

**A social constructivist grounded theory exploration
into the impacts of infant sleeplessness on 'normal'
experiences within the transition to motherhood**

Item Type	Thesis or dissertation
Authors	Dash, Suzanna
Download date	2025-05-18 10:58:54
Link to Item	http://hdl.handle.net/2436/620902

Research Report

A social constructivist grounded theory exploration into the
impacts of infant sleeplessness on 'normal' experiences
within the transition to motherhood

by

Suzanna Dash

A thesis resubmitted to the
University of Wolverhampton
for the
Practitioner Doctorate: Counselling Psychology
Award: D Couns Psych
July 2017

Abstract

Background: The aims of this qualitative research were to explore a range of challenges encountered by mothers coping with infant sleep difficulties, and subsequent impacts on the transition to becoming a parent. The intention was twofold – to raise awareness amongst practitioner psychologists that “*many new mothers experience some level of emotional distress and all deserve systematic and compassionate support*” (Boots Family Trust, p.1), with particular reference to early relationship formation, and to encourage opportunities for translation from multidisciplinary research into practice.

Method: Five semi-structured interviews were conducted. Four with mothers who were either experiencing, or had in the past experienced sleep difficulties with their babies. The fifth was with a professional ante-natal educator, herself a mother. The interviews were transcribed and analysed according to a constructivist version of grounded theory methodology guided by Charmaz (2006).

Analysis: A central narrative of ‘the wearing mask of transition’ was developed from four analytic categories: being me’, ‘being pushed to the limit’, ‘relationships’ and ‘coping, learning and trusting’. The interconnectedness of the categories was conveyed via the visual translation of the proposed pluralistic model – ‘the coping mask of transition’.

Conclusion: After having been neglected within mainstream mental health services, perinatal mental wellbeing is currently being prioritised, representing a unique opportunity for multidisciplinary consultation and sharing of expertise and training. The ‘normal’ experiences of the women interviewed were revealed as emotionally complex. They worked through their sleep deprivation and distress feeling largely unsupported, and often unwilling to disclose even to partners the extent of their difficulties.

It is hoped that this small-scale study, with its focus on a non-clinical population, and the significance of maternal mental and emotional wellbeing and outcomes for children, will encourage professionals to consider the distressing impacts of ‘normal’ sleep disturbance and deprivation within the broader context of this major life transition.

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i. Introduction

...these women talked about sleep the way a hungry person talks about food

Hochschild (1989, p10)

Becoming a parent has particular significance as a life transition by bearing directly on the experiences and wellbeing of the next generation. The quality of interaction developed is generally accepted as highly influential on the emotional, social, behavioural and psychological development of infants and children (Early Intervention Foundation, 2015; National Scientific Council on the Developing Child, 2004; Shonkoff et al., 2012). Due to the potential long-term effects on both the developing child and parent-child relationship, and the wider societal significance of negative outcomes, factors affecting parenting in the early years (0-5) has come under scrutiny by UK policy makers in the last decade (Allen, 2011; Department of Health, 2010; Field, 2010; Marmot, 2010; Monroe, 2011; Tickell, 2011). Meanwhile the widespread and enduring negative effects of sleep deprivation on adult physiological and neurological functioning increasingly attract mainstream attention (Cambridge Brain Sciences, 2017; Diering et al., 2017; Elmenhorst et al., 2017; Killgore, Balkin, Yarnell & Capaldi, 2017).

Whilst the importance of paternal involvement with infants is clearly acknowledged (Hogg, Coster & Brookes, 2015; Nolan, 2015b), the majority of the burden of day and night-time early infant care remains with mothers (Arber, Hislop & Meadows, 2006; Burgard, 2010; Cusk, 2001; Hochschild, 2003; Maushart, 2003; Miller, 2005; Wong, 2012), exposing them to the effects of sleep disturbance expected during the perinatal, more specifically, postpartum period (Baiardi et al., 2016), during which time women's mental health is uniquely vulnerable (Royal College of Obstetricians and Gynaecologists, 2017). Accordingly, the current study focuses on mothers' experiences in relation to issues arising from sleep disturbance and deprivation,

implications for maternal mental health and wellbeing, and effects on the development of parental interaction in the postnatal transition to motherhood.

The perinatal period is variously defined as that which extends from pregnancy to the end of the first year following childbirth (Boots Family Trust, 2013; London School of Economics & The Centre for Mental Health, 2014), or as the 1001 days from conception to second birthday (Leadsom, Field, Burstow & Lucas, 2013). Despite recent UK policy commitments to address longstanding issues of neglect in the planning and execution of primary care services for the perinatal psychological wellbeing of women, the current provision is recognised as broadly failing in terms of identification, facilitating and handling disclosure of distress, and provision of effective interventions (Kahn, 2015; Royal College of Obstetricians and Gynaecologists, 2017). The acknowledged outcome is that women are routinely “falling through the gaps”, and that there are attendant negative implications for the wellbeing of their partners and families (Kahn, 2015, p.1; Royal College of Obstetricians and Gynaecologists, 2017). Meanwhile the psychiatric diagnostic label ‘postnatal depression’ (PND) persists as a widely applied “catch all category” (Nicholson, 2010, p. 193), despite evidence of its clinical misrepresentation of the issues, and potential negative impacts for women who are wrongly diagnosed (Royal College of Obstetricians and Gynaecologists, 2017). The current situation resonates with observations made two decades ago, that challenged the appropriateness of a clinical diagnosis of ‘depression’ as explanatory of the highly-contextualised distress of new mothers, that is exacerbated by sleep disturbance and deprivation. The risks were then posited by Barclay et al (1997) thus, “non-pathological distress is trivialised or to be taken seriously needs to be pathologised” (Barclay, Everitt, Rogan, Schmied & Wyllie, 1997, p.136).

Meanwhile, of the suggested one in five mothers identified as having a perinatal mental health issue (Rahman, Surkan, Cayetano, Rwagatare & Dickson, 2013), it is estimated that three quarters do not fully disclose the extent of their difficulties and only 40% receive any treatment. It is also recognised that many do not disclose their distress at all and therefore are not represented in prevalence statistics (Boots Family Alliance, 2013; Hogg, 2012). Issues of disclosure as a first step in seeking help represent a significant and ongoing barrier as the

mental, psychological and emotional wellbeing of mothers reflects a complex interplay of factors besides categorically diagnosable features, including guilt, stress and distress (Choi, Henshaw, Baker & Tree, 2005; Nicholson, 2010), all of which are adversely affected by lack of sleep (Bauer, Parsonage, Knapp, Lemmi & Adelaja, 2014; Ross, Murray & Steiner, 2005). In the UK, it is estimated that approximately 700,000 women give birth every year (ONS, 2014). A report into crying and infant sleep commissioned by the NSPCC (Hogg & Coster, 2014) concluded that an unsettled baby is the most common cause of parental help seeking, with 1 in 6 seeking professional advice, citing that infant crying and sleeping problems cost the NHS an estimated £65 million in 2001. The means by which mothers distinguish between normal and problematic sleep disturbance may be complex and relate to a range of subtle variables, not all of which are accounted for by infant sleep behaviours (Loutzenhiser, Alquist & Hoffer, 2011). Postnatal sleep deprivation, both empirical and perceived, has however been significantly associated consistently with postpartum mental health problems in first-time mothers and fathers (Baiardi et al., 2016; Chang, Pien, Duntley & Macones, 2010; Parfitt & Ayers, 2014; Wolfson, Crowley, Anwer & Bassett, 2003). The pressure to succeed as a mother, including amongst other expectations, that of being able to settle an infant to sleep, is cited as a contributing factor to the stress and subsequent anxiety created (Boots Family Alliance, 2013; Choi et al., 2005), with potential to influence not only the initial transition to motherhood, but also subsequent experiences with other children.

Issues surrounding distress experienced in the transition to motherhood have been explored for decades. Commenting on their findings in the 2005 paper “Supermum, Superwife, Supereverything”, Choi et al (2005) suggested that little had changed in terms of attitudes and experiences in the time since Oakley’s (1986) assertion two decades earlier “[i]t is hard to avoid the fact that there is something really depressing about motherhood” (Oakley, 1986, p. 61). Research findings from a wide range of academic fields continue to appear to resist translation beyond the professional sphere of midwifery and other specialist postnatal practitioners, into facilitating broader understanding of the potential complexity yet ‘normality’, or at least, commonality, of women’s experiences, and impacts thereof.

