as a result of both me having personal experience of the research topic and the fact that the study was conducted without a research team to enhance triangulation (Tindall, 1994). In order to manage pre-existing assumptions and monitor how these impacted on my approach to the research and analysis (Casper, 1997), a research diary was kept. Furthermore, issues raised within the research diary were continually explored with the supervisory team and through peer debriefing. A more in depth exploration of the trustworthiness of this research will be addressed in section 3.9.

### 3.4 The researcher

I am a trainee Counselling Psychologist and during my three years of training I gained experience working therapeutically with parents, particularly during my placement in primary care where I gained experience working within a systemic reflective team, offering therapy to families and couples. A clinical and academic interest in this subject was heightened by a personal rationale for pursuing this research as a result of having experienced this phenomenon with my own child.

While this provided me with passion and energy for this research, I was also aware that there was potential for my own experience to influence how I interpreted data during the research process. This was explored in depth with my supervisory team before embarking on the research and then regularly throughout the research process.

### 3.5 Participants

#### *3.5.1 Inclusion criteria*

This research incorporated relatively broad inclusion criteria in order to facilitate data collection from a cross-section of mothers. A definition was not placed on ‘night-time sleep difficulties’ because of both the dominance of quantitative research on this subject and the philosophical underpinnings of this piece of research; it felt important to acknowledge and gain understanding through the lived experience of the participants rather than to set boundaries on what this experience should and should not be.

Inclusion criteria were defined as *mothers of children with night-time sleep difficulties*. The inclusion criteria also required that the child be over the age of one year as a result of research to date primarily focusing on the first postpartum year. Furthermore, sleep difficulties during this time are generally more expected, with fatigue being ranked among the most common health complaints for parents following the birth of a baby (Glazener et al., 1995). Finally, inclusion criteria also required that the child have no known underlying health conditions or disabilities so that the mother’s experience would be more directly linked to the sleeping difficulties.

Criteria were communicated to potential participants through a recruitment poster (see Appendix A) and then again when they first made contact with the researcher.

### *3.5.2 Recruitment and theoretical sampling considerations*

In accordance with GT data collection and analysis ran concurrently and a theoretical sampling technique was adopted where possible in order to obtain data that had the potential to fill gaps or expand the breadth of information identified as the analysis progressed. Initial recruitment was conducted with the aim of recruiting as many participants as possible within the time constraints surrounding this piece of research.

Recruitment was conducted through the displaying of posters (please see Appendix A) and a recruitment letter (Appendix B ) at local parenting groups and through advertising on community parenting websites mumsnet (<http://www.mumsnet.com/>), netmums (<http://www.netmums.com/>) and Busy Parent Network ([www.busyparentsnetwork.com](http://www.busyparentsnetwork.com)).

This process initially led to the recruitment of seven potential participants however three of these volunteers were unable to participate because of work and home responsibilities. These volunteers all cited their child's sleep difficulties as exacerbating this problem as it meant they felt unable to meet in the evenings because of their responsibilities at home.

A purposeful approach was taken to the four interviews that resulted from this recruitment drive, with flexibility in the semi-structured interviews being utilised in order to focus on experiences that were relevant to emerging codes and categories. Reviewing analysis after the first four interviews it became apparent the 'coping' category had not yet reached saturation. Furthermore, with one of the mothers stating that she would not have more children as a result of her experience it seemed

worthwhile to pursue a participant who had more than one child who had struggled with sleep in order to explore how this might impact on the experience. Thus the fifth participant was then recruited as a result of theoretical sampling.

An attempt was made to recruit further participants, particularly of those who shared night-time care responsibilities with their partner. Unfortunately, while two more mothers expressed interest in participating, one did not get in touch following initial contact and the other decided to withdraw because she felt unable to find time to attend an interview. Possible reasons for the lack of success in recruiting more participants will be discussed in the Limitations section of Chapter 5.

While five participants is a small number for GT, it has been suggested that small, non-random samples of fewer than ten participants are considered adequate if the sample is homogenous and the research question relatively simple and clearly formulated (Carey, 1984; Guest, Bunce & Johnson, 2006). This study focused purely on mothers in part, to aid homogeneity. Furthermore, the selected group of participants for this research were close in age, from similar cultural backgrounds and geographical locations, and considered of similar socio-economic status. This was therefore considered a homogenous sample, which, as cited by Grimmer and Tribe (2001), aided the acquisition of rich data. Differences between participants (such as number of children) grew out of the need for theoretical sampling.

### *3.5.3 Description of participants*

Five participants were recruited for this study and are described below having been given pseudo names that will be used throughout this report. They were interviewed in the order that they appear, with Margaret being interviewed first and Louisa being interviewed last. Interviews took place over a four month period.

- 1- Margaret is a 32 year old, married, full-time working mother of a 21 month old boy who had struggled with sleep since the age of six months. She described herself as having two to six hours of disrupted sleep a night.  
  
*'we haven't really had a patchy more than a couple of days that he's actually slept through the night completely since he was six months old.'*
- 2- Charlotte is a 38 year old single mother of an 11 year old daughter who was described as having sleep difficulties from birth. At the time of the interview Charlotte was not working although she had experience of working while experiencing the sleep difficulties. At the time of the interview Charlotte's daughter was coming into bed with her to fall asleep and she described her sleep as being very disrupted due to sharing a bed with her daughter which resulted in Charlotte very rarely sleeping through the night.
- 3- Elaine is a 35 year old, married, full time working mother of two children. The youngest (two years of age) slept well while the eldest (four years of age) had had sleep difficulties since birth. At the time of our interview the mother was off work with a broken leg which meant that the father had recently had to take over much of the night-time care. Elaine described a typical night involving around two hours of 'prattling around' in the night between 1:00 a.m. and 3:00 a.m. and then waking between 5:00 a.m. and 6:00 a.m.
- 4- Francesca is a 32 year old full-time working mother of a two and a half year old daughter who was living with her partner/ father of child. She described getting around six hours of broken sleep a night with her daughter waking around three times a night. Francesca described having to lie next to her daughter in her bed each time she woke until she would fall back to

sleep. This would take varying amounts of time to happen and ultimately would often lead to the daughter coming into bed with Francesca. She described sleep at its worst being when she got about three hours a night for a period of six months.

5- Louisa is a married, 34 year old, part-time working mother of three children between the ages of 29 months and five years of age, all of whom had struggled with sleep. The youngest was still having difficulties with sleep at the time of our interview. Louisa described on average having around five hours of disrupted sleep a night, with her daughter sleeping in bed with her and her husband. She stated that it had been since '*Christmas 2006, the last time I slept through the night.*'

#### *3.5.4 Procedure*

Once potential participants had shown interest in participating in the research, an information sheet outlining the content and purpose of the study (Appendix C) was forwarded to them by email. Once they agreed to take part in the research, participants were forwarded a small demographics form to complete. Participants were then invited to an interview at their convenience. The interviews were held at a neutral location (these included rooms booked at their local libraries and meeting rooms at their places of work).

Prior to interviews, participants were reminded of their rights in the study and asked to sign a consent form (see Appendix F). Interviews were digitally recorded and subsequently transcribed. Transcripts were labelled and line numbered and details

were made anonymous to protect participants' identities. All materials were kept securely, in a locked filing cabinet.

### 3.6 Data collection

A semi-structured interview schedule was used to elicit maternal views on the experience of being sleep deprived as a result of having a child who does not sleep regularly (Appendix E). Exploration was made into possible effects on mood, stress levels and relationships. Questions were open-ended and non-directive (for example, 'Tell me about your experience of having a child with sleep difficulties' and 'What aspects of your life have been affected by having a child with sleep problems?' and 'In what ways?'). Other areas explored were perceived impact on partners, available support, and how the participants have managed this experience. Questions also explored the impact of working/ not working on the experience of having a child with sleep difficulties. A process of reflecting and probing was adopted and a brief summary toward the end of the interview was given by the interviewer in order to ensure that the participant's views were fully understood.

Following the interviews, participants were asked for their feedback regarding the questions asked. The first interview of the study was considered a pilot and questions were adjusted based on the feedback obtained. Furthermore, it became apparent after the first interview that it would be important to take notes after the interview concluded as a more relaxed form of reflection after the formality of the interview had finished. The pilot interview was included in the data analysis due to the development of strong themes and rich data. This process of adjustment to interview focus and early analysis continued in accordance with GT approach. Data collection

and analysis ran concurrently, with the process of data collection being informed by early coding, sensitive to emerging categories.

### 3.7 Analytical strategy

Interviews were transcribed by the researcher and then analysed following a contextual constructionist version of GT (Charmaz, 2006). Initial line by line coding was conducted on hard copies of the transcripts with a focus on identifying actions, meanings and assumptions. For example, the line '*And also you kind of get the idea of um of being judged*' (Charlotte, L309-310), was coded as *perceiving judgement from others*.

Incidents were also labelled. This involved looking for incidents in the data and labelling them according to the significance of its content. For example, where Louisa is describing sleep training techniques that she tried (Line 104-105) the code '*sleep training*' has been selected. Whenever it was possible, *in vivo* coding was used, prioritising the language of the actual participants in an attempt to preserve meaning.

After initial analytic directions were established through line by line coding, focused coding began in order to allow for the identification of codes that represented emerging themes. During this stage, the most frequent and significant codes found during initial coding were used to sift through the data. The goal of this stage was to determine the adequacy of initial codes and then to scale these codes up into categories (or properties of these larger categories) that were important to the research question. Here the analysis process involved moving between interviews and observations, comparing experiences, actions and interpretations in order to reform the data in an analytically meaningful way. At this stage, concepts began to

emerge and new lines of analysis were followed. This was done until a category was saturated. During this stage, memo writing became increasingly important, helping me to explore thoughts, reflections and ideas that were emerging during the coding process, in a way that kept these early musings separate from the detailed and more procedural coding that was taking place.

The chronology of events was also explored through data ordering in order to examine the processes within the data (Pandit, 1996). This involved organising events from the data in a sequence in order to develop an understanding of the processes involved in the experience of having a child with night-time sleep difficulties. A chronology was documented which provided the basis for *The Stages* category.

In accordance with Charmaz's approach (2006), axial coding (Strauss & Corbin, 1998) was not actively applied to this research. It seemed that for this study, such an approach would be at odds with my approach to theory construction, casting a restrictive overlay on the data (Charmaz, 2003). As a result, theoretical coding was the next form of analysis applied to the research. This was used to conceptualise and integrate categories and then to make links between them. This approach to analysis is supported by Glaser (1992) who suggested that theoretical coding can preclude the need for axial coding, weaving 'the fractured story back together' (p.72).

During the final stage of analysis, theoretical coding involved mapping categories and subcategories. Theoretical memos were used for defining codes, detailing processes, making comparisons, asking questions of categories and identifying gaps in the data. Integrative diagrams (Strauss, 1987) were also used to further integration and gain additional understanding of the interaction between categories. While the

final stage in GT analysis is theoretical coding, the method allows space for analysis to continue to develop during the process of writing. Within this stage, as with all others, constant comparative methods (Glaser & Strauss, 1967) were used to establish analytic distinctions and to test the emerging theory.

All coding was conducted manually rather than through the use of a computer programme. This was due to both personal preference and the limitations that may become apparent when using computer software (Roberts & Wilson, 2002). As a computer can only code based on the information it is given, difficulties can arise when coding for implicit information, where category preparation is essential for coding (Palmquist, Carley & Dale, 1997). Furthermore, when using “cut and paste techniques”, it is possible to lose sight of the context in which the fragment is located (Oka & Shaw, 2000). It is hoped that coding manually, although time-consuming, has minimised the possibility of these particular difficulties.

### 3.8 Ethical approval and considerations

Ethical approval for this study was obtained from the University of Wolverhampton’s Behavioural Science Ethics Committee. Ethical considerations were considered throughout the research process. In particular the Code of Research Ethics (BPS, 2010) and Code of Ethics and Conduct (BPS, 2009) were adhered to.