The aim of the current research was to explore the effects of the challenges of unsettled infants faced routinely by some mothers, the significance and impact of which are largely overlooked, both by society and services, being often minimised or dismissed by over-reassurance (Kahn, 2015). By interviewing a group of mothers, self-identified by perceiving sleep difficulties in their infants, both concurrently at the time of interview, and retrospectively, as well as the perspective of a professional supporter of women during the transition, this study explored the immediate and longer-term effects of this stressor on mothers' psychological and emotional wellbeing. The women in this study identified themselves both as mothers, but also as co-parents with their male partners. Accordingly, the analysis of their responding prioritised identifying processes which underpin or jeopardise coping strategies, and explored how these adaptations impact the transition to motherhood within the context of a parenting dyad.

The implications of sleep deprivation within serious mental health conditions are recognised, however the impacts are relatable by all. With a focus on mothers who are not identified as having a mental health requirement, and by the specific exploration and elucidation of their experiences, this study intends to raise awareness of the extent of the impacts of their sleep deprivation, and encourage development of an atmosphere of recognition and disclosure. In turn, this will facilitate and enable women to feel supported and legitimised to prioritise self-care. Increased awareness of the issues, amongst both practitioners and women and their families, would ease distress, whilst clinical adoption of early interventions that support the period of adjustment potentially mitigate the development of clinically recognised symptoms of serious mental ill health for others (Barlow, Bennett, Midgley, Larkin & Wei, 2015; Parfitt & Ayers, 2014). Consistent with the selected grounded theory constructivist methodological approach a spectrum of literature and theoretical frameworks representing a range of academic fields and disciplines have been consulted, directed by the data collection and analytic processes (Charmaz, 2006).

1. Literature Review

1.1 Infant sleep patterns and parental expectations and impacts

...there have been times when I've sat in my bedroom and rocked on my hands... if I get off my hands I don't know what I'll do...no sleep for like four nights

(Natalie: 366)

Crying in neonates is accepted as part of normal neuro-behavioural development, and whilst it is subject to significant individual differences, generally reaches a peak of three hours a day at six weeks after birth, declining to less than an hour a day at 12 weeks (Kurth, Kennedy, Spichiger, Hösli & Stutz, 2011). Infant colic, characterised as excessive infant crying – more than three hours a day, for more than three days a week in the first three months, is hypothesised to result from pain although this is not well understood (e.g. Gudmundsson, 2010). However, it is experienced by an estimated one in six families (Kaley, Reid & Flynn, 2011), and is a much-debated example of a common problem which lacks an evidence-based solution. Soothing, or failure to soothe a crying baby, is a source of distress for mothers in particular, as they recover from labour and manage the impacts of their own sleep deprivation in what, for the primiparous, is a landscape of new challenges (Dahlen, Barclay & Homer, 2010), whilst for those with other children may additionally include a range of other pre-existing and competing demands. Additionally, sleep disturbance may, in some cases, form part of the family experience for an indeterminate length of time as children grow past infancy (Blunden et al., 2004).

Perhaps at odds with contemporary societal and cultural norms, and arguably, parental expectations and desires, sleeping through the night, or 'settling', was established in an early influential study as a period of undisturbed infant sleep from midnight to five o'clock in the morning (Moore & Ucko, 1957). A key finding from this study, that 70% of infants begin to sleep through the night from the age of 3 months, continues to inform current guidelines, cultural perspectives and thereby expectations. However, reference to this statistic in

isolation appears to neglect those infants (35%) which revert to nocturnal waking from 6 to 12 months, and those that never sleep through a night in the first 12 months (Moore & Ucko, 1957). More specifically expectations of sleep in infants may neglect to take account of normal variations in sleep patterns resulting from infant sleep architecture indicating cycles of active and deep sleep that are thought to influence development in the infant brain (Rudzik, 2015). They may also reflect a lack of awareness of infant sleep cycles - duration approximately 45 minutes - around half that of adults, and patterns which are qualitatively distinct from that of adult humans, being initially unattuned to the circadian rhythm of cyclical dark and light (Bertelle, Sevestre, Laou-Hap, Nagahapitive & Sizun, 2007).

Babies and infants require different patterns of sleep which alter and adjust in line with their changing developmental needs over the course of their early months and years, as highlighted by a global review of sleep duration studies in infants aged 0-2 years, which provided evidence for wide ranging norms (Galland, Taylor, Elder & Herbison, 2012). An exploratory small scale study ($n=22$) suggests early postnatal infant circadian cycles respond to entrainment to 24-hour social synchronisation via maternal activity cues (Tsai, Barnard, Lentz & Thomas, 2011), however parents may be unprepared for such a requirement to facilitate their infant's day and night, sleep-wake cycle. The meeting or challenging of expectations shapes experiences with potential to influence the developing parent-child relationship, and the development of postnatal symptoms of depression have been linked to expectations which run counter to the reality of infant sleep patterns (Baiardi et al., 2013; Dennis & Ross, 2005; Douglas & Hill, 2013). Parents may interpret infant behaviour as problematic, and seek advice and interventions for what are perceived, perhaps erroneously, as sleep problems but may more accurately reflect incongruity with infant sleep biology or emotional developmental stages (Rudzik, 2015). In light of variability highlighted above in the developmental pattern of infant sleep, the present study maintained an awareness between the expectations and experiences of mothers of infants (0-12 months) whose sleep patterns were not as anticipated by parents, and those with older

children (older than two years) with ongoing sleep issues (Alcala, 2013; Meltzer & Mindell, 2007).

A debate exists amongst academics, antenatal practitioners and educators about the extent to which parents' expectations of infant sleep are unrealistic and unhelpful (Rudzik, 2015). It is suggested that expectational norms idealising a pattern of sleep which occurs at night, in a single unbroken eight-hour period, are based on cultural influences predicated on economic imperatives (Rudzik, 2015). Accordingly, evidence attests that in western cultures there exists a long held early aim of many parents to have a baby that sleeps through the night (Schaefer & DiGeronimo, 1992), with such babies often being characterised as 'good' or 'easy'. However, there is little evidence supporting this attribution of temperament. For example, in a comparison of 30 children aged 12 months identified as having either regular or irregular sleep rhythmicity, there were no links found between sleep and temperamental characteristics, whilst limitations of maternal perception in assessing infant temperament were suggested (Scher, Tirosh & Lavie, 1998). Coping with an infant that is unable to "self soothe" (Germo, Goldberg & Keller, 2009, p. 225), or an "unsettled baby" (p.12) was indicated as an additional pressure and source of stress for some respondents in the Boots Family Trust survey (2013). Whilst night waking and excessive crying are, as mentioned earlier, the most common reason parents with small babies to seek assistance or intervention (Hogg & Coster, 2014).

Coping with sleep disturbance is cited by mothers as causal in the early cessation of breastfeeding (Douglas & Hill, 2013). This has potential negative implications, not only for infants, but also maternal outcomes, as unfulfilled breastfeeding desires are implicated in exacerbating mental ill health (Chen & Rogan, 2004; Kendall-Tackett, 2007). Breastfeeding 'on demand' which is determined by a baby's own needs for feeding, and confers obvious strictures on the mother as feeding is likely to occur throughout day and night, has in recent decades replaced generations of western parenting expert advice of time-regulated feeding patterns which have also, but not exclusively promoted bottle over breast feeding (Dewar, 2014). An evolutionary perspective supported by comparisons of milk composition

recognises humans (primates) as 'continuous' rather than 'spaced' feeders (Dewar, 2014), which supports the appropriateness of baby-initiated feeding schedules. A purely evolutionary perspective considers the conflicting desires of parent-offspring in relation to breastfeeding on demand as a function of genetic survival delaying sibling birth (Haig, 2014). Current research findings indicate implications of enforced feeding patterns which include positive impacts on maternal depression but concomitant potential negative impacts on infant cognitive developmental, as indicated a large scale, longitudinal study of 10,419 participants (aged 8 weeks - 33 months), and measured by children's performance on standardised tests and IQ scores (Iacovou & Sevilla, 2013). Breastfeeding on demand, even small quantities, has been demonstrated to reduce stress and pain in babies (Shah, Aliwaslas & Shah, 2007), whilst skin to skin contact, which co-occurs with breastfeeding, is recognised to act as an analgesic in infants (Gray, Watt & Blass, 2000; Gray, Miller, Phillip & Blass, 2002). Bedsharing with infants may occur, particularly if breast feeding, as the decision can result in less night time disruption associated with demand feeding. However, these actions run counter to current UK guidance advising against bedsharing as a precaution to combat sudden infant death syndrome (SIDS) or infant asphyxia (NICE, 2014). Although a tragic but rare possibility for any baby, evidence suggests there are with increased risks for infants younger than 12 weeks, and with mothers who are smokers (Vennemann et al., 2012). It has been suggested that breastfeeding is a protective factor against SIDS as it increases frequency and duration of feeds (Mosko, Richard & McKenna, 1996), with a meta-analysis providing substantial evidence for the protective effects of exclusive breastfeeding (Hauck, Thompson, Tanabe, Moon & Venneman, 2011). A cross cultural perspective provides much support for the developmentally significant aspects for infants of sleeping close to their parents (McKenna, 2007) - it is suggested that a proximity which allows a baby to smell their parents (4-5 metres) and hear their breathing is beneficial in soothing infants (Grille, 2008). Current guidance on bedsharing provides information and evidence leaving parents to exercise their own judgment, but understandably this is an anxiety-provoking decision. In a counter measure, infant sleep

specialists invite parents to reflect on their likely reactions and responses in anticipation of tragic consequences prior to making their decision (McKenna, 2015). If somewhat bleak, and at the extreme end of a spectrum of parental reflective tasks this is an applied example of developing parental reflective function (Fonagy & Target, 2007; Slade, 2005).

Development of reflexivity is encouraged as an acknowledged and effective means of enhancing parental sensitivity to their infant whilst underpinning efficacy and agency (Early Intervention Foundation, 2015, p.16).

Behaviourally based sleep training interventions are advocated only for children older than six months, with evidence suggesting long-term positive impacts on maternal depressive symptoms and no adverse effects on child mental health at two years (Hiscock, Bayer, Hampton, Ukomunne & Wake, 2008), as attested by the CEO of the Parenting Research Centre, Melbourne:

“...we believe that evidence-based behavioural sleep interventions have an important place, especially in relation to sleeping difficulties in infants older than six months. Indeed, a sleep intervention may be the intervention of choice in the case of high parental stress and fatigue in this group” (W.Cann, personal communication, October 12, 2015).

A systematic review concluded that sleep training interventions for infants younger than six months pose a range of risks identified as increasing crying and maternal anxiety and vulnerability to depression, increasing the likelihood of cessation of breastfeeding and introducing an increased potential for SIDS if infants are separated from caregivers (Douglas & Hill, 2013). With no available sleep modification intervention, fatigued parents of infants less than six months must therefore manage the distress of infant crying, the worry and guilt associated with bedsharing, and the potential for fatigue exacerbating neglect of their own self-care which has implications for a worsening of both psychological and physical wellbeing (Dunning, Seymour, Cooklin & Giallo, 2013).

The development of anxiety and distress in the newly forming relationship between parents and their infants is potentiated as they are confronted with challenges to their own capacities, needs and expectations which may find expression in many ways (Grille, 2008).

Informed by links with crying and increased incidence of child abuse (Blom, van Sleuwen, de Vries, Engelberts & L'hoir, 2009), raised awareness has led to the development of an NSPCC programme based around a psychoeducational video (Hogg & Coster, 2014) to support parents and safeguard infants through a period that is recognised as highly stressful.

1.2 Chronobiology and sleep deprivation

The baby is roaring.

It is the sort of sound that permits no pause between deep sleep and full activity...my thoughts have become rat-like and rudimentary...with lack of sleep

Cusk (2001, p.63)

The average duration of sleep in the general adult population is approximately 7 hours per night, suggested to be the least in recorded history (Lockley & Foster, 2012), and is in decline (Chang et al., 2010). With particular relevance to the current study, evidence suggests that women generally are more vulnerable and at greater risk from the negative chronic effects of the trend of less sleep (He, Zhang, Li, Dai & Shi, 2017; Pires, Andersen, Giovenardi & Tufik, 2010), with adverse effects on perinatal mental health well documented (Ross, Murray & Steiner, 2005).

An adult sleep cycle consists of two distinct types of sleep – rapid eye movement (REM), and non-rapid eye movement (NREM), alternating to form a sleep cycle of 90-100 minutes, which repeat several times throughout the duration of the continuous sleep period, supporting identifiable stages of brain activity, progressing from light, to deep, restorative sleep (Lockley & Foster, 2012). Sufficient and regular sleep, which underpins circadian rhythm in adults, is demonstrated via neuroimaging techniques as critically restorative across a range of functions, and is implicated in maintenance of general emotional physical and behavioural health and wellbeing (Born, Lange, Hansen, Molle & Fehm, 1997; Dang-Vu et al, 2010; Guadagni, Burles, Ferrara & Iaria, 2014). Sleep duration and quality affects

endocrine and metabolic processes, memory consolidation (Deikelman & Born, 2010) and cortical recovery (Drummond & Brown, 2001). Practical impacts of sleep loss include increases in reaction time, and lapses of attention (Lim & Dinges, 2008), decreased hand-eye co-ordination (Elmenhorst, Elmenhorst, Luks & Samal, 2009), and increased susceptibility to negative interpretations and emotions (Babson & Feldner, 2010). Insufficiency of sleep and disrupted circadian rhythm in adults are implicated in suppression of gene expression, with negative health consequences including cognitive impairment, obesity and cardio-vascular disease, and putative links to altered responses to stressors and challenges (Moller-Levet et al., 2013), and effects on emotional regulation (Guadagni et al., 2014).

It is suggested that 46 - 87% of new mothers adapting to the 24-hour needs of a neonate, report tiredness or fatigue, indicating an imbalance between activity and rest, wherein fatigue is defined as a pathological rather than physiological state which 'persists' through the circadian rhythm, being unresolved by a single period of sleep (Kurth et al., 2011). A longitudinal study of 1000 women conducted by the Parenting Research Centre in Australia, considered physical and psychological health and recovery after childbirth, and explored a proposed link between the commonly conjointly experienced fatigue and depressive symptoms (Giallo, Gartland, Woolhouse & Brown, 2015). They sought to differentiate between the two constructs in order to map development of symptoms at one year and four years' postpartum. Their findings suggested that fatigue and depression be most usefully considered as separate but related constructs, highlighting the clinical relevance of differentiating the signs and symptoms.

A comprehensive literature consistently points to the links between sustained sleep deprivation, lowered mood and emotional reactivity (Gujar, Yoo, Hu & Walker, 2011) and decreased ability to concentrate (Bertelle et al., 2007; Davis, Parker & Montgomery, 2004). Of significance to the developing relationship between mothers and infants, is that the largest adverse effects of sleep deprivation evidenced from neuroscientific research, appear to be on the functioning of the prefrontal cortex in mediating emotional responding to others,

in particular by being able to empathise with another's perspective (Guadagni et al., 2014; Killgore et al., 2008; Oschsner, 2013). This has implications for the sensitivity of attunement possible, as mothers attempt to balance meeting their own needs with understanding the often-changing needs of their infant (Hughes & Baylin, 2012; Stern, 1985; Tronick, 2007). Neuroscience in the last decade provides evidence for parental brain circuitry as a duality - a mammalian caregiving core situated in the limbic system (Porges, 2011), overlaid with the essentially human abilities of reflection, self-awareness, emotional regulation, personal growth and change made available via the prefrontal cortex (Bridges, 2008). Porges' polyvagal theory (2011), offers an "organising principle" (p. xiii) for emotions, physiological responses, and the mediating effects of human interactions. The theory posits a state regulation system "to navigate the stress of life" (p.36) developed during infancy, which underpins and influences individual ability to regulate internal states of mind via the autonomic nervous system (Porges, 2009). It cites the vagal nerve, which relays sensory feedback from the visceral organs via proprioception (Tortora & Grabowski, 1996). Whilst the lower vagal system controls digestion via the gut, its upper region exerts parasympathetic control over heart and lungs, and it is proposed that this section regulates calm states by enabling deep social connections such as those that characterise, underpin and regulate positive parent – infant relationships (Cree, 2015; Hughes & Baylin, 2012; Porges, 2009).