Before the interviews took place, participants were made aware of the British Psychological Society’s code of Ethics and Conduct (2009). Participants were offered an opportunity to ask questions and were reminded that they could withdraw

from the study at any point. Before each interview it was also reiterated that confidentiality and anonymity would be maintained throughout the research project and that all names and potentially identifying material would be removed from the research report. Due to the research's focus on maternal experience, descriptions of interactions and relationships with children were expected to emerge from the interviews. Therefore issues of safeguarding were considered and participants were informed through the consent form (see appendix F) that confidentiality might need to be broken if risk was disclosed (BPS, 2010). This was addressed verbally and with sensitivity prior to each interview, with the opportunity for participants to ask questions and to raise any concerns.

While it was deemed that participants were not members of a vulnerable group, I was mindful that participating mothers might be experiencing stress or low mood as a result of lack of sleep. For this reason, I was guided by participants during the interviews and exercised sensitivity around emotive areas of discussion. Participants were made aware at the beginning of each interview that they were welcome to take breaks and could end the interview at any time. Participants were always asked how they felt at the end of the interviews and signposting information was available for those who wanted it. This included information on organisations offering psychological support, parenting groups, and information on childhood sleep difficulties.

### 3.9 Trustworthiness

Due to the constructivist assumptions from which this research has emerged, this section aims to illustrate the trustworthiness, rather than ‘truth’ of its findings.

Trustworthiness is demonstrated when the experiences of the participants are accurately represented (Streubert, Speziale & Carpenter, 2003, p. 38) and is made up of credibility, transferability, dependability and conformability (Lincoln and Guba, 1985), all of which will be explored below in relation to this research.

In relation to credibility, there are several issues that can be considered. As outlined in section 3.4, my familiarity with this subject was central to the development of this research. As a result of both this personal familiarity and the research process spanning over two years, it can be considered that sufficient time was spent to gain a “prolonged engagement” and a resulting understanding of the “culture of the participants” (Lincoln & Guba, 1985, pp. 302). Research developments and the research process itself were regularly discussed with a research supervisor.

Additionally, peer debriefing also took place with both a counselling psychologist and a clinical psychologist where ideas and concerns were discussed and analysed (Erlandson, Harris, Skipper & Allen, 1993, p. 140). Finally, three participants reviewed categories and the theoretical model of the study, all verifying that the findings reflected their experience.

Moving on to transferability, this research has purposely incorporated a range of information about the context of the research and a section on participant characteristics in order to enable analysis of its transferability. Additionally, limitations are discussed in detail (including in relation to the small sample size and

homogeneity of the group) and an emphasis has been placed on including the participants' own words within the analysis, to allow readers to assess how well the theoretical model may transfer to any context with which they are concerned (Shenton, 2004). Finally, it is hoped that the appendices, with examples of emerging categories and the research diary will allow the reader to make an informed decision as to whether this research is transferable to other settings. Hopefully this will also offer other researchers the opportunity to transfer the conclusions of this inquiry to other cases, or to repeat, as closely as possible the procedures of this research.

Again, with regards to dependability, the research, interview transcripts, interview guides, research memos, emerging categories and personal reflections of the researcher are included in the appendices and were also continually discussed with the research supervisor. Furthermore, feedback on the applicability of the model was obtained from those participants who consented to follow-up contact. Finally, examples of research diaries and a critical review have been included with the aim of being a means by which the reader can access both the detail of the data collection process and the content of the reflective appraisal (Shenton, 2004). It is however relevant here to note a shortcoming of this research, being that as a sole researcher, triangulation within a research team was not carried out. However it is hoped that by the above steps being taken, enough information has been provided to allow readers to determine if the conclusions reached are ones with which they would reasonably concur (Lincoln & Guba, 1985).

Finally, moving on to confirmability, Thomas and Magilvy (2011) suggest that if the criteria for credibility, transferability and dependability have been met then it is likely that confirmability will have been achieved. However, it is also relevant here to refer to the importance of reflexivity in determining if the analysis and conclusions

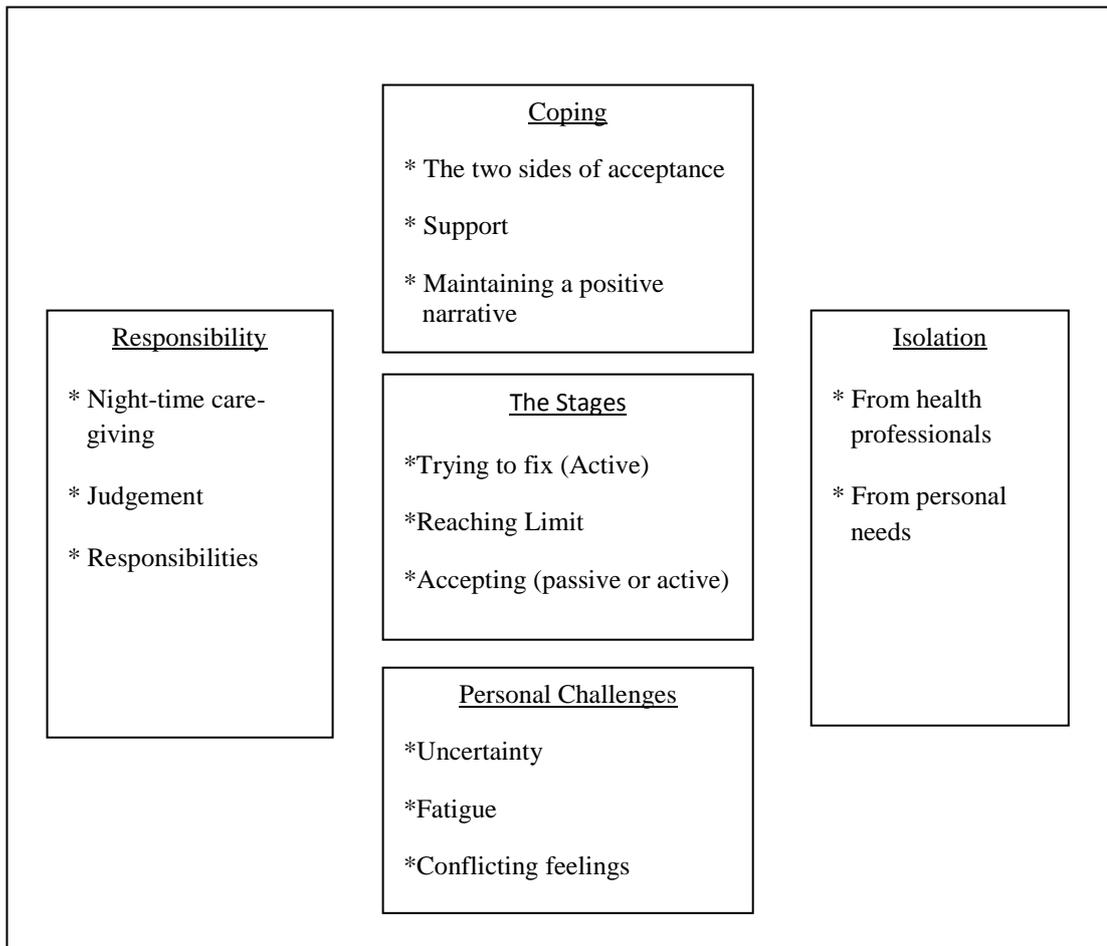
drawn during the research process represent the participants or the underlying assumptions of the researcher. As discussed previously, this is particularly pertinent to this piece of research due to my personal experience of the research topic. As a result, constant questioning of analysis and possible assumptions was employed throughout the research process. Interview transcripts, diary extracts and a critical review have been included to demonstrate personal reflections and influences in the hope of promoting transparency within the research.

## Chapter 4: Analysis

### 4.1 Introduction to analysis and categories

The following section presents an analysis of the data obtained through interviews with five mothers who were experiencing sleep deprivation as a result of having a child with night-time sleep difficulties. An overview of the categories and subcategories which developed through the analytical process is identified in Figure 1. Following this will be an in-depth explanation of each category and subcategory. Examples from participant interviews will be used to illustrate these categories and to provide the human voice that has been previously missing from this area of research. The storyline and theoretical model (Figure 2) will then be provided which illustrate not only the categories and subcategories that emerged through analysis, but also the relationships that exist between them. Finally, a descriptive overview of the storyline will be provided, offering an interpretation of the theoretical model.

Figure 1: Categories



## 4.2 Description and explanation of categories and subcategories

### 4.2.1 The stages

All of the participants interviewed seemed to have a very fixed narrative of their initial experience with their child's sleep difficulty, all of which followed a very similar process which will be outlined below. This seemed to be a process of adjustment with the initial stage being the noticing of a problem, seeking guidance and then attempting to fix. For all of these mothers, 'sleep training' in various forms was the method used to try to address the sleep problem. All mothers described this as a distressing experience, as the method did not work as guidance declared that it would, leading to feelings of *uncertainty*, *self judgment* and *isolation*. Furthermore, all mothers described upset in seeing their child so distressed during sleep training. The participants all described a period of change when they reached their *limit* and decided, against advice, to allow their child/children into bed. This is described in various terms including 'acceptance', 'giving in' and 'a relief' but marked a phase for all of no longer trying to solve the problem, accepting, at least for that period in time, it was not something that could be fixed.

#### *4.2.1.1 Trying to fix (active stage)*

The process of identifying the 'problem' - having accepted sleep difficulties as normal in infancy - seems to be a gradual one with the mothers describing an increase in fatigue as a result of their child's night-time waking, and beginning to recognise that it was a more long-term issue than 'normal' baby sleep difficulties. This soon became a problem to 'fix' and 'fight', with mothers describing themselves as proactive during this stage, raising the issue with GPs and health visitors (often alongside other 'more medical' issues) along with reading information and guidance

on the subject and speaking to family and friends. All participants described the advice and guidance that was available to them as focusing on various forms of 'sleep training' with a message that if you 'do it right' then it will work and with no mention of the possibility that it might not work or suit a parent or child.

For all participants, sleep training was actively employed during this stage. The mothers described finding this to be distressing for both themselves and their child but emphasised repeatedly (this will be explored further within the category of *Responsibility*) how much they had tried to implement sleep training and yet it did not work. Charlotte described her experience of trying to follow advice and persist with sleep training:

*she would scream for huge amounts of time and it didn't seem to matter how long you leave her, she didn't give in and she didn't stop and you know as we were told the advice is that they will stop after however long. She just didn't seem to...*

(Charlotte, L40-42).

Here certain degrees of *uncertainty* seem to have developed for some participants, with them describing how uncompromising the guidance (both from health professionals and literature) is, and how it states that sleep training will work, offering no guidance or acknowledgment for if it does not. In contrast, Louisa described having a health visitor who said 'Well try it. If it hasn't worked after a couple of nights, despite what the books say, it probably isn't going to' (Louisa, L100). This was described as a helpful and welcome approach as it minimised feelings of *judgement* and *uncertainty*.

#### 4.2.1.2 Reaching the limit: the moment of change

All mothers described a stage at which point, after attempting sleep training, they reached their limit. This was referred to in varying ways. Some described reaching an emotional limit, feeling distressed by the method of sleep training and the perceived distress of their child. Louisa described herself during this stage: *'I was shattered, fraught, crying most of the time. I can't do it'* (Louisa, L119-120). Others emphasised reaching their limit as a result of physical exhaustion, with Elaine and Charlotte both describing how this resulted in allowing their child into bed with them:

*it gets to the point where you'll just do anything for a night's sleep, and I don't really care- if you want to fall asleep at the end of my bed, do it, because I'm that knackered*

(Elaine, L81-83).

*...after you've gone through that night after night for a very long time and not seen any results, um whilst it might have been reinforcing her behaviour I suppose, you get to the point where you're so desperate to get some sleep that you will let them into your bed*

(Charlotte, L47-50).

The issue of allowing their child into bed, was not a decision that was taken lightly by any of the mothers, all aware of the strong medical guidance against doing this, which for some triggered feelings of *uncertainty* and worry about their child's wellbeing. All mothers described feeling a pressure not to have the child in bed, with Louisa describing conversations with health visitors on the subject:

*...the infant death stuff, and the suffocating, and one of them actually said “we had a baby die the other week - professional couple.” And I thought: I don’t need to hear that. I don’t need to hear that.*

(Louisa, L318-320).

However the mothers interviewed described feeling that they had no other option but to have their child in bed with them. The response seemed for some participants, to initiate avoidance and *isolation* from health professionals, with Louisa going on to say: ‘... so I stopped going. I didn’t have Anna weighed at all, I don’t think’ (Louisa, L326-327).

#### 4.1.1.3 Accepting

This stage of no longer fighting the sleep difficulty was often described by mothers as a stage when they accepted that living with the sleep difficulties was, at least for the moment, part of their lives. They described this to be a time when they stopped fighting the problem, looking for answers and trying to *fix* things and instead, just did what they could to *cope*. Significantly, this stage was for all mothers identified as a way to gain some form of sleep, with Charlotte stating ‘*at least you can grab a few hours*’ (Charlotte, L 51) and Louisa stating:

*It made it lots easier, because you get rest. Not sleep, sleep, but rest. You’re not sitting in a chair cursing and swearing. It’s a fitful sleep, but you’re still switched off, and horizontal and comfortable.*

(Louisa L154-156).

However this shift in stages appeared to evoke mixed feelings for the participants. For some, there was a feeling of relief to no longer be fighting with their child and

experiencing the accompanying distress that they associated with sleep training. Furthermore, this shift in approach also seemed to reduce some of the pressure that some mothers experienced around trying to do the right thing and trying to ‘find the answers’, with Elaine referring to this as feeling ‘liberating’ (Elaine, L410). Despite the relief that many mothers described around the ceasing of sleep training, this was for some a forced acceptance of doing what they had to do to function, with no other available options. In contrast, Margaret and Louisa seemed to experience a more active form of acceptance, describing how they had chosen to accept the situation and viewed it as a ‘normal’ part of their lives, that while difficult, felt manageable. These two different versions of acceptance will be further addressed within the category of *coping*.

While the stages were initially followed in the sequence described above, Charlotte, Elaine and Francesca then moved between the active stage of ‘attempting to fix/fighting the problem’ and the more passive version of the acceptance stage. Movements between these stages continued to be triggered by both feelings of *uncertainty* and *self judgement* as well as feelings of *reaching the limit* as the acceptance phase could invite feelings of uncertainty, with questions of ‘what’s causing it?’ and ‘have I done enough?’. Furthermore, fatigue would continue with feelings of frustration about how the situation would grow. The fixing phase also pushed mothers to their limit, often involving a method of sleep training which they found distressing and physically exhausting. Disillusionment seemed to then set in when the training did not work as hoped. Patterns of movement between stages also varied, with Charlotte seemingly spending long periods of time in the ‘acceptance’ phase, before ‘attempting to fix’ (possibly a result of having an older child and having experienced the problem for a longer period of time). In contrast, Elaine and

Francesca seemed to move more rapidly between the stages, sometimes within one night.

#### 4.2.2 Personal challenges

The experiencing of personal challenges was raised by all participants. All described fatigue, uncertainty, and conflicting feelings about their child as issues that had resulted from the experience of having a child with night-time sleep difficulties.

##### *4.2.2.1 Uncertainty*

During the interviews, all participants demonstrated varying forms of uncertainty which was echoed by the unpredictability of the experience. Questions such as ‘is anything wrong?’, ‘could I be doing more?’, ‘what caused it?’, ‘how is this affecting my child?’ were expressed throughout the interviews.

*‘it’s frustrating because you try and think what is it that we did that created it or was it something psychological, or is it something, you know, even medical’*

(Francesca, L115-116).

Even during stages of *acceptance* when the participants felt they had ceased trying to fix the problem, they described struggling with not knowing what the cause was, feeling that if they knew what was wrong they would have more ‘control’.

Uncertainty seemed heightened by the lack of advice and understanding available for the experience, with mothers feeling that having exhausted advice and techniques they were now in a world of unknowns. An illustration of this can be found in many participants’ doubts as to whether they had done everything possible to fix the

problem, with participants contradicting themselves during interviews, swaying between saying they should or could try more and then saying that they knew they had tried their best and done everything that they could have.

*Which maybe is a good thing 'cause it will force me to really really handle it completely head on and you know, really deal with it. Um but then I say that, but I have, I feel that when we have tried it, I really have given it everything*

(Charlotte, L320).

This uncertainty, and the desire for all of the women with the exception of Louisa to emphasise how they really had tried everything ( Margaret, L62, Francesca, L 221-222, Elaine, L79, Charlotte, L86 ) also seemed to be fed by feelings of *judgement* which will be further explored within the category of *responsibility*.

#### 4.2.2.2 *Fatigue*

Understandably, fatigue also featured in all of the interviews with physical, cognitive and emotional aspects of this being described by all participants. Fatigue was described as an expected aspect of daily life that was not worth much consideration as there was nothing that could be done to change it. Fatigue while constant, was described as something that could shift in intensity, varying from manageable to forcing the mothers to their *limit*. Reaching this limit would, as discussed earlier, often have implications for how the mothers would respond to the sleep difficulty, instigating change between the active and passive stages. However, many mothers also described, when they reached their fatigue limit, this often being the only time when despite feelings of *responsibility*, they would ask their partner or mother for help for one night so that they could catch up on some sleep.

All of the mothers described physical effects of fatigue, with Margaret describing her experience as follows:

*I think that's possibly why I do get ill quite frequently and I'm kind of, you know, sometimes not actually with it. I feel sometimes I'm having conversations and I feel I'm having an out of body experience*

(Margaret L128).

However, they all felt that the way fatigue most significantly impacted on them was emotionally, with Francesca stating ‘...you are moody all the time, and I'm so tired you know...’ (Francesca, L85) and Margaret describing how she knew when she had reached her limit ‘when I lose my temper for no apparent reason, about things I feel I normally wouldn't be fazed by’ (Margaret, L157-158).

#### 4.2.2.3 *Conflicting feelings towards child*

Another area of personal conflict for the mothers interviewed (although highlighted with less intensity than the above two subcategories) was that while they demonstrated deep levels of compassion, love and worry for their children, the participants also described conflicting feelings towards their child, citing feelings of frustration, anger, resentment and at times strained relations as a result of the sleep difficulty.

*I also think our relationship with xxx individually and as parents would be easier because there is a level of resentment there which is very hard to admit to ... You know, I love her to bits; I'd do anything in the world for her. But blimey, you know, if it was fifty years ago, she'd have probably been given a real slap... You know, it's not the way people – or I – bring up my kids these*

*days. But you can see why people lose their rag sometimes ... And then I feel really sad: how could I even think that?*

(Elaine, L315-32).

*yeah, I do feel slightly resentful in that I don't kind of feel that I have any time to do the things I need to do in the evening*

(Charlotte, L217-218).

*and I think it does take its toll on you, and you know, there are times when xxx been crying and I just feel like that bond isn't there*

(Francesca, L309-310).

However, all mothers interviewed also empathised with their child, worrying about how the lack of sleep was impacting on them. Furthermore they were reflective when considering how their exhaustion and frustration might be impacting on the child.

When referring to how frustrated she can get due to lack of sleep, Francesca went on to share: *I am getting better at controlling it now, and you know, sympathising with her. You know, she doesn't understand I'm tired...* (Francesca, L350-351).

While Elaine went on to illustrate not only her compassion for her daughter but also worry about the impact the experience was having on her: *I feel sorry for her, most of all, I feel it must be really affecting her development and you know, she won't understand why we're getting cross necessarily* (Elaine. L172-174).

### 4.2.3 Responsibility

Feelings of responsibility were laced throughout the interviews with all mothers describing a history of being responsible for the majority of night-time care giving. Additionally mothers described feelings of responsibility for the wellbeing of both the child and partner and a sense of other work and home responsibilities to manage.

#### *4.2.3.1 Night-time care-giving*

While responsibility for managing the child's sleep problem was often referred to as a responsibility shared with their partners; when speaking in more depth, all participants described taking responsibility for the majority of the night-time care giving during the time that their child had been struggling to sleep. Participants who were in relationships cited that they felt that they were better able to cope with the lack of sleep and night-time care giving than their partners were. This was explained in a variety of ways including feeling they did not need as much sleep, the desire to protect their partner, and a feeling that they could better handle the situation. Furthermore, two participants described their child not settling for their partners, demanding them specifically.

Margaret emphasised her husband's involvement and support with night-time care giving but described how not being a 'big sleeper' she felt she could better manage the situation. However she also acknowledged that she did not get enough sleep.

*'I need more sleep than I actually get. It's kind of a balancing act and I don't get enough sleep. But perhaps, um, I don't need as much sleep as perhaps my husband does' (Margaret, L31-32)... 'I try to take a bit more of the responsibility where I can' .... 'but it's usually me that kind of does it 95% of the time, purely because I can cope far better with less sleep' (Margaret , L148-149)*

While Elaine had done the majority of night-time caring in the past, at the time of our interview, she had recently broken her leg and her husband had had to take over much of the night-time care. She also commented that she felt that she was able to cope with it better, having described previously, concerns about her husband getting depressed as a result of their recent change of roles: *'...it really, really used to grind me down, but not up to the point of getting depressed, or not being able to get up and do stuff the next day..'* (Elaine, L58-59).

Francesca also described a feeling of wanting to protect her partner: *'I protect him more from it rather than me. But there are times where I just say I'm exhausted you're going to have to do something and get up, and he'll do it.'* (Francesca, L106-107). And she went on to explain one of the reasons that she thought she might try to protect him: *'... and with his job, you know, he earns more than me, and the commute, so I try to protect him more.'* (Francesca L137-138).

All participants also expressed a reluctance to accept help from others (mainly discussed in the form of the participants' mothers). This was explained by Margaret:

*but we've never kind of handed him over to somebody else for the night so we could have a night's sleep. Cause I just feel that I know that I'm handing over a sleepless night, to people, and even though my parents, or my brothers have offered and whatever, I feel that I'm, that of everybody, that I cope best with no sleep*

(Margaret, L286- 288).

Who went on to further illustrate her point as follows:

*he's my child and therefore he's my responsibility if he doesn't sleep. He doesn't sleep, and that's why... he doesn't sleep, and that shouldn't affect other people's lives in that way*

(Margaret, L316-317).

Francesca also expressed a reluctance to ask for help stating *'I want my mum to be a grandmother, and not feel that she has to help and it become a chore for her'*

(Francesca L279-280).

#### 4.2.3.2 Judgement

Participants also described feelings of responsibility for not being able to fix the problem. This for some resulted in feelings of self-judgement about how they had handled the sleep difficulties and about themselves as mothers. Demonstrating the relationship between self-judgment and uncertainty, Elaine also questioned what she was doing wrong: *'...It does make you question what you're doing wrong. I have to admit, it does affect your confidence, big time'* (Elaine L60-61).

Louisa however described how self-judgement decreased as she had more children and became more 'relaxed' in her outlook but described how moments of self-judgement could still return:

*I'm less bothered about it now, though I do still get... only a couple of weeks ago I was chatting to a mum in the playground, and she was going 'oh no, you're doing it wrong' and you sort of question yourself again. I really did it with xxx when it was the first time, because it was completely new.*

(Louisa, L183-185).

*... so everything gets a bit easier and having seen a child get to six relatively unscathed, you sort of trust yourself a little bit more...*

(Louisa L203-204).

All participants also described an awareness of other people having opinions about what they should and should not do in relation to ‘the problem’ and often this seemed to the participants to feel as though other people were making judgements about how they had addressed the sleep difficulty.

When discussing her experience of health visitors, Charlotte illustrated how feelings of being judged by others and self-judgement could become intertwined:

*And also you kind of get the idea of um of being judged, particularly by health professionals or you know, if you ask advice from the health visitor you know it gets to a point where you kind of, you know, they’re almost too old I guess*

(Charlotte L309-311).

*You kind of think gosh people are thinking you need to have dealt with this.  
Sort of, several years ago*

(Charlotte L362).

*Or is there something else that I’ve missed, is there something you know, is there something that I’m not doing or not paying attention to...*

(Charlotte L316-317).

Francesca described a lack of understanding she feels from others when describing conversations with her mum, Francesca said that her mum would say “‘*but you’ve*

*got to be firm with her” and it’s like, yeah, I will be firm... almost like you’re the weak person as if you can control it, and you can’t’(Francesca L284-286).*

Further illustrating the feelings of judgement the participants experienced was that during the interviews for this piece of research, all participants seemed to need to justify that they had done everything that they could to address the sleep difficulty. This was emphasised by all, often repeatedly, making statements such as ‘we really have tried everything’.