The result is a dual process, complementary but complex, bottom-up and top-down system of reacting and responding, within which the phenomenon of 'parental blocked care' may be made manifest (Hughes & Baylin, 2012). With reference to this dual process model, Hughes and Baylin (2012) suggest that in the face of sufficient stress, such as that induced by sleep deprivation, *all* parents may lose their ability or capacity to prioritise caring for their child, instead succumbing, however momentarily, to primal impulses emanating from the limbic system, associated with fundamental, emotional, visceral drives (Panksepp, 1998). They suggest that self-defensive feelings negate the openness required for deeply felt safety, which can give rise to love and trust (Cree, 2015; Hughes & Baylin, 2012; Rockliffe, Gilbert,

McEwan, Lightman & Glover, 2008). This state of arousal from the primitive brain renders a temporary disconnect from higher brain functions producing, for split seconds, or perhaps a more extended period, an effectively 'mindless' state - the time taken to repair this rupture in parental consistence depending upon individual ability to recover from the negative emotional state, often provoking subsequent feelings of guilt and distress (Siegel, 2010). The time course of emotional responding may be enhanced or diminished by a range of personal, interpersonal and external factors, with consistency demonstrated between brain functioning, reported emotional and life satisfaction and biological measures linked to physical health, which is of course dependant on sufficient sleep (Davidson, Jackson & Kalin, 2000).

Sleep and depression are strongly related and identifiable by reciprocal causal links, although the significance of associations between sleep patterns and emotional wellbeing have been indicated as a neglected area for many years, with much extant sleep research focussing on men (Wolfson et al., 2003). Methodological inconsistencies are often cited in relation to sleep studies of women in pregnancy, with some suggestions that the results from polysomnographic studies likely lack generalisability, due to the arguably atypical characteristics of women who feel able to participate, when many feel prevented by health or other family constraints (Chang et al., 2010; Ross, Murray & Steiner, 2005). However, evidence suggests sleep disturbance underpins the development of depression in those who had no prior experience (Chang et al., 2010). Meanwhile current interest focusses on the "pivotal role" played by changing sleep patterns during the perinatal period (Baiardi et al., 2016, p. 2). At three months postpartum, fragmented sleep of less than four hours between midnight and 6 a.m. has been found to be more strongly correlated with depressive symptoms in mothers than infant temperament (Goyal, Gay & Lee, 2009). New mothers have been identified as being at an extended risk of daytime sleepiness at four months postpartum, which a recent report suggests has implications for policy makers and employers in particular in relation to women planning a return to work (Filtner, MacKenzie & Armstrong, 2014). Although the findings may have wider implications for the functioning in

daily life of all new mothers who are experiencing some degree of sleep deprivation. Additional factors that may impact negatively on parental sleep include recovering from birth, breastfeeding, older maternal age, lone parenting and low income (Dunning, Seymour, Cooklin & Giallo, 2013), whilst frequent night waking is associated with increased risks of clinical fatigue and exhaustion (Fisher, Feekery & Rowe, 2004).

The effects of fatigue in new parents have been extensively explored with evidence highlighting impacts on parenting practices (Cooklin, Giallo & Rose, 2012), with some new parents characterised as in “survival mode” (Giallo, Rose, Cooklin & McCormack, 2013, p.1). A grounded theory study that explored the effects of sleep disturbance in children older than 12 months, whereby the issues were felt to be beyond ‘normal’, defined by Alcala (2013), as “the first six months or year...while difficult is generally accepted to be relatively normal” (p.12), concluded that the five mothers interviewed, identified as principle night time carers of the children in the study, had “no choice but to function” (p.ii). The author suggests that the impacts on maternal wellbeing of sleep difficulties in children beyond infancy, despite its high incidence (Blunden et al., 2004), has been conceptualised within a medical model that seeks a solution to ‘fix’ what is identified as problematic behaviour. In cases such as those in Alcala’s (2013) study, when the professionally sought solution did not solve the problem it seems that mothers felt judgment and shame, despite initially presenting similar positive narratives. The theoretical categories reflect similarities with the current study, with a focus on ‘responsibility’, ‘isolation’, ‘reaching limits’ and ‘personal challenges’ (Alcala, 2013). The theoretical model identifies a core category as ‘stages’ in which mothers attempted to ‘fix’ the sleep ‘problem’, by means of sleep training. When the problem resisted ‘fixing’ the author is interested in understanding the means by which the women adapt and tolerate their situation within the context of their lives, families and wider society. The “no choice but to function” central storyline highlights similarities within the linear processes and conflicted emotions of mothers whose narratives transformed within the context of the research undertaking, to reveal complex tensions underpinning a desire to appear as “functioning people” (Alcala, 2013, p.60). It is worthy of note that the mothers interviewed disclosed more depth of

emotion 'off the record', in a literal sense when the tape recording was over, suggesting a desire to reveal that was prevented by a greater desire to mask the extent of their distress. As mentioned earlier, experimental studies of pregnant women and new parents present recruitment problems, so the lived experiences of these groups may not be accurately reflected or generalisable from findings obtained from other samples. Indeed, the ability of research participants to opt out of sleep deprivation studies has been identified as a potential confounding factor (Medina, Lederhos & Lillis, 2009), and one which serves to emphasise the distinction between the actual experience of new parents and academic endeavours to reconstruct phenomenology. Accounts from qualitative studies, such as Alcala (2013) support the current study's findings that the relentless, inescapable and unpredictable nature of sleep disturbances experienced by, particularly breastfeeding, mothers render a qualitative difference, exacerbating their sense of challenge and loss of control which sleep laboratory studies, with a quantitative design, fail to capture and are unable to replicate. By contrast, Guadagni et al (2014) provide experimental evidence from *a single night* of sleep deprivation for the wide-ranging implications of sleep deprivation for regulation of empathic responses via neural networks and mediation of the limbic system in neurotypical adults. The sleep laboratory based study analyses data obtained from 37 healthy participants under conditions of normal sleep or a night of non-sleep, and a daytime control group, after which their responses to visual images of emotional situations and facial expressions were assessed by verbal and physiological responses. Participants were asked "how calm/aroused does this picture make you feel?", and "how strong is the emotion you feel about this person?". Significantly reduced responding was found in the emotional empathy demonstrated by the sleep deprived group, therefore it would seem reasonable to infer that the compounded effects of sleep deprivation over a period of days, weeks, months might be reflected in a reduction in emotional empathy in mothers. However, as stated earlier, it has been suggested that experimental sleep research lacks ecological validity for this population (Medina et al., 2009).

1.3 Stress, distress, and perinatal mental health and wellbeing

*Perhaps the question should be not, why do some women get depressed, but why do some mothers **not** get depressed?*

Oakley (1979, p. 143)

In addition to, and exacerbated by the effects of broken sleep, many mothers feel themselves distressed and overwhelmed with the stress of trying to live up to their own and, arguably societally endorsed expectations (Barclay, 1997; Boots, 2013; Choi et al., 2005; LeMasters, 1957; Oakley, 1979). Postnatal distress is frequently ascribed in terms of “raging hormones”, although the explanation often appears to lack clarity of definition, and rather reinforces feelings of a lack of choice or control (Darvill, Skirton & Farrand, 2010, p.362), whilst mothers’ anticipation of, or vulnerability towards mental ill health exacerbates feeling of anxiety, stigma and shame. Perinatal mental ill health can also affect partners, with moderate positive correlations found between maternal postnatal depression and paternal depression at 3-6 months postpartum (Paulson & Bazemore, 2010).

Stress resulting from a perceived lack in the appraisal of fit between individual abilities and resources and contextual or circumstantial demands (Lazarus & Folkman, 1984) is recognised generally as a significant factor in the transition to parenthood (Cowan & Cowan, 1992; 2000; Hogg, Coster & Brookes, 2015). Stress, clinically defined as a range of responses to stimuli which disturb an organism’s equilibrium or “tax or exceed its ability to cope” (APA, 2017, p.18), may have particular relevance for parents as they navigate the complexity and extent of novel and dynamic demands placed on them by the arrival of a new baby, with subsequent implications for potential hormonal, in particular cortisol, imbalance (Elder, Wetherell, Barclay & Ellis, 2014). Cortisol, commonly referred to as the ‘stress hormone’, supports homeostasis of fight-flight responses, and maintaining long term functioning of sleep-wake regulation (Elder et al., 2014; Fries, Dettenborn & Kirschbaum, 2009).