#### *4.2.3.3 Life responsibilities*

For all of the women interviewed there was a strong sense of not just responsibility with regard to the sleep difficulty, but also for work, home life, and the wellbeing of those they cared about. There seemed to be for many a resulting sense of duty and pressure, with participants describing prioritising these responsibilities over self-care and sleep.

Margaret described how when her son did go to sleep ‘early’, rather than rest or catch up on sleep, she would use it as an opportunity to attend to other responsibilities: *I don’t see that as a sleep opportunity, but an opportunity to get things done that I wouldn’t get done if he was up.* (Margaret L44-45).

All of the mothers interviewed who were working at the time described feeling that it would be easier to manage the sleep difficulty if they did not work. This seemed to relate to the struggle of working in highly responsible jobs when feeling exhausted.

Louisa who worked part time described finding it easier to manage her fatigue when she isn’t working. ‘... *the days when I don’t work are a lot less taxing mentally*’ (Louisa L623). She described this being as a result of having choice about what she

does during her days off and went on to say *'I'm in a job where I don't always control what lands in my inbox, and what walks through my door'* (Louisa L626-627).

Furthermore, all participants described an image of a more relaxed parenting that could take place if they were not working, with more flexibility and fewer pressures. For example, Margaret stated that:

*because I think you haven't got that commitment tie... that if he then slept, in the morning I hadn't had the alarm going off to get me up and then have to go to work, and if I wanted to, if we'd had a really bad night, we probably just wouldn't do that much that day*

(Margaret L356-359).

However, Margaret also described working as being an active choice, feeling that it provided her son with other opportunities and also work as something that was meaningful to her as an individual.

Reflecting on the differences between working and not working during this experience, Charlotte reflected: *'working kind of was nice in that I spent my working day, I was spending with other adults so in some ways it was, it was um nicer I guess because I felt like I did get a break'* (Charlotte L258-259).

However, she also reflected on the more difficult aspects stating:

*but from a kind of physical tiring point of view it would impact me more in the evening knowing that I'd got to get up for work very early and I'd got loads of things that I needed to get done and I was getting back quite late as well*

(Charlotte L266).

#### 4.2.4 Isolation

Working closely with the category of Responsibility is that of Isolation. All participants described a situation of being isolated from health professionals, feeling disillusioned about professionals' ability to help with the problem. Furthermore, as a result of feelings of judgement, many made an active decision to disengage from the help of GPs and health visitors. Additionally, participants described, often as a result of feelings of responsibility, becoming isolated from their own needs including those of self-care, relationships and time for self.

##### *4.2.4.1 From health professionals*

Participants varied in how much they would seek advice from health professionals but all did initially explore the issue of sleep difficulties with either a GP or a health visitor. However, as described within *the stages*, there seemed to be an overall perception that there was little that health professionals could do to help the participants with this experience. For Margaret this was a result of feeling that she had a better understanding of the subject than health professionals due to having done thorough researching on childhood sleep difficulties and feeling the issue was more psychological than physical and therefore not for the domain of GPs. For others there was a feeling of being judged or blamed for the problem which led them to

avoid seeking further advice or support. Furthermore, for all, there was a feeling that the only advice that would be given would be sleep training, an option that the mothers felt that they had already exhausted and therefore they felt that there was nothing further that could be offered. Consequently, participants seemed to become increasingly isolated from health professionals.

The following excerpts from Charlotte's interview illustrate not only the feeling of judgement that she felt from health professionals in relation to her daughter's sleep difficulties, but also her active choice to not engage further in accessing their support in future:

*I kind of got the impression that they that they felt that perhaps I hadn't just tried hard enough maybe. Maybe I hadn't because it would work if I kept going, it would work. That was the, you know, it will, it will work if, it always works and that wasn't my experience...*

(Charlotte, L363-365).

*...and I kind of felt a little bit like they didn't quite believe me...if you do your sleep training properly, it will work*

(Charlotte, L367...373).

*...I kind of just, well just said yes, yes... Said what I thought they wanted to hear and then just thought oh I won't bother kind of seeking advice again*

(Charlotte, L376-377).

Elaine also illustrated how feelings of *self-judgement* could lead to isolation from health professionals:

*I wouldn't want to waste their time, that sort of thing. You know, if she was... it's not an illness, is it... so I thought of it as more of a failing on our part rather than-as parents - rather than something medical*

(Elaine, L192-195).

Francesca, however, also described a less active route towards this sense of isolation, describing an experience of almost being abandoned by the professionals to whom she turned to for help.

*...and I said to the health visitor at that time as well that we'd tried everything; if we weren't going to get help from anywhere, you know, again, we were at breaking point. And I didn't even get a phone call or anything back to say "are you coping ok, are you all right" (R: yeah), and all that. And I put it ... between that and... from the time I spoke to the health visitor until her two year checkup that I went to during the week that I hadn't had contact with her or anything*

(Francesca L221-225).

Interestingly, Francesca was the only participant who decided to seek further support which she did by contacting a private organisation to help her address the sleep difficulty. She explained this as a result of not having 'any luck with the health visitors or doctors' and went on to describe how she had reached 'breaking point':

*...I felt that if we didn't do something, something drastic, that xxx and I would separate, or... and it really did get that serious, where I thought 'I'm going to phone social services and say I can't cope any more.*

(Francesca, L209-212)

#### 4.2.4.2 From personal needs

For the purpose of this category, ‘personal needs’ refers to the investment in self, leisure and relationships - those activities that nourish and provide pleasure for the individual. Mothers interviewed described the experience of having a child with sleep difficulties as consuming, and as a result seemed to become isolated from ‘normal life’. All participants described some degree of prioritising responsibilities over leisure activities, socialising, and for some, their relationship with their partner. The lack of attention to their own needs also extended to more basic levels of self care, with some mothers describing eating and drinking too much, not engaging with healthy activities, not going to bed early enough and also noticing themselves getting ill more frequently than they might once have done.

When describing reaching her limit, Charlotte described how her daughter’s sleep difficulties led to her not having the chance to engage in any restful activities for herself:

*I think just kind of feeling like I’ve not had any space (mm hmm) not that I don’t want to be with her but just because I’m going to bed with her now (mmm) and I’m getting up at pretty much the same time as her, there’s no kind of break so I don’t get any sort of time in the evenings when I’ll sit and watch telly or whatever on my own*

(Charlotte, L101-105).

And Louisa stated that ‘*there is no telly time for me, there is no adult time for me, I just need my sleep*’ (Louisa, L542-543).

Francesca further explains not only how she lost contact with some of the fulfilling aspects of her life, but also the significant impact that this had on her life:

*... xxx and I were going through problems in our relationship, I think just because sleeping in separate beds, and... we weren't arguing or anything, but that closeness was just... our, friendship... was dysfunctional. We were going to work, coming home, and just doing whatever we could to get through the day. You know, I wasn't feeling particularly happy because my social life was affected, work was affected, I often couldn't work as well as I wanted to work because I was so tired all the time, I was grouchy at home you know.. xxx didn't want to go out to friends either, he was exhausted. And um you know, we tend to go out on bike trips on weekends and I was absolutely knackered and couldn't even do that*

(Francesca, L202-209).

#### 4.2.5 Coping

*Coping* was something that all mothers referred to in their interviews and referred to an ability to 'carry on', to be able to continue to work, meet responsibilities and to continue to function as best as possible. The need to cope would impact on what stage they were in with regard to how they approached the sleep difficulty. This need could also lead to feelings of isolation, with coping at times more resembling surviving and mothers doing what they could to get through each day, often to the exclusion of leisure and social activities. However, 'coping' was something that all mothers did describe doing and this category also highlights what the participants

found helpful in this situation and their reflections on what could have helped to improve their situations.

#### *4.2.5.1 The two sides of acceptance*

As is briefly described within *the stages* category, two different forms of acceptance emerged through analysis. The first described a resigned form of acceptance that seemed to grow from disillusionment, exhaustion and no other options. However, the participants still viewed their acceptance as a helpful approach psychologically, highlighting the benefits of no longer fighting the problem. However these participants seemed to also demonstrate greater uncertainty, self-judgement and a more frequent experience of reaching their limit. Furthermore, this form of acceptance tended to be more short term in nature than the acceptance described by Margaret and Louisa.

The second form of acceptance demonstrated by Margaret and Louisa is a more active rather than passive form of acceptance, with mothers describing a sense of ownership and choice about how they approached the situation. Unlike the other three participants, these two appeared to remain within the acceptance phase, seemingly experiencing less self-judgement and uncertainty. For these mums, *reaching the limit* seemed to be best addressed by a ‘break’ of a good night’s sleep or even simply a break from responsibility during the day, from which they would return feeling their ‘batteries’ had been ‘re-charged’.

Louisa in particular seemed to demonstrate a feeling of choice and ownership around the experience:

*It was a conscious decision to have more than one child. It was a conscious decision to have them all close together. So while sometimes I*

*go: "oh what did I do that for?!" I know it was what I wanted, and when it works, and when it feels lovely, it all makes sense*

(Louisa, L525-528)

#### 4.2.5.2 Support

It seemed that for all, although support with the actual night-time care-giving might not feel realistic unless having *reached the limit*, support in other forms was still very valuable to all participants. It seemed that having a friend, or knowing others who had, or were experiencing similar difficulties both helped to fight feelings of isolation and also had a normalising effect helping to act against feelings of *self-judgement*. Only Margaret and Louisa described having this as part of their lives with Louisa sharing that ‘*it helps a little, knowing that you’re not the only one with not having a perfect child, because it’s seen as failing*’ (Louisa, L178-179).

The acknowledgment that sleep difficulties are not always ‘fixable’ also seemed something that would be helpful in combatting feelings of judgement. While only Louisa described receiving this acknowledgement from a health professional (see Louisa, L99), several participants also seemed to receive a form of this through family narratives about how they themselves had never slept. This seemed to help these participants to normalise and better ‘accept’ their experience and to gain some distance from feelings of judgement.

A further useful form of support is described as that which *empowers*, with Louisa sharing how she felt her family, husband, and health visitor had all helped to instil in her with a ‘*give it a go*’ (Louisa L104) approach, helping her to trust her own instincts and quiet the voice of self-judgement and uncertainty.

#### 4.2.5.3 *The coping narrative*

As described above, a degree of *isolation from personal needs* seemed to occur for many of the women, with seemingly very little time spent considering or attending to their own needs. Related to this is the emotional distancing from the situation itself that seemed to happen for many of the mothers interviewed. Several participants acknowledged this as a coping method in itself, with Elaine sharing '*I try not to reflect on it too much, because I think I'd just drive myself too potty otherwise, or get more insecure about it*' (Elaine, L258).

Furthermore, in the interviews themselves there seemed to be a dissonance between the positive exterior that the mothers would present where they described keeping the problem in perspective and not letting it take over their lives. At times there seemed to be almost a narrative of the experience that seemed practised and distanced from emotion. Interestingly, when the recorder was turned off, participants who had just been describing how they managed and coped would say things like '*It's a form of torture you know?*' (Charlotte) and '*I feel I am cracking up*' (Elaine).

#### 4.3 Central storyline: 'No choice but to function'

The experiences of those interviewed revealed a central story line of '*no choice but to function*'. All categories and their relationships with each other are illustrated in the theoretical model below (see Figure 2), which describes how this maternal state of being, one which is both 'coping' but also 'struggling', comes to be.

*I just, I have no choice but to function, (yeah) um, and I think I just kind of do the best that I can with the fact that you know, I have to function, I*

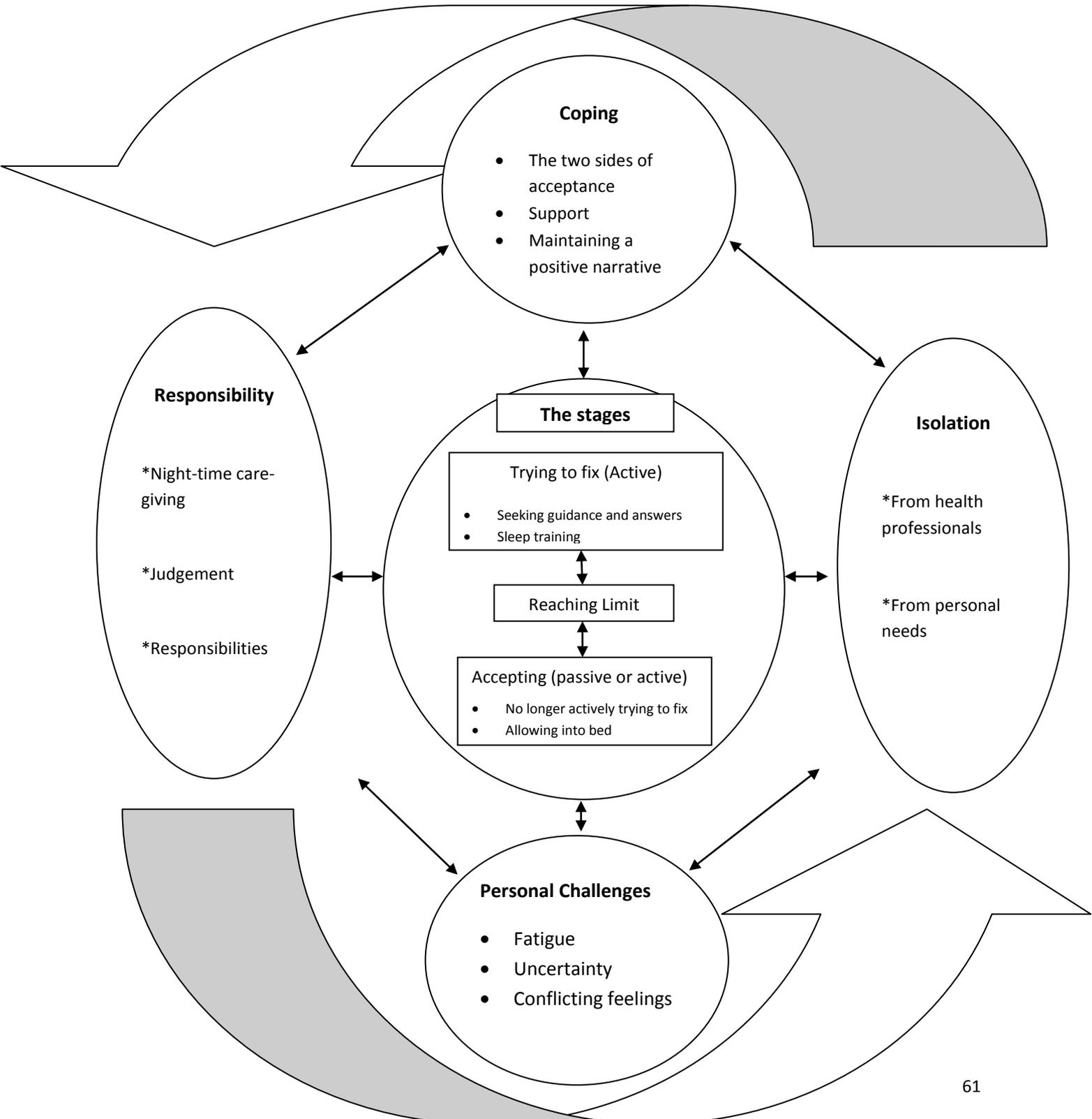
*have to come to work, I have to be Henry's mom, and I have to look after him regardless of whether I've had no sleep or not. I do things that are required regardless of whether I feel I'm actually functioning normally or am able to do it; it's not really an option*

(Margaret, L 131-136).

Conflicting statements, emotions and presentations were all strong features of the interviews with participants and were evident throughout the analytical process. Striking was the apparent contrast between mothers presenting what initially appeared to be a relatively positive narrative of a process that they described as difficult but yet one which they had (in the cases of Margaret and Elaine) not considered a 'problem' or 'issue' until hearing of the study, and the content of the actual interviews describing feelings of hopelessness, exhaustion, poor self-care, worry, self-doubt and for some, shame. 'No choice but to function' describes this contradiction between the personal struggle that these mothers experience and the need and desire they feel to be 'functioning' people. This is illustrated in the theoretical model (Figure 2) below.

### 4.3.1 Figure 2: Theoretical Model

‘No choice but to function’: The maternal experience of having a child with night-time sleep difficulties



#### 4.3.2 Overview of model with a focus on relationships between categories

##### The Stages

All mothers described a similar initial, linear process that they followed once realising that there was a ‘problem’. This began with actively trying to ‘fix’ their child’s sleep difficulty through seeking advice and guidance and then implementing a form of sleep training (the recommended approach to solving baby and child sleep problems). For all participants, however, this stage did not work and after reaching their ‘limit’ with this approach, all mums described abandoning the sleep training and allowing the child in bed with them as a means to getting some form of sleep themselves. This was described as a form of acceptance and a means of coping and forms the ‘acceptance’ stage. While two of the mothers interviewed remained in this stage of *acceptance*, the other three mothers moved between the *trying to fix* and *acceptance* stages. This movement seemed to be triggered by *reaching the limit* in either stage, which would often be influenced by feelings of fatigue, *uncertainty*, and *judgement*.

*Relationships with other categories:* The unsuccessful sleep training that was identified by all participants in the initial stage of *trying to fix* was found to lead to feelings of *uncertainty*, *judgment* and *fatigue*. Both *personal challenges* and feelings of *judgement* were found to then impact on participants feelings of *reaching their limit*. Furthermore, the action of allowing the child into bed within the *acceptance* phase was frequently described as having a direct relation with *isolation* from health professionals.

## Personal Challenges

Along with sharing a similar narrative about the stages of the process, all participants also described a similar narrative about the *personal challenges* that they faced, describing fatigue which impacted on their relationships and how they engaged in their lives. Participants also described and demonstrated in their interviews a high level of uncertainty around the cause of the problem, how they were responding to it and how it was impacting on their child. Furthermore, many described a degree of conflict in how they related to their child as a result of the experience, describing feelings of love, care and worry, but also feelings of frustration and resentment.

*Relationships with other categories:* The *personal challenges* category of this model had a relationship with all other categories, with particularly strong links between *uncertainty* and *judgement* and *fatigue* and *isolation*. Furthermore, *personal challenges* were seemingly also directly linked with participants feeling that they had *reached their limit*, which for some resulted in movement between stages.

## Coping

Despite the personal challenges that were identified, participants described various degrees of '*coping*', with acceptance described by all as a key factor in this. The meaning of acceptance varied between an active acceptance initiated by choice, and a more resigned form of forced acceptance. Possible support for this experience was also explored within this category, with approaches such as empowering and normalising potentially offering relief from *uncertainty* and feelings of *judgement*. Furthermore, a desire or need for a positive narrative of the experience was also identified within the coping category with participants describing the need to try and keep the experience in perspective and also sharing in the interviews what seemed a

relatively positive narrative of the experience. However, after the recording device was turned off at the end of the interviews, frustrations were more freely shared.

*Relationships with other categories:* The desire to present a *positive narrative* could possibly be a result of fears of *judgement* and in turn, may result in participants, again, becoming further *isolated* from possible support. Furthermore, the category of *coping* can be directly linked with that of *responsibility*, with feelings of responsibility being what for some forces, and for others drives, them to cope with the *personal challenges* that are presented.

### Responsibility

While the participants who were in relationships all described feeling supported by their partners and in some cases by other family members or friends, they all echoed an ‘only I’ perspective on the situation, describing how they felt they were the only person who should, could or would provide night-time care. This was often described in terms of feeling better able to cope and feeling protective of the wellbeing of their partners and family members. Responsibility highlights the ownership of the problem taken by the mothers which seemed in most cases to result in feelings of both internal and external judgement, with mothers seemingly judging themselves with frequent questions of ‘what am I doing wrong’ as well as a perceived judgement from others. Furthermore, the category of Responsibility illustrates the general feeling of responsibility that these mums seem to feel in their daily lives for not only the sleep problem but for their work, household jobs and the wellbeing of significant others, with this often being used by many to explain why there was *no choice but to function*.

*Relationships with other categories:* As described above, *responsibility* appears to be what drove or forced participants to *cope* with the *personal challenges* that were presented. Furthermore, feelings of *responsibility* for care giving and for the problem itself seemed to lead to *isolation* from the support of others (family, friends, partner) and from health care professionals.

### *Isolation*

The category of Isolation describes how mothers seemed to become isolated from health care professionals during this process. This isolation often results from the mothers perceiving the health professionals as judging them, but also from some mothers' self-judgement and feelings of embarrassment or shame about not handling the situation in the way that they feel they should be. These feelings of self-judgement were often a result of the strict medical guidance against allowing a child in bed (part of the model's acceptance phase) which was a course of action that all mothers followed. Within this category is also the subcategory of isolation from personal needs, with mothers finding that as a result of their responsibilities and levels of fatigue, the only way for them to cope was to reduce leisure and social activities often becoming even more isolated physically and emotionally from their partner as a result of frequently sleeping in separate beds.

*Relationships with other categories:* As has been illustrated, the category of isolation is directly related to that of responsibility with the two categories having a cyclical relationship. Feelings of responsibility were found to highlight the mothers' feelings of aloneness in the situation, and likewise as the mothers became more isolated they seemed to feel more responsibility for the problem.

## **Chapter 5: Discussion**

The aim of this study was to gain insight into the maternal experience of having a child with night-time sleep difficulties. It was hoped that through the use of Grounded Theory, a rich understanding could be gained of the processes and meanings within the experience and that an explanatory hypothesis could be developed. These aims were developed in response to the vast amount of quantitative research indicating not only the significant impact that a lack of sleep can have on an individual's physical and mental health, but more specifically, demonstrating strong relationships between maternal sleep deprivation and depression, anxiety, marital disharmony and reduced parental self-efficacy. These issues are central to those that Counselling Psychology aims to support and therefore this seemed a much needed investigation. Counselling Psychologists are well placed to make use of these findings and to implement change both through therapeutic work with the individuals who are affected and through training other Allied Health Professionals. The training of health care professionals would not only help increase those professionals' psychological understanding of this experience but could also help them to identify individuals who may be struggling to adjust to having a child with night-time sleep difficulties, and as such may benefit from psychological support and/or increased practical support and guidance.

Previous research has neglected to ask individuals' opinions and experiences of having a child with poor sleeping habits, and whilst many issues raised from previous research were found to be relevant to this research, the complexity found within the model suggests deeper processes take place than what has previously been identified. The model that has been produced through this research is a model of 'no choice but to function' which refers to the place these mothers found themselves

after attempts to solve their child's sleep problem had proved ineffective. With what felt like no other options available to them; they were coping as best they could. As is illustrated within the theoretical model (Figure 2) and accompanying analysis, this form of coping was complex and full of contradictions as mothers struggled with internal and external pressures, uncertainty, feelings of isolation and, unsurprisingly, fatigue.

This discussion will reflect on the theoretical model that has been created as part of the analytical process, describing how the identified themes and processes relate to previous findings. Implications for future research as well as for clinical practice will also be discussed which will then be followed by a thorough examination of the limitations of this study.

### 5.1 A review of the findings

This study provided a new model to help understand the different processes that mothers can go through when they are trying to adjust to having a child who does not sleep. The No Choice But To Function (NCBTF) model illustrates the complexities of human nature as it highlights the different constructs which are interlinked and affected by having a child with night-time sleep difficulties. Grounded Theory aims to produce a process based model that can illustrate how and why participants construct actions and meaning from certain contexts. Individuals experience many different levels of processing especially in situations where they feel overwhelmed as they are trying to create new understanding, make meaning and adjust to the situation, all whilst trying to manage their feelings. Owing to this, it is not surprising

that the constructs in the model all interlink, as one construct impacts and imposes its power over other constructs.

The NCBTF model produced bears similarities to the CBT 'hot cross bun' formation model (Greenberger & Padesky, 1995), illustrating how all categories can inter-relate and feed each other. This results from the differing emotional, psychological and social implications that the mothers encounter, and whilst all interlink, it does not follow that everyone will experience the same thing at the same time in their experience, as previous learnings, disposition, support levels, intrapersonal insight and self awareness will all play a vital part.

Owing to the interlinking and mutually reciprocating nature of the model, it is difficult to extrapolate or explain any one construct without the danger of being reductionistic. However, for the purpose of this discussion, the NCBTF model could be conceptualised by its core, 'The Stages' that the mothers all encountered during their journey. The participants were found to oscillate between trying to fix (the sleep problem) through to accepting the difficulty (either actively or passively). This movement between stages was based upon the impact that the mothers were feeling at that point in time from the other four categories (responsibility, isolation, coping, personal challenges), with each of these constructs there in response to the intrapersonal or interpersonal experiences of the participants.