As mentioned earlier, specific sources of stress include expectations, which may be unattainable, and perceived or self-imposed pressures to 'do it (everything) right', which may include having a baby that reliably sleeps according to expectations (Boots, 2013). Of particular relevance to this study is the strand of research that considers the impact of maternal mental health distress on parenting behaviours due to the acknowledged psychosocial consequences for children (Early Intervention Foundation, 2015). It is currently under significant scrutiny in terms of aetiology, epidemiology, outcomes for infants and parents, and financial implications for UK society, as evidenced by a range of reviews and commissioned reports (Boots Family Trust, 2013; Hogg, 2012; London School of Economics & The Centre for Mental Health, 2014). Recognition and identification of factors influencing maternal wellbeing, and by inference the longer-term outcomes for children's mental health, critically informs current UK public health models of 'progressive-universalism' in tiered parenting support approaches (Hogg, Kennedy, Gray & Hanley, 2013).

Sources suggest that between one in five (Rahman et al., 2013), and one in ten (Hogg, 2012) mothers experience some form of recognised mental illness during the perinatal period. Of particular relevance for the present study some sources cite that 40% of women suffering from mental distress have experienced a traumatic birth (Boots Family Trust, 2013), yet NHS adult mental health services have not traditionally addressed the needs of service users as parents, with mothers particularly poorly served due to issues identified as lack of resources, knowledge, clinical skills, and poorly defined professional roles that result in a discontinuity of care within services (Barlow et al, 2010; Kahn, 2015).

Identification and clinical management of the mental health of women during the perinatal period has traditionally focussed on those women with an existing history of mental health issues (Boots Family Trust, 2013, p.11), however a recent report, which surveyed 2300 women in the UK, indicates that three quarters had no such history (Royal College of Obstetricians and Gynaecologists, 2017). The most recently updated guidelines have a focus of "women of childbearing potential who have a new, existing or past mental health problem" (NICE, 2014, 1.2.1). Reasons for this arguably restricted and deterministic approach have

been suggested as due to lack of professional training, lack of continuity of care and support services and “the reluctance of women to talk about their mental health” (Boots, Family Trust, 2013, p.11), in addition to the aforementioned inconsistencies in provision of appropriate support.

Although diagnoses, or ‘provisional’ diagnoses within IAPT services of postnatal depression (PND) are common, with depressive symptoms the primary focus of concern for much research (Buist et al., 2008; O’Hara & Swain, 1996; Paulson, Dauber & Leiferman, 2006), evidence increasingly indicates the prevalence of low mood (69%) and anxiety (49%), rather than depression (37%) (Royal College of Obstetricians and Gynaecologists, 2017). In common with the general population the experience of women during the perinatal period may include low mood, anxiety and depression, which may co-occur (Seymour, Giallo, Cooklin & Dunning, 2014, Teixeira, Figueiredo, Conde, Pacheco & Costa, 2009), with prevailing symptoms of low mood and tearfulness (Boots Family Trust, 2013).

The implications of sleep deprivation within the stress-diathesis model of mental health conditions are widely accepted (Baiardi et al., 2016; Cree, 2015; Dennis & Ross, 2005; Hogg, 2012; Parfitt & Ayers, 2014; Wolfson et al, 2003). The incidence of anxiety disorders, resulting from increased stress, is recognised as common during the perinatal period (Miller, Pallant & Negri, 2006), with specific disorders - generalised anxiety and obsessive-compulsive - more highly represented in postpartum women than the general population (Ross & McLean, 2006). Whilst comorbidity with depression is common (Fairbrother, Young, Janssen, Antony & Tucker, 2015; Reck et al., 2008), it has been suggested that maternal anxiety, characterised as worry, restlessness, sleep disturbance and apprehension (American Psychiatric Association, 1994), has traditionally been overlooked in routine screening assessments for depression in new mothers (Matthey, Barnett, Howie & Kavanagh, 2003; Reck et al., 2008). Additionally, an NSPCC review (Hogg, 2012) suggested that mental health conditions such as perinatal obsessive-compulsive disorder (OCD) (Williams & Koran, 1997), panic disorder (Cohen, Schel, Dimmock & Rosenbaum, 1994), post-traumatic stress disorder (PTSD) and the rarer puerperal psychosis, which affects 1 in 1000 pregnancies (Mind, 2015), may be

precipitated or, if pre-existing, aggravated by the stress induced caring for a new baby. The Hogg review (2012) identified the lack of consistent provision of timely and appropriate services for those experiencing perinatal mental health problems, making a compelling financial case for development of universal and specialist services, which is currently being addressed with the launch in August 2016 of the specialist perinatal mental health community service fund (NHS, 2016).

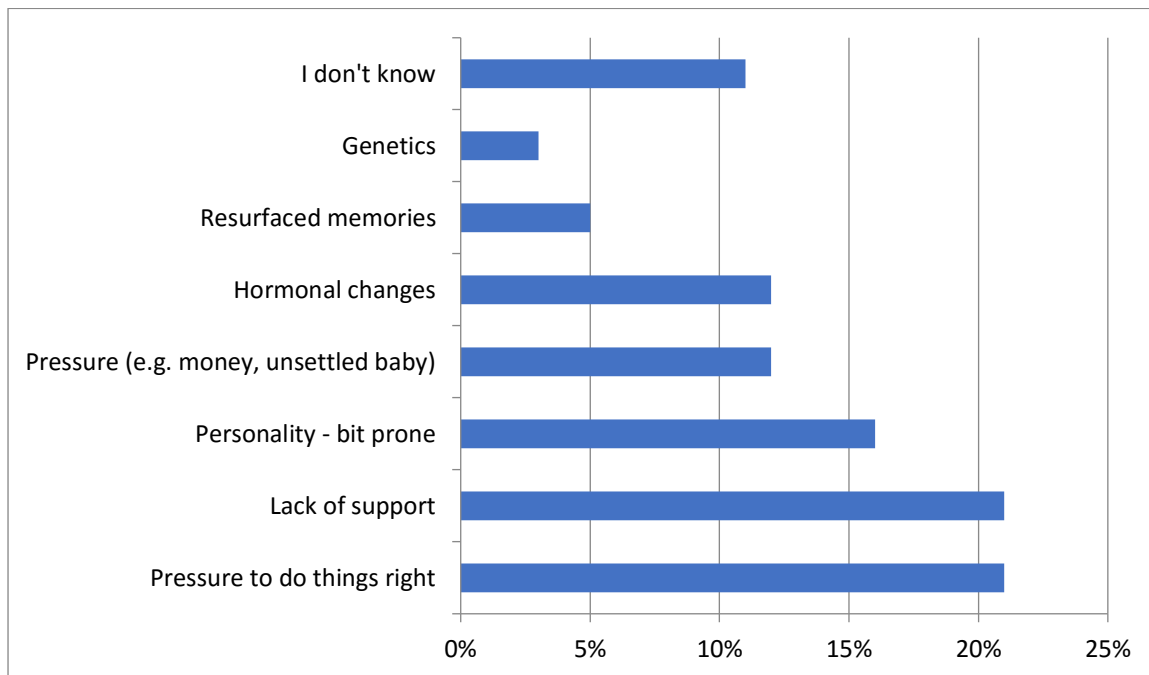
Whilst acknowledging the risks to mental health associated within identified vulnerable groups, the review highlighted the necessity of raising awareness of the potential risks to *all* women:

“over half of the women who committed suicide during pregnancy or shortly after birth in the UK between 2006 and 2008 were white, married, employed, living in comfortable circumstances and aged 30 years or older...universal services who work with women during the perinatal period must be alert to the risks of perinatal mental illness in all the women they work with. The onset and escalation of symptoms of mental illness can often be prevented through proper management of a woman’s condition, avoidance of environmental risk factors and *triggers such as stress or sleeplessness*, and making prompt and informed choices about medication. This is why it is critically important to identify women who are at risk and ensure they get timely and appropriate support” (Hogg, 2012, p.10, emphasis added).

As stated earlier, statistically-based prevalence rates for mental ill health (e.g. Joint Commissioning Panel for Mental Health, 2012) only reflect those women who are identified, or who recognise and actively seek help for their distress, with a review of the literature indicating that only 40% of incidents of perinatal depression are identified (Gavin et al., 2005). The numbers of women affected by adjustment difficulties whilst in the period of transition, but who hide their distress and continue to function apparently as normal is suggested to be as high as 150-300 in every 1000 pregnancies (Hogg, 2012).