The findings of this research provide, seemingly for the first time, a deep understanding of this common parental experience through the voices of the mothers themselves. Identified within the results is how all participants went through similar initial stages in addressing the sleep difficulty, first trying to fight and fix the problem through sleep training. This was found to be distressing and ineffective for

this group, leading to feelings of fatigue, uncertainty and judgement. At this stage, if it had not happened already, many participants also began to question health professionals' ability to help them. The personal challenges brought on by this phase led all participants to a stage of reaching their limit, where they felt unable to continue with sleep training and stopped fighting the problem. For some this was an active form of acceptance while for others it felt forced upon them. As a means of coping, participants allowed their children to come into bed with them, an action that they were aware was not approved of by health professionals and led to further isolation from GPs and Health Visitors.

Acceptance was described by all participants as an important aspect of coping, as the alternative (trying to fix) was seen as exhausting, often distressing, and leading to feelings of uncertainty. All mothers described the need and desire to cope but due to both feelings of responsibility and isolation, coping seemed to be something participants had no choice but to do.

The category of personal challenges demonstrates the unrelenting challenge to the need to cope. Fatigue, uncertainty and conflicting emotions are described as disorientating, confusing, and at times unmanageable (and yet have to be managed).

Feelings of responsibility were highlighted by all participants and offer some explanation for *why* and *how* the processes that have been identified take place.

These feelings of responsibility and their relationship with isolation provide some understanding of the barriers to seeking support and to initiating the self care that as described by Giallo and colleagues (2013) might be helpful in fighting the effects of fatigue.

To summarise the NCBTF model demonstrates how the participants involved in this research felt that they had no choice but to function, a concept that they engaged with either actively or passively at different stages during their experience. Whilst these constructs can be held as being applicable to mothers who are experiencing lack of sleep, individual differences will impact upon how and when these constructs are experienced. It is for this reason that the model is to be seen as a whole as opposed to the sum of its parts (an approach which can be echoed in both Systemic and Gestalt philosophy). This concept will be one which is readily assimilated and conceptualised by Counselling Psychologists, and as such it would be useful to be used within group and individual therapy to help clients formulate where they are and how their experiences impact upon their well-being.

## 5.2 Findings in relation to existing theory and research

### *5.2.1 What does acceptance mean?*

Acceptance was described by all participants during their interviews, often referring to it as a way of coping. As described within the category of ‘Coping’, through analysis, two different forms of acceptance emerged: one of a resigned, forced nature and the other an active choice.

Working from a counselling psychology perspective, it is important to acknowledge and respect first person accounts as valid in their own terms and not to assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing (Division of Counselling Psychology, 1995). Therefore, the analysis has acknowledged the help that participants felt that ‘acceptance’ gave them, even when in resignation. However, part of the role of counselling psychology is to also

elucidate, interpret and negotiate between perceptions (Division of Counselling Psychology, 1995). It therefore feels important to acknowledge that while acceptance as described within Acceptance and Commitment Therapy (ACT) as an ‘active, vital embrace of the moment’ (Hayes, 2005; p.7) is considered a psychologically healthy approach, the seemingly forced acceptance described by some within this study is a different form of acceptance. Substantial literature within the field of health psychology has found evidence for the benefit of acceptance in supporting patients with chronic health conditions. Active acceptance, as advocated by ACT, can involve the re-evaluation of personal goals, values and life priorities (Brandtstadter & Rothermund, 2002) and has been found to lead to a better adjustment to chronic pain (McCracken et al, 2004), and to improved psychological wellbeing in CFS patients (Van Damme et al, 2006). Due to the emphasis placed by participants in this study on acceptance, and the seemingly chronic nature of their children’s sleep difficulties, further investigation into how acceptance based therapeutic work might support mothers (and fathers) whose children experience night-time sleep difficulties would be beneficial. However, it is also important to acknowledge a possible conflict between the potential therapeutic benefits of acceptance, and the humanistic aim of supporting clients on their journey towards self-actualisation. Participants within this study described themselves, and often their partners, as feeling relatively alone in a situation that was resulting in them feeling low in mood, frustrated, resentful, exhausted, physically unwell, and isolated from their personal needs. If exploring this in relation to Maslow’s hierarchy of needs (1943), which describes a human’s needs in order to reach self-actualisation, it is evident that for all participants, their physical and psychological needs were not being met. This too must be taken into consideration when investigating how to better support this population.

This is the first piece of research investigating maternal sleep deprivation that identifies a relationship with the theme of acceptance. Not only are these findings important to this specific area of research but they are also significant to the broader field of psychology, highlighting that this form of coping can be found within more populations than are currently represented in the psychological literature. This is also of value to Counselling Psychologists as it could indicate the value of acceptance based therapeutic approaches (such as ACT) when working with this population. This is an important area of research that deserves further investigation.

### *5.2.2 The experience of fatigue*

Recent research (Moller-Levet et al, 2013) has found that getting less than six hours sleep can have a broad impact on wellbeing, and result in the suppression of genes that govern the immune system, metabolism, and the body's response to stress. These findings are highly relevant to the population under investigation in this research, with all participants describing frequently getting fewer than six hours sleep a night. Participants in the current study all emphasised feelings of fatigue and its significant impact on their physical and emotional wellbeing, as well as on their daily functioning. This is consistent with Giallo and colleagues' findings (2013) in their thematic analysis of parental fatigue. Also similar are the findings from both studies that indicate that fatigue can impact on parenting and relationships. This is further supported by recent findings that indicate that fatigue may interfere with parents' capacity to be constantly sensitive, flexible and responsive to the changing needs of their children (Kienhuis, Rogers, Giallo, Matthews & Treyvaud, 2010). Also related are the findings that fatigue can be associated with increased parenting stress, irritable and hostile parent-child interactions and low parenting warmth (Cooklin et al., 2012). Perhaps most significantly, both Giallo and Colleagues' findings and those

of the current study offer, it seems for the first time, a human voice that describes the lived experience of unrelenting fatigue as a result of having a child with night-time sleep difficulties. In contrast, the current study highlights how fatigue does not happen in isolation, with the current model illustrating a more holistic process, of which fatigue is a significant theme but one which inter-relates with others which are equally significant, including those of uncertainty, self-judgement and isolation. This could be supported by the findings of Giallo, Rose, & Vittorino (2011) who found that limited self-care behaviours and lack of social support were the strongest predictors of fatigue even when accounting for child sleep characteristics such as frequency of night waking and sleep quality. Parental fatigue remains a complex phenomenon and with fatigue ranking among the most common complaints for parents following the birth of a baby (Elek, Hudson, & Fleck, 2002) and found to persist beyond the first postnatal year for many women (Parks, Lenz, & Milligan, 1999) it remains a deserving area for further future research.

### *5.2.3 Impact on mental health*

As identified throughout this report, there is significant evidence that supports the relationship between child sleep problems and maternal mood, stress, and fatigue (Meltzer & Mindell, 2007). Consistent with the literature, participants in the current study also described their child's sleep difficulty as impacting on their emotional wellbeing. Further similarities were found between the findings in the current study and those of previous research, in that stress within relationships, the subjugating of personal needs, and at times low parenting self-efficacy were all found to be related to having a child with sleep difficulties (Dunnings & Giallo, 2012). However, the qualitative nature of the research allowed for the lived experience to be explored,

giving way to a human voice that described feelings of, at times, lonely desperation, survival, and cycles of self-blame.

It is hoped that this research provides an insight into how these mothers arrive at these feelings of low mood, parenting stress and fatigue. With the pressure and judgement of responsibility, the loneliness of isolation, uncertainty throughout, and, of course, fatigue, it is entirely understandable that the mood of these mothers was affected. It has long been known that the effects of environment, behaviour, physical wellness and mood are all deeply intertwined (Greenberger & Padesky, 1995). It is therefore logical to assume to some degree that, as illustrated by the present research, the effects of social isolation, fatigue and mood will also be inter-related.

Counselling Psychologists are able to formulate around this concept from a Cognitive Behavioural approach (Beck, 1976; Greenberger Padesky, 1995). There is also growing evidence to support the humanistic approach of sitting with an emotion, valuing the client's experience, and being curious about its impact (Hayes, *et al*, 2008). This is an approach that could benefit individuals who (such as several of the participants in this study) are experiencing feelings of isolation and judgement and are left feeling misunderstood and unheard. Furthermore, as has already been identified, within the field of health psychology there have been significant findings that illustrate the benefit of Acceptance and Commitment therapy (Hayes, 2005) when supporting individuals during the adjustment process. It would be worthwhile for Counselling Psychologists to further investigate how the evidence based therapeutic approaches that they employ as practitioners could help to guide further research and practical support for mothers and families who are experiencing sleep deprivation. This will be further explored within the Implications for Practice section of this discussion.

#### *5.2.4 Responsibility*

Within this small sample, findings were consistent with previous research suggesting that mothers provide the majority of night-time care (Arber et al, 2006; National Sleep Foundation 2004). However, as will be discussed further within the Limitations section of this study, this is not intended to be representative of the general population. What this research does is begin to offer some explanation as to *why* mothers might be the main night-time carers, with participants describing deep feelings of responsibility for the wellbeing of both their child and partner, and significantly, with regard to feelings of judgement, for the situation that they all found themselves in. Participants consistently described themselves as best able to cope with the night-time care, as well as describing their desire to ‘protect’ their partner from such a difficult, and at times painful experience. This is consistent with the findings of Venn and colleagues (2008) who found women to be more likely to subjugate their own sleep needs to those of their family.

The findings can also be considered in relation to research around Raphael-Leff’s mothering orientations, and in particular to the orientation of Facilitator which is in part defined as a maternal identity that aims for perfection, with feelings of self-judgement and guilt over minor lapses (Raphael-Leff, 1986). This orientation appears to have many similarities to the experiences and attached meanings of several of the mothers interviewed for the current study, indicating a potential means of expanding on the present research through identifying the mothering styles of participants alongside their experience of having a child with night-time sleep difficulties. Further support for such an investigation can be found in relation to Scher and Blumberg’s (1999) findings that mothers of a Facilitator style orientation more frequently have night-time waking children than those of the other orientations.

With facilitators described as experiencing feelings of heightened maternal responsibility, both pieces of research highlight a possible relationship between feelings of responsibility, and children's night-time waking. However, due to the qualitative nature of the current research, no linear relationships can yet be drawn. What is clear is that Scher and Blumberg's research (1999) adds strength to the theme of responsibility within the current research and also illustrating the need to further explore the relationship between responsibility and the experience of having a child with night-time sleep difficulties. Given Scher and Blumberg's findings, recommended would be investigations into how responsibility and the Facilitator mothering style might relate to the experience of sleep training.

#### *5.2.5 Relationship with health professionals*

Clearly demonstrated within this model is how and why mothers can become isolated from health professionals when facing the experience of having a child with sleep difficulties. Findings were consistent with those of previous research which indicated that parents rarely seek support for fatigue and their children's sleep problems (Glazener et al, 1995; Blunden et al, 2004). However, until now there has been very little understanding as to why this is. The findings from the current research offer valuable insight into how and why mothers can become isolated from health professionals when experiencing difficulties with their child's sleep, with feelings of responsibility and judgement often acting as a barrier to the mothers accessing further support. The relationship between feelings of responsibility and judgement, and isolation from health professionals is shown within the NCBTC model which demonstrates how mothers would take ownership and responsibility for the sleep difficulty and this in turn, for most participants, would result in feelings of both internal and external judgement. These feelings of judgement would then for many

lead to mothers isolating, distancing themselves from those from whom they felt or predicted judgment.

While participants described initially seeking advice and support through their Health Visitor or GP, they all described having ceased to raise the issue with health professionals. Participants described a variety of reasons for this including feelings of self-judgment, feeling judged by the health professional, feelings of disillusionment, no longer feeling that there was anything that the health professional could offer them that would help, and feeling abandoned by the health professional. For many, the process of isolation seemed to begin when sleep training failed to solve the difficulty, with participants feeling unsupported if they stopped, with a message of 'if you do it properly, it will work'. Furthermore, all mothers described feeling judged for allowing their child into bed with them as a means of coping, with messages of 'this could result in the death of your child', alienating, upsetting and at odds with their maternal identity.

Also illustrated within this research is the desire of the participants to contain and normalise their experience. This was demonstrated in the analysis of this research, with a discrepancy found between a seemingly rehearsed and perhaps philosophical narrative offered by some participants during the interviews, followed by a more frank description of struggle that was offered once the voice recorder was turned off. This practiced way of presenting the experience could also result in, at times, mothers presenting a more positive view of their experience when speaking to health professionals, wanting to present an image of being a good mother. This could, in turn, result in health professionals lacking in awareness of the mother's true experience.

While the clinical implications of this thesis will focus on support for mothers and families who are experiencing this phenomenon, there are recent findings that indicate that health professionals might also benefit from further support in this area. With little research currently exploring the health practitioner's experience of working with child sleep problems, a recent Canadian study (Boerner & Coulombe, 2013) has contributed valuable insight on this topic, finding that when considering barriers to providing evidence based behavioural sleep related care to children and families, health professionals' most frequently reported barrier was a lack of knowledge, training and education. This could help to provide a more holistic understanding of how and why mothers can come to feel not only isolated from health professionals but also left with feelings of uncertainty about how they can and should address their child's sleep difficulty. Not only does this demonstrate another valuable area for future research but it also indicates the potential value of Counselling Psychologists working together with health professionals as they would be able to provide guidance on possible behavioural interventions, and on how mothers and families can be best supported.

#### *5.2.6 Supporting mothers during this experience*

Along with the experience of fatigue, Giallo and colleagues (2013) explored participants' views on managing fatigue. Strategies such as taking time out for self, exercise and social support were found to be helpful, with fathers also describing work as a source of respite and having realistic expectations as important.

Participants within the current study also described social support (to some extent) and realistic expectations as helpful in coping with their experience of having a child with sleep difficulties. This is in keeping with not only Giallo and colleagues' 2013

findings but also with research that has found that a lack of social support can be a strong predictor of levels of parental fatigue (Giallo, Rose, & Vittorino, 2011; Giallo, Wood, Jellett & Porter, 2011 ). However more exploration was made in the current study to investigate how participants felt that they could be better supported throughout the process, identifying empowerment, normalising and awareness of other mothers in similar situations as possibly helpful. This is consistent with findings from cognitive behavioural research (Donker, Griffiths, Cuijpers & Christensen, 2009) that indicates the value of psychoeducation in fighting uncertainty and providing reassurance through normalising a client's experience. It seems that rather than an aim of fighting fatigue, the current findings demonstrate a desire within the participants to fight the feelings of self-judgement, uncertainty and isolation that they described as part of their experiences. This illustrates the complexity of this phenomenon and the far reaching potential impacts on wellbeing that it can have that go well beyond that of fatigue. Furthermore, the needs that have been identified indicate the value that Counselling Psychology can offer to the practical support of this population, with Counselling Psychologists trained in delivering interventions aimed at empowering the individual and helping them to find ways to view themselves with more compassion (Gilbert, 2009), challenge relationship with negative thoughts (Hayes, Villatte; Levin & Hildebrandt, 2011) and to recognise and assert their own needs and desires (Perls, 1976).

A critique of Giallo and colleagues' 2013 study within the current literature review highlights a lack of attention to potential barriers to the strategies that were identified to help with managing fatigue. The current study provides insight into these potential barriers, with feelings of responsibility preventing mothers from asking for support,

leaving them feeling overwhelmed and exhausted, with no time to spend on themselves.

### 5.3 Implications for future research

This study was exploratory in nature and highlights many possible areas for future research. The participants for the current study who were in relationships highlighted the significant impact that they felt the situation had on their partners, describing a feeling that it was harder for their partners to cope. Fathers were described as experiencing the fatigue deeply, both physically and emotionally. Due to this and the general lack of research in this area, it is clear that the exploration of the paternal and systemic family experience would add another layer to the findings from this study.

Already suggested has been the potential benefit of research that explores the use of approaches such as ACT in therapeutic work with this population. Also identified has been the potential for further research exploring the relationship between mothering orientations (Raphael-Leff, 1986) and the maternal experience of having a child with night-time sleep difficulties. This was particularly relevant in relation to the theme of responsibility and how it might relate to the mothering orientation of Facilitator.

Also related to the theme of responsibility was an unexpected issue that was raised and yet regrettably underexplored in the current study due to time constraints. This relates to the discovery that four out of the five mums had experienced significant physical health concerns in relation to their child as an infant or toddler. With mothers briefly describing their distress, worry and uncertainty during the period of illness, it would be worthwhile to further explore the relationships between early

childhood illness, the maternal experience of responsibility, and childhood sleep difficulties.

The current research indicates that participants experienced significant isolation and perceived judgement from health professionals with regards to their experience of having a child with sleep difficulties. These findings along with previous research indicating that health professionals may under report sleep problems in children even when the issue has been raised by parents (Blunden *et al*, 2004), illustrate the relevance in gaining an understanding of the experience from the perspective of the health professional in order to offer a more holistic understanding of the processes that are described in the current study, particularly with regards to the theme of isolation.

#### 5.4 Implications for practice

##### *5.4.1 Raising awareness*

With two participants sharing that they had not thought of their child's sleep difficulties as an issue until they had seen the recruitment letter for this piece of research, and with one participant sharing that she had not sought professional support due to viewing the problem as a result of her own parenting failings; raising awareness of the experience would be helpful in normalising some of the processes that mothers might experience. This could help in reducing feelings of judgement (both of self and perceived from others), and in turn reduce feelings of isolation. It is interesting to note how when seeking feedback on the current model, two participants reported that following their interview, not only did they experience some level of relief from learning that others experienced similar experiences, but also shared that

they had sought further help after the interviews which had led to vast improvements in their individual situations.

#### *5.4.2 An intervention to help manage the experience of fatigue*

The current research also illustrates why an intervention such as Wide Awake Parenting (WAP) (Giallo *et al.*, 2012) might be an effective method of support for some mothers of children who are experiencing night-time sleep difficulties. With initial findings suggesting that the intervention was particularly effective in strengthening parents' self-efficacy to manage fatigue and their intention to engage in self-care behaviours, this approach could be beneficial to a population such as the participants within the present research. A particular benefit of this method in relation to the current study is that it is not aimed at 'fixing' the child's sleep problem, but instead at helping the parents to manage fatigue, something which in itself acts as a normalising message, quieting the voice of judgement and acknowledging that sometimes the sleep problem cannot be fixed. Furthermore, as a result of the lack of success the current study's participants found with sleep training, not to mention the emotional distress they experienced as a result, an intervention such as WAP could be empowering; encouraging an active acceptance while also recognising the parents' personal needs.

#### *5.4.3 Finding new ways of 'fixing' child sleep difficulties*

The above recommendations work in partnership with acceptance and address the need expressed by participants for the sometimes 'unfixable' nature of infant and child sleep difficulties to be acknowledged. However, participants all also shared that if they could fix their child's sleep problem, they would. Furthermore, they all described discomfort with the sleep training methods that they had tried. It is

therefore also relevant to explore new ways of approaching (and possibly ‘fixing’) childhood sleep difficulties in a way that acknowledges the potential barriers to current methods.

#### *5.4.3.1 Learning from good practice*

Current National Health Service (NHS) guidance (NHS, 2011) recommends traditional behavioural sleep training methods to parents, stating that with ‘patience, consistency and commitment, most sleep problems can be solved’. If these methods are found to be unsuccessful, parents are advised to seek further guidance from their GP and told that if available in their area, they may be able to attend a drop in clinic where they can discuss the issue in more depth and be provided with further guidance on behavioural interventions. While there are also some private companies that seemingly offer a more engaged and ongoing form of support, currently there does not appear to be any additional support for this issue within the NHS.

Guidance could be taken from research in Australia, which currently appears to be the most prolific in the exploration of infant and child sleep difficulties. Not only does there appear to be an increased awareness and interest in the parental experience of child and infant sleep problems from health professionals and academics in Australia, but it is also possibly one of the few countries in the world that provide residential health facilities for mothers or parents who are experiencing difficulties with their child’s sleep patterns (Matthey & Speyer, 2008). These are known as residential Mothercraft or Parentcraft Units and families are referred when difficulties have not been resolved through contact with child health community clinics or specialist day centres. This form of residential support has been found to lead to improvements in both infant sleep behaviour and maternal mood (Matthew &

Speyer, 2008) with the units offering a holistic approach and staffed by maternal and child health nurses, along with psychologists, social workers, psychiatrists and paediatricians. With a view to the current research, it is possible that some form of residential support such as Parentcraft units could assist with feelings of responsibility and isolation, enabling parents to meet others in similar situations and to receive help and support from professionals (for whom mothers would not have to feel responsible).

#### *5.4.3.2 A new form of sleep training*

While residential support might be an ideal to aim for, there are also relatively simple (and cost effective) changes that could be made to the advice given to parents with regard to sleep training. Blundell's (2011) preliminary findings indicate that a more gentle and interactive version of sleep training could also be highly effective in treating infant and childhood sleep difficulties. With previous research indicating that traditional methods of sleep training can be difficult to adhere to (Long, 2001; St James- Roberts *et al.*, 2006) and with the current research adding strength to the argument that this form of behavioural intervention can be distressing for parents (Mindell *et al.*, 2006; Scher & Blumberg, 1999), it seems that further investigation into methods of sleep training that feel more sustainable and comfortable for parents is imperative. Alternative approaches to sleep training could then potentially be integrated into the current NHS guidance on behavioural interventions for childhood sleep difficulties.

#### *5.4.4 A model of support*

As has been discussed, the present study has raised important considerations in relation to how the situation could be improved for mothers whose children struggle

with sleeping. While not all explicit, the potential needs of this client group can be identified within the theoretical model. These include non-judgemental, normalising, empowering, informed, client/patient-led support. Due to GPs and Health Visitors often having more regular contact with this population, it seems there would be many benefits of counselling psychologists working together with those health professionals on a model of support which would recognise the importance of:

- Acknowledging and hearing parents' experience
- Normalising this experience
- Offering informed and patient-led options to address the problem (i.e. sleep training), but acknowledging that this does not suit or work for everyone
- Support with sleep training if the parents want to pursue this option but are finding it distressing. This could be in the form of practical assistance or psychological support around the parental distress and the possible reasons behind this.
- If desired, a patient-led support group where parents could share their experiences
- Empowerment, encouragement and emotional support. Depending on the level of need, this could be GP/Midwife-led, or involve sessions with a counselling psychologist.
- Night respite for parents who reach 'breaking point'

### 5.5 Limitations of study

While a number of advantages found in the use of grounded theory have been described within the methodology section of this report, there are some additional issues worth discussing with regard to the methodology. As a result of the small scale and exploratory nature of this study, it does not aim to represent anything other than the subjective experience and the views of the five participants who took part. As described earlier, while theoretical sampling did aim to recruit for diversity in many respects, the group of participants recruited were in fact a quite homogenous group with regard to socio-economic status, all from white, middle class backgrounds and all from a relatively small geographical location within the UK. As a result, while the study may provide some generalisable insight into the experience for a specific group, it is not generalisable to a wider population as it is possible that similar interviews with participants from other backgrounds (particularly from different socio-economic backgrounds) may yield different responses.

The study was intended to be the first step in what could potentially be a larger piece of work. It is hoped that it may provide some suggestions for useful further consideration and that the emerging models may provide some information on the themes and processes that may be involved in this experience. However as a result of the chosen methodology, the author's interpretation may differ from that made by another researcher. For this reason transparency with regard to the model's evolution has been attempted at every stage of analysis. This is consistent with constructivist approaches and further issues pertaining to the trustworthiness of the research are discussed within the Methodology section of this report.

As was discussed under implications for future research, a limitation of this study was the exclusion of fathers from this study. Relating to this, another limitation of the study is the missing perspective from a mother who shared the night-time care giving with a partner. This was pursued early in the recruitment process in order to provide a more complete picture of the experience but unfortunately no participant matching this description could be found. It could be hypothesised that mothers whose partners share in the night-time care-giving do not view the experience as such a difficult one and therefore did not identify with the recruitment literature. Reflecting on the current research, this could be due to fatigue, isolation and feelings of responsibility all potentially being reduced as a result of having a partner with whom to share the experience. However it is also possible that with research indicating that mothers do provide the majority of night-time care, that this was a much smaller population, and as a result and simply more difficult to recruit from. This again remains an area for further exploration.