In an attempt to explore the individual lived experiences of mothers, the Boots Family Trust report (2013) conducted an on-line survey of around 1500 women who had been diagnosed,

Figure 1 Self-reported causes of illness (adapted from Boots Family Trust, 2013, p.12)



or self-diagnosed, perinatal mental health conditions – depression and anxiety during pregnancy (50%), postnatal depression (66%) and in rare cases puerperal psychosis (2%). Over and above any predisposition to mental health problems, participants were asked to attribute the sources of their difficulties as presented in Figure 1. Most commonly cited factors included unrealistic or unattainable expectations – the “pressure to do things right” (21%), and “lack of support” (21%). According to the survey women with a history of mental health difficulties attributed this to their personality, considering themselves “a bit prone”, which it is suggested, evidenced a failure to recognise the significance of their mental health history.

Of particular relevance for the present study, additional stressors, such as financial or work problems, also included having an “unsettled baby” (p.3), and was indicated by around a third of respondents. Although not explored by the survey, in addition to those unable to assign a cause (11%) it is also relevant to this study to note “resurfaced memories” were cited by 5% of women surveyed. Biological determinants which were not explored further by the survey were offered as causal in terms of “hormonal changes” (12%) and “genetics” (3%) (Figure 1). Whilst physical changes to a woman’s body in pregnancy are expected and well

recognised, and emerging evidence indicates significant, long-lasting and unmistakable restructuring which pregnant women's brains undergo (Hoekzema et al., 2017), the report suggests that, in comparison, emotional impacts of becoming a mother are relatively neglected as trigger for mental distress by parents, but also professionals and the wider society. This was evidenced as almost half of respondents indicated that anger was an issue, a finding replicated in a study based on semi-structured clinical interviews with first-time mothers and fathers (Parfitt & Ayers, 2014), and many of those surveyed disclosed that they had not felt able to reveal their true feelings in relation to their mental health distress for fear of losing custody of their child (Boots Family Trust, 2013).

For those who do seek help, they are as likely to first disclose their distress to a GP, midwife or health visitor, as to their partner (Boots Family Trust, 2013). Whilst GPs represent a distinctive gatekeeper to services for women disclosing struggles during the transition with a new baby, the disengagement of their involvement in perinatal and maternity care in the last decade has resulted in "potentially deskilling" (p.11) them, according to a report, endorsed by the Royal College of General Practitioners (RCGP), which represents 50,000 family doctors practising in the UK (Kahn, 2015). Following on from the Boots Family Alliance (2013) report, this subsequent report describes an "unreliable system of perinatal care" (p.27) characterised by "inconsistencies and discontinuities" (p.6) and "poor identification, unreliable referral pathways and poor follow up" (Kahn, 2015, p. 37). In response, a commitment was undertaken by the RCGP, that within the following three years, "all GPs (will) have the knowledge, skills and confidence to effectively identify and treat pregnant women with depression and anxiety" (Kahn, 2015, p.5).

In cases identified as presenting a particular risk due to maternal mental health difficulties, a range of targeted interventions are available for mothers and their babies. These special cases include, for example mothers and babies less than 24 months old whose relationships are identified as at risk due to being in prison, maternal attachment difficulties, or a diagnosis of post-natal depression or puerperal psychosis. Interventions include the Family Nurse Partnership programme (Mason, 2016), parent-infant psychotherapy (PIP), compassion

focussed therapy (Cree, 2015), video-interaction guidance (VIG) and psychoeducation (Barlow et al., 2015).

However, of particular relevance for the present study, which considers the experiences of a non-clinical population, the report findings indicate that “many new mothers experience some level of emotional distress and *all* deserve systematic and compassionate support” (Boots Family Trust, p.1).

1.4 Theoretical approaches offered for the transition to parenthood and motherhood

It is a terrible thing to be so open: it is as if my heart put on a face and walked into the world

Plath: Three Women (1962, p.185)

The ubiquitous experience of being parented, and in turn becoming a parent, has long been recognised by practitioners, researchers and academics as highly complex, dynamic and vulnerable to disruption (Cowan & Cowan, 2000; Grille, 2008; Hrdy, 2000; Nelson, Kushler & Lyubomirsky, 2014; Stern, 1977; Winnicot, 1960), and despite its unique significance as a life transition, degree of preparation for which is a matter for the individual or couple.

Historical perspectives of parenting attitudes and practices offer insights which illuminate the challenges inherent in what is often deemed a natural instinctive transition, revealing a social behaviour subject to shaping by role models, life experiences and contextual circumstances (Grille, 2005). As the only primates that kill their own young (Hausfater, 1984), it could be argued that a purely evolutionary perspective would suggest potential for intra-personal conflict in the human experience of parenting, as infants impose their survival needs on parents who may not always provide selfless loving responses (Cree, 2015; Grille, 2005; Leadsom et al., 2013), particularly if under additional pressures such as those conferred by sleep deprivation (Hogg & Coster, 2014). According to the 1001 Critical Days report (Leadsom et al., 2013) babies in England are at an increased risk of up to seven times more

likely to be killed than older children, and are recognised as being 'disproportionately vulnerable to abuse and neglect' (Leadsom et al., 2013, p.5).

In common with many species, humans may be inherently violent whilst also capable of altruism and nurture, or crucially, as posited by Grille (2005), the capacity for innate violence, and conversely love, may, in addition to the stressors mentioned earlier, also depend upon childhood triggers, relating directly to the formative experience of having been parented (Oakley, 1979), with adverse and traumatic childhood experiences sometimes reappearing as "ghosts in the nursery" (Fraiberg, Adelson & Shapiro, 1975), with power to exert negative transgenerational influence on parents' cognitions, perceptions, interpretations and behavioural responses to their offspring. Whilst the tension arising from the complete vulnerability of the human infant of being both "life giver" and potential "life taker" can raise complex and distressing issues for some women as they face the demands of meeting their baby's needs (M. Cree, personal communication, March 3, 2016). As mentioned earlier Porges' polyvagal theory (2011), posits that individual differences in emotional state regulation that moderates stress responses are established in infancy via the experiences of received parenting, whilst another significant mediating and influential variable for consideration is that of the prevailing parenting philosophy of the time (Grille, 2005).

The transition may usefully be viewed through the lens of a general theory, such as Schlossberg's (1981) model for analysing human adaptation to transition. This theory identifies mediating factors; the individual's perception of events - as being predicted or unexpected, how they become accommodated within changing circumstances, characteristics of the individual and of the environment within which change occurs, and how the interplay of these factors affects levels of stress experienced. The focus is on challenging pre-existing assumptions, of self and the world, which require adjustments in behaviour and relationships (Schlossberg, 1981). Factors such as degree of prior experience of similar change, perceived control over events, concomitant stress and role changes are all associated with how the person copes with the transition (Schlossberg, 1981).

In association with theories of transition, stress and coping it is pertinent to consider cognitive appraisal theory (Arnold, 1970; Lazarus, 1991) which offers underpinning to individual differences in emotional responding which is considered to comprise relational, motivational and cognitive aspects in response to environmental stimuli or stressors (Lazarus, 1991). As a useful adjunct to the aforementioned theoretical perspectives, “liminal experiences” (Charmaz, 2006, p.108) describe being at the threshold, or “on the cusp of uncertain or ambiguous circumstances” (Vance Peavy, 1997, p.5). This notion of liminality provides a useful conceptualisation of transition as experienced by parents, underpinned by the constructivist perspective employed by the sociodynamic model of counselling with which it is closely associated (Vance Peavy, 2004).

Early research largely based on retrospective parental accounts concluded that the period was characterised by crisis (Dyer, 1963; Le Masters, 1959). Subsequent prospective longitudinal studies which followed parents through the transition from pregnancy to parenthood suggested mixed outcomes citing personal fulfilment and growth in addition to emotional upheaval (Belsky, 1984; Cowan & Cowan, 1988, 2000; Palkowitz, 1996). Meanwhile broader issues face contemporary couples in their endeavours to raise children, including increasing rates of separation and divorce (Cowan & Cowan, 2015).