As has already been discussed within the Methodology chapter of this study, recruitment was difficult for this study, resulting in fewer participants than had been hoped for. Several of the mothers who initially volunteered, later removed themselves from the study, often citing time constraints as a reason. This is consistent with the findings in this study that indicate the high level of responsibility held by the mothers interviewed and the resulting lack of time and energy to engage in anything other than that which is deemed necessary. With many of these mothers experiencing difficulties with 'settling' their children as well as with sleep during the night, many felt that in the evening, while no longer at work, they continued to be dominated by duties and responsibilities. If this is indeed a reason for some mothers

not participating in the study, it seems an opportunity has been missed to gain further insight into what could be a heightened experience of responsibility and pressure.

## 5.6 Conclusion

The aim of this research was to gain a deeper understanding of the maternal experience of having a child with night-time sleep difficulties. It was hoped that the findings would then provide an interpretive theoretical understanding (Charmaz, 2006) of relevant meanings and how they impact on the process of therapeutic interventions. It was proposed that an understanding such as this could be used to inform not only the practice of counselling psychologists but also that of physical health professionals who have regular contact with this population.

The research aims have been met, with a new and deeper understanding of the experience having been gained. A central storyline of *no choice but to function* was identified, with categories emerging that not only provide insight into the psychological processes of these participants but also provide insight into potential barriers to accessing care and support during this experience. Non-judgemental, informed, normalising and empowering support has been proposed as needed for this population. This would likely involve not only counselling psychologists working with parents on issues such as feelings of responsibility and acceptance, but also working together with physical health professionals to improve the overall care of this significant population.

This research highlights how the experience of having a child with sleep difficulties goes beyond that of fatigue. As has been indicated throughout this report, current literature suggests significant physical and mental health impacts as a result of sleep

deprivation. However, within this research participants described not only physical and emotional impacts of the sleep deprivation that they were experiencing, but also described, at times, feelings of desperation with seemingly nowhere to turn:

*I think I felt that if we didn't do something, something drastic, that James and I would separate, or ... And it really did get that serious, where I thought I'm going to phone social services, and say I couldn't cope anymore'*

(Francesca, L 202-204).

This is a population in need of support and yet currently under-represented in psychological literature. Also suggested by this research is that the current approach not only does not work for all mothers, but can in fact make the experience worse, leading to uncertainty and feelings of judgement. It is hoped that this research provides an insight into this experience and illustrates the need for increased psychological understanding and support of this population.

## **Chapter 6: Critical appraisal**

The work contained in this research portfolio is the result of nearly three years endeavour, from deciding on a research topic through to submission. This chapter is based on my research diary that was kept throughout the process. As such, it contains personal reflections on the experience of the research process itself, and explores my own personal experiences and views and examines how these might have impacted on the analytical process.

### **6.1 Find a subject that means something to you**

‘Find a subject that means something to you’ was the advice that was continually given to me during the initial months of embarking on the course and when discussing choice of a thesis topic. Early within the first year, I began to consider the idea of basing my research on the maternal experience of having a child with night-time sleep difficulties. Having a young daughter, I was very interested in the maternal experience. Furthermore, as my daughter had struggled with sleep for several years, this subject had personal meaning for me. As a result, I felt I had an insight into a phenomenon that seemed a potentially useful area of investigation. However, it was not easy for me to settle on this idea, frequently dismissing it as not only too personal (and thus I worried too biased), but not ‘significant’, ‘serious’, or ‘worthy’ enough. Reflecting back, I can see how this was a necessary process of critique prior to embarking on the thesis. However, it was also a process that I can now understand in relation to the theoretical model that has emerged from this research, with me likely practiced at normalising the experience and judging myself for my struggles with it rather than recognising the situation as a difficult one in itself.

My dismissive approach to the topic was in a sense reinforced when tentative investigations led me to discover that there was a paucity of research on this subject, with most initial searches yielding medical findings in nursing, midwifery and paediatric journals. This research enforced a strong message of infant and child sleep problems being a behavioural issue with no therapeutic perspectives available on the phenomenon. Even as I began to find more evidence to suggest significant relationships between parental sleep deprivation and mood, the recommendations that developed from these pieces of research focused on finding ways to ensure that the child slept. These findings, which clearly indicated a relationship between parental sleep deprivation and mental health, gave me confidence to begin to share my idea with tutors and began to normalise my own experience.

The findings also ignited a passion in me to add to the current literature by providing a human voice and illustrating the processes involved in this phenomenon. This drive was led in many ways by the therapist in me who wanted to meet the mothers where they were and to understand what that felt like rather than trying to ‘fix’ or ‘make better’. I knew that therapeutically, this could feel dismissive and would also be at conflict with the humanistic underpinnings of counselling psychology which places emphasis on a client’s autonomy (du Plock, 2010; p.132) and the search for understanding and meaning (Strawbridge and Woolfe, 2010; p.3). This is not to say that the research did not have aims to support parents whose children struggle with sleep difficulties, but I felt certain that a deep understanding from the perspective of these mothers was needed before this could be achieved.

## 6.2 Bracketing

I was very conscious throughout this process of the need to be aware of my own thoughts and assumptions on this topic. I was aware of the importance of me, not only being able to 'bracket' (Giorgi, 1985) my own personal reflections on this subject, but also of being able to justify and defend the categories and model which emerged. In order to do this I constantly questioned and challenged my own processes and the emerging analysis, both within my research diary and during research and clinical supervision. By the time I began to interview participants during my second year of training my daughter's sleep had dramatically improved and I felt I had some distance from the experience. However I still worried that my analysis would be clouded by my personal experience, noticing that at times my story was echoed in the narratives of my participants. Furthermore, I noticed that when it was not, I was naturally led to reflecting on why their experience was different to mine. This was useful in that it began a critical process of constantly asking questions of my analysis. However, I am aware that it meant that my attention might have been drawn to some aspects of the mothers' narratives more than others. A category that particularly held my attention was that of responsibility for night-time care giving. While my experience was in some ways similar to that of the participants in that I too had done much of the night-time care giving, I was not entirely comfortable with this and had often questioned the arrangement from a more feminist perspective. I noticed that while I could understand participants' reasons for providing the majority of night-time care; I struggled with understanding their acceptance and seemingly initiation of this role acquisition. Thanks to clinical experience of bracketing, I felt able to recognise when my own narratives and reflections entered into my reflections during the interview and analysis processes

and remain present in the experience of the participants whom I interviewed.

However it did raise an interest in how this research might be different if done from a feminist perspective.

GT and a feminist approach can share several common elements such as placing the participants at the centre of the study and respect for the participants' experience as a major source of knowledge. However, from a feminist perspective it has been described that every study ought to be conducted and written with an acute consciousness of what is being left out and the implications of omissions for the claims that can be made (De Vault, 1999; pp. 212-213). When reflecting on my research, I found myself increasingly wondering if there were additional factors that influenced why these women (and their partners) felt it was the mothers' responsibility to provide night-time care. The participants described a variety of reasons which have been outlined in this research but I could not help but wonder how our society's expectations for women and mothers might have influenced this situation. While this remains an area of interest for me that I believe warrants further exploration, it was not part of the narratives of my participants and as a result it felt important for me to bracket my musings on the subject in order to provide as close a representation as possible to the experiences of these mothers.

### 6.3 Engaging with participants: my roles

Charmaz (2000; p.522) describes the theory that emerges from GT as reflecting 'the viewer as well as the viewed'. Within this thesis, I am the researcher and an observer. However, I am also a mother who has experienced living with this phenomenon and a practitioner who is used to not only empathising and 'being' with clients, but also, at times, analysing, questioning and challenging their narratives.

This research has been influenced by the voices of all of these aspects of me as well as by those of the five participants who took part in the process. As a mother whose child struggled with sleep for several years I have a deep, and at times biased, understanding of this experience. As a researcher and practitioner, I am able to compare participants' narratives and view them from a more holistic perspective. During all of the interviews I was very aware of the tensions between my roles of researcher, practitioner and mother. While I was able to draw on my awareness of the need to remain within the ethical boundaries of my role as researcher (BPS), I was also able to draw on my personal and clinical knowledge and experience in a way that I feel was beneficial to this research.

Mearns and McLeod (1984) argue that qualitative research is similar to doing therapy in that researchers use empathy, genuineness and acceptance in forming relationships. I noticed that I used my therapy skills in order to assess the participants' level of comfort and to try to ensure that the interview process was at a manageable level for the participant (Rogers, 1961), letting the clients lead how much or how little they wanted to engage with various areas of exploration

Being aware of my own personal processes was important to this research, not only for the purposes of bracketing but also for gaining understanding of what was happening in the interviews with these participants. After my interview with Elaine, I noted in my diary the protectiveness I felt of what seemed to be a very fragile protective armour that she was wearing. During the interview I was aware of this being the first time that Elaine had discussed the experience in depth and I could visibly see her fighting new emotions as they emerged. During this time I was conscious of the need to maintain a research rather than therapeutic interview. While I did not work therapeutically with Elaine, I let myself be informed by my clinical

experience, recognising the need to offer containment within the interview and the importance of the coping mechanisms that Elaine was currently employing to protect herself from some of the more difficult emotions that she was experiencing. I had learnt from my work with trauma inpatients that the overwhelming nature of a situation is sometimes only manageable by using psychological defences to block pain. Furthermore, I was aware that discussing the issues faced in depth could make blocking more difficult as the subject and situation can be made more real through its acknowledgement (Firestone, 1983). This informed not only the care I took during my interview with Elaine but also led to much reflection on the similarities between this population and that of the inpatients with whom I was then working with on my placement.

#### 6.4 Working in health

My final year placement working in Burns, Oncology and Trauma departments of a busy city hospital also inevitably had an impact on this research process. This was an intensive placement that led me to deeper levels of self-reflection than any placement had previously. This was an exciting and overwhelming setting. The horror that clients had to face led to a second period of questioning the value of my research, with a ‘normal’, maternal issue seeming insignificant in comparison to the challenges that many of my clients were facing. However, this time coincided with more interviews, transcribing and analysis taking place and I noticed that I became engrossed in the narratives of these women, developing a renewed passion for the research and the seemingly unheard (both by research and practitioners), voice of this experience. Here I began to feel the similarities between client work and the research process, noticing how I focused on the participants’ lived experience, giving me some degree of necessary distance from my own experience.

I was also able to observe similarities between what had initially seemed the very different natures of my placement and research. I noticed that my client work was often around issues of acceptance and adjustment to change. This led me to consider the experience of having a child with night-time sleep difficulties from a different perspective, drawing comparisons between chronic childhood sleep difficulties and chronic health conditions, both of which leave the parent/patient with no choice but to live with the accompanying pain and disruption to 'normal life'.

Finally, my placement in physical health also highlighted for me how far reaching counselling psychology can be when it works in partnership with physical health. This impacted on my reflections when considering the clinical implications of this research. I was aware that not only could these findings impact on the development of therapeutic interventions for this population, but how they could also guide collaborative work between counselling psychologists and physical health professionals which could potentially demand little intervention and yet lead to meaningful change.

### 6.5 Conclusion

The aim of this critical appraisal was to offer an insight into how my personal perspectives might have impacted on the research process. I have attempted to provide an open and honest view of my own processes through sharing a summary of my research diary reflections. This was my first experience of using a qualitative methodology and I found that engagement with this approach required a great deal of cognitive investment, creating constant questions and feelings of uncertainty. This relentless questioning of myself, my reflections and my analysis often felt overwhelming and echoed feelings of uncertainty described throughout all of my

research interviews. Feelings of uncertainty and self-judgment were heightened by my passion to give a voice to this population and I would find myself continually returning to the transcripts to check if I was accurately representing the experience of the participants. It took some time (and supervision) to accept the feelings of uncertainty, embrace the process and to trust myself as a researcher. This combined with the positive feedback I received from the three participants with whom I shared the emerging model helped me to view the research from a freer and less critical perspective. I am hopeful that this piece of research and the emerging theoretical model can act as a baseline for future research having highlighted not only the struggles of the experience but also the potential ways in which this population can be supported.

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