Research interest over several decades, with a focus primarily on White, middle-class, two-parent heterosexual families (Shannon, Baumwell & Tamis-LeMonde, 2013), has developed the following theories which conceptualise the transition to parenthood. Systems theory (Cowan & Cowan, 1992; Minuchin, 1974) informs much contemporary family therapy and considers the complexity introduced by the birth of a baby into an existing relationship dyad. This involves the relational perspectives and impacts within the family, wider societal, and global systems, with parents adapting to successfully negotiate competing and potentially conflicting areas of personal and family life (Cowan & Cowan, 1992). Developmental theory (Entwisle & Deoring, 1981; Feldman & Nash, 1984; Miller & Sollie, 1980; Rossi, 1968) espouses the role of transition within a stage model which replaced the earlier ‘crisis’ model. Parenthood is conceptualised as a normal life span transition which likely impacts

relationships and identity. Role theory (Belsky, Lang & Huston, 1986; Cowan & Cowan, 1992; Eagly, Wood & Diekmann, 2000; Feldman & Nash, 1984) focuses on competing resources within the partner relationship contrasting before and after the birth of a baby. It concludes that valued elements of partnership become proportionally scarce as the roles of parents develop and this has implications for expectations, both implicit and explicit, which must be negotiated. Dialectical theory (Fedele, Goldman, Grossman & Pollack, 1988; McHale & Huston, 1985; Rossi, 1968) considers the naturally occurring contradictions encountered in family dynamics, most notably between change and stability and “autonomy and affiliation...in the search for the balance between self and other” (Fedele et al., 1988, p.96). Notwithstanding prevalent models and conceptualisations, the parent-child present primarily as a dyadic relationship, dynamic, subject to power differentials and evolving over time, a process largely mediated by the personalities, dispositions and characteristics involved (Grille, 2005).

Motherhood, whilst within the “province” of women (Nicholson, 2010, p.192), attracts widespread attention and commentary from all sides. Characterisations of ‘intensive mothering’ (Hays, 1996) based on the ideals arising from the population demographics widely represented in research studies, are subject to escalating and “impossible standards” (Wong, 2010, p.4), both self-, and other imposed, that are significantly and inextricably linked with the role identity (Medina & Magnusen, 2009). Of US women with children (n=1200) interviewed between 1988 and 1992, the identity of ‘mother’, rather than occupation or marital status, was seen to reflect greater role salience due to the commitment required (Rogers & White, 1998). Whilst it is well recognised that maternal mental wellbeing is improved by employment outside of the home, women routinely struggle with cognitive dissonance provoked by attempting to balance and blend competing ‘devotions’ to motherhood and to work (Medina & Magnusen, 2009).

Becoming a mother as ‘destiny fulfilment’ (Badinter, 1981) was developed from Freudian concepts that have arguably been erroneously interpreted (Sayer, 1982), and extensively examined and criticised from a feminist perspective (Choi et al., 2005; Wong, 2010). The socially constructed nature of motherhood has been relatively neglected within some

discourses, perhaps most ironically within the field of mental health professionals, however practitioners working with women who have children have a duty to consider and “reflect on their own subtle beliefs about motherhood” (Medina & Magnusen, 2009, p. 94). The mother-infant relationship has been regarded as somewhat unique with the expectation of a guiding parental, or more specifically “maternal instinct” (Rich, 1977, p.42), reflecting a psychological essentialism influenced by the observable physical manifestations of the transition for mothers, but which is challenged as overly deterministic in its perception of mothers as a real and natural category (Park, Banchefsky & Reynolds, 2015). The conceptualisation of a ‘motherhood constellation’ (Sterne, 1995), that arguably characterises the normative transition, represents a widely accepted shift in maternal cognitions, priorities and behaviours, from the individual to a triad encompassing the baby and the mother’s own mother.

A seminal theory of ‘maternal role attainment’ (MRA), that locates the transition to motherhood as normatively inherent in female identity, has been foundational within obstetric nursing (Rubin, 1961,1967). The bi-partite theory identifies ‘binding in’, or bonding to the infant, and ‘maternal role identity’ in which women become comfortable with the new role as they began to identify with it during pregnancy and within the first months after birth. Four stages located within a temporal frame of 2-6 weeks postpartum indicate preparation, making acquaintance, learning, and physical restoration and integration of an idealised maternal identity. The theory suggests that transitional adjustment tasks becoming completed at around four months, whilst grieving for lost aspects of a former life now incompatible with the new role accompany the adjustment process (Rubin,1967). Later revisions emphasised the process nature of the evolution of maternal identity and behaviour as linked to the ongoing development of the child, and supporting the uniqueness of each childbearing experience, and thereby individual transitions (Rubin, 1984). Despite an argument posited to replace the earlier description of ‘maternal role attainment’ with ‘becoming a mother’ (BAM) (Oakley, 1979; Mercer, 2004) both terms remain within the literature. Mercer’s (2004) complex and multidimensional BAM theory has undergone revision and absorbed extant theoretical bases concerning developmental

process, role enactment and role acquisition, with the conceptual model originating from the nested systems of micro-, meso-, and macrosystems from Bronfenbrenner's transition theory (1986). It aims to account for a range of variables including cognitive and behavioural normative processes undertaken by women during the transition, whilst identifying key factors such as skin contact, minimising time apart in the earliest period postpartum, and the promotion of early breastfeeding that are acknowledged as having a positive contribution to the transition (Husmillo, 2013). Mercer's (2004) conceptualisation emphasises the significance of information and guidance seeking, replication and development of competence via practice, and acknowledges the impact of a range of factors including stress, social support and parental relationship that impact the mother's 'microcosm' – her immediate family situation and dynamics, accordingly the partner relationship assumes a key significance. The stages have applications in describing the range of processes of incorporation of adjustment during the transition, including changes in maternal sleep (Kennedy, Gardiner, Gay & Lee, 2007). Although highly influential in providing a theory of transition to motherhood that informs nursing care, Rubin and Mercer's work has been criticised, from within nursing and midwifery (e.g. Aber, Weiss & Fawcett, 2013; Barclay et al, 1997; Noseff, 2014), but also from critical and feminist perspectives (Badinter, 1981; Oakley, 1979; Smith, 1999; Wong, 2010), as presenting the transition as a normative universal and unilateral adaptation, with insufficient consideration for the lived experience of the individual and the infant, which is context-bound, and not necessarily conforming to the four stages and time frames indicated. Deterministic conceptualisations have led to "mother blaming" (Wong, 2012, p.11) when women fail to live up to notional standards and norms, and the aforementioned pathologising of women's subsequent distress according to psychiatric diagnostic criteria (Barclay & Lloyd, 1996). From a clinical perspective, the inability of Mercer's (2004) theory to ultimately define a conceptual time frame has been noted as problematic for practitioners (Noseff, 2014). Oakley's (1974-79) highly influential qualitative, interview-based, longitudinal study (n=55), credited as establishing a "a new paradigm of feminist research" (Oakley, 1981, 2016, p. 195), explored the contextual framework within which the transition to motherhood (BAM) is

located within a woman's "biographical context" (Oakley, 1979, p.23). The findings suggested that the process is highly individual and not constrained to a pre-determined time frame or form of process, but that it is influenced by a range of factors, including sleep deprivation (Miller, 2005; Oakley, 1979). The impacts of which, as elucidated by neuroscientific evidence, may adversely impact the bi-directional reciprocity of the mother-child relationship that is mediated by co-regulation (Beebe & Lackman, 2005; Brazelton, Koslowski & Main, 1974).

A cross disciplinary qualitative literature has explored the lived experiences of women during the transition (e.g. Barclay et al., 1997; Darvill et al., 2010; Miller, 2005; Nelson, 2003). Two comparable grounded theory studies - Barclay et al (1997) and Darvill et al (2010), conducted in social contexts separated by two decades, sought to explore and define the 'normal' within the period of transition for primiparous women. Barclay et al (1997) additionally aimed to address a perceived failure, at that time, of translation from sociological and feminist research to inform nursing and midwifery studies in this area. Data provided by focus groups (n=55) of mothers with babies from 2-26 weeks old, was analysed to produce a core storyline, 'becoming a mother', a process of change identified as often distressing, that integrated the categories of 'realising', 'unready', 'drained', 'aloneness', 'loss', and 'working it out'. The concepts within the categories described a lack of preparedness for the rigours and demands of early motherhood, with 'drained' reflecting commonly experienced exhaustion that often precipitated women crying, which was attributed to lack of sleep, in addition to the mental fatigue associated with being on a steep learning curve.

The similarities between the narratives in the studies referred to above and those within the current study demonstrate to some extent the universality of the experiences, and the ongoing relevance for contemporary parents. Across the literature women routinely comment that they feel let down by ante-natal education and advice, which they suggest neglects postnatal experiences thereby affecting their ability to become prepared for the challenges ahead. Choi et al (2005) refer to sensitivity surrounding the raising of awareness of postnatal issues in the ante-natal period, the responsibility for which is seen as taken up

by midwives and then health visitors, and often resisted by women due to anticipatory anxiety, fear and issues of perceived salience on the part of mothers, or parents-to-be. It has been argued that such attitudes underpin a contemporary perpetuation of the “conspiracy of silence” surrounding the realities of the tasks and challenges that have been recognised for decades (McVeigh, 1997, in Mercer, 2004, p. 230), whilst the researchers above pointed to the increased medicalisation of the process and lack of cultural elaboration as underpinning the issues. As women progressed through the transition, via their lived experience they headed “towards a new normal” (Martell, 2001, in Mercer, 2004, p. 230) via observation and learning – this was, perhaps not surprisingly, more evident in women with higher self-confidence. Notwithstanding this progression to some accommodation of the new demands, the storyline ‘becoming a mother’ was one of isolation, feeling alone and depletion, that was explained to be mediated by infant temperament, women’s previous experience of babies and social support (Barclay et al., 1997).

By contrast, Darvill et al (2010) interviewed mothers (n=13) of babies from 6-15 weeks old, and included the antenatal period within their questions that sought to identify the psychological processes underway in order to address any unmet needs during the transition, and to define the normative time frames inherent within the process, although this aim was unmet. A core category – ‘altering the self-concept’ was developed from themes of ‘control’, ‘support’ and ‘formation of a family’. A lack of preparedness and ill-informed expectations identified within the category ‘control’ reflected the earlier findings from Barclay et al (1997), but with the addition of feelings of loss of bodily control during pregnancy which was regained postpartum, but which left mothers with a heightened sense of vulnerability exacerbated by extreme tiredness. The theme ‘support’ identified a need for ‘mentors’, primarily the women’s own mother, to some extent her partner, and importantly new mother peers with whom the women could ‘normalise’ feelings and experiences by expressing negative emotions. Sadly, a lack of such support was evidenced in the study by one participant, with the result that, although she did not attribute her isolation and low mood

experienced during pregnancy and post birth to her loneliness, nonetheless felt that it had been a contributing factor.

It is relevant to note that all the women interviewed by Darvill et al (2010) reported positive birth experiences, which were less distressing than they had anticipated, most reported positive role models in their mothers, and all, bar one had planned the pregnancy. Although not addressed or accounted for, these factors are indicated as having potential psychological impacts. It seems relevant to also note that the issues reflected in both studies remain similar despite the passage of two decades, and that both studies were published within nursing and midwifery journals, which seems to highlight the issues raised by Barclay et al (1997), regarding interdisciplinary research and translation of research findings into practice. By means of a specific focus (sleep deprivation) that lends itself to clinical working, a primary aim of the current study and resulting theoretical model, is to offer a visual representation that emphasises and normalises the elliptical and iterative nature of the processes that have been thoroughly outlined in extant general models. In so doing this will provide practitioners and mothers an accessible but highly adaptable framework of interlinked categories within which to identify and personalise their lived experiences.

1.5 Ambiguity and self-identity in the transition to motherhood

...a stereotyped and romantic image of new motherhood...how many of us really feel like that? And even if there are wonderful moments, what about the times in between?

A woman who is distressed often thinks she must keep it a dark secret.

No one wants to hear about feelings of panic and failure.

She believes she is different from all other mothers. They are coping. She is not

Kitzinger: Birth Crisis (2006, p.5)

In taking on the role of mother, for which individuals are given a “few cues, hints, and stage directions” (Goffman, 1959, p.72), similar with other roles successful implementation and maintenance is contingent on “looking and acting the part” (Collett, 2005, p.1). Additionally, for contemporary mothers, the prevalence of social media as a normative substitute for physical proximity with peers offers unprecedented opportunity for social support by accessing a “sisterhood” (p.155) but conversely much scope for perceived and actual “judgement” (Davis, 2015, p. 226), as women continuously adapt and self-censor their online presence and levels of disclosure.

The struggle to make sense of psychological ambiguity arising from maternal ambivalence, is characterised as a ‘healthy’ response (Kitzinger, 2006; Raphael Leff, 2010) to the liminal experiences which reveal aspects of themselves that can be paradoxically “more virtuous and more terrible” than they might have previously felt possible (Cusk, 2001, p. 8). The transition to becoming a mother, unsurprisingly therefore, has the potential to prove “disruptive to a sense of self” (Miller, 2005, p. 25), being subject to the dominant biological, social and moral precepts of the time, with mothers accordingly influenced to suppress or deny experiences which fall outside of perceived ‘normal’ responses, but which often find themselves expressed retrospectively (Choi et al., 2005; Miller, 2005; Nicholson, 1998). Acknowledgment of this complexity has implicated the “obdurate grip” (Plummer, 1995,

p.131) surrounding 'myths' which are perpetuated by reluctance to "tell the hard things about motherhood" (Maushart, 1999; Ross, 1995, p. 398) and which result in unattainable and unrealistic expectations. This conceptualisation resonates with Goffman's summarising of the theory of presentations of self - "I assume that when an individual appears before others (s)he will have many motives for trying to control the impression they receive of the situation" (Goffman, 1959, p.145), as women strive to maintain a presentation of self that is acceptable to self and society. Feminist literature most notably has commented on the lack of alternative discourses of femininity within which women might create a narrative of their experiences that more closely accords with their lived experience, in challenge to the so called "superwoman" ideals, in which the resulting 'performance' presents a version of self which is closest to the ideal (Butler, 1999; Choi et al., 2005; Ussher, Hunter & Brown, 2000). A small-scale phenomenological study of the changes in women's identity over the period of pregnancy and postpartum, emphasised shifts from the external, to the internal world, before returning to an external focus (Smith, 1999). Although it did not explore the many issues raised by participants about their partners relationships, the significance of the "relational self" was highlighted, as new relationships, often with other women, became dominant within their social context and identity formation (Smith, 1999, p.295).

As an example of one phase of the transition to parenthood, labour has been recognised as one of the most "emotionally intense" periods of a woman's life (Raiment, 2015, p.9), yet a dominant workplace culture within midwifery, understandable given the complex and often fraught nature of the demands of the role, has an emphasis of "getting on with the job" (Raiment, 2015, p.9). Thus, it is suggested that one of the earliest and most intense experiences associated with becoming a parent is characterised, drawing on theories of presentation of self (Goffman, 1959), by a hypothesised professional coping strategy of masking distress whilst 'performing' emotions – perhaps acting in ways that present coping by denying emotional impact - which engages less with the emotional, and more the practical component of the experience (Raiment, 2015). This then perhaps serves as an early example of modelling, by professionals, of attending to the practical and if not ignoring,

then minimising the emotional content of a highly emotionally significant experience, which may be interpreted by mothers and subsequently applied as the most appropriate coping strategy.

For new mothers, or mothers who are confronted with new challenges, whether in pregnancy, labour or during the transition to parenthood, potential impacts on self-identity in relation to environmental demands and challenges to personal constructs (Kelly, 1955) based on self-expectations or perceived assumptions of others can be undermining to self-confidence and self-efficacy. Models of appraisal and emotional responding in consideration of a more general conceptualisation of interrelating and transition underpin the broader theoretical framework during the period of transition, stress and challenges to self-concept. An illustrative example of such, Higgins's self-discrepancy theory (1987) posits that emotional vulnerability is conferred on those for whom self-inconsistency arises. This theory identifies self-states arising from domains ('actual', 'ideal', 'ought') and standpoints ('own', 'significant', 'other') on the self. According to the theory discrepancies between the self-concept ('actual'/ 'own self state') and 'ideal' self-states predicated on beliefs and aspirations become associated with "dejection-related emotions" (e.g. sadness and depression) in the absence of positive outcomes (Higgins, 1987, p.319). Whereas discrepancies arising from 'actual' and 'ought' self-states which are founded on beliefs of expectations give rise to "agitation-related emotions" (p. 319), for example fear and anxiety, in response to perceived negative outcomes. As evidence from the present study attests, neglecting to acknowledge or respond to emotional distress does little to reduce its manifestation or address its long-term resolution. Meanwhile the greater the degree to which individuals are able to tolerate reconsideration and flexibility within their self-imposed standards is often reflected in positive outcomes as they adjust into the role (Mauthner, 1999).

1.6 Secure attachment and 'good parenting'

...an infant cannot become an infant unless linked to maternal care

Winnicott (1960, p.589)

Attachment theory, first developed by means of prospective and observational methods in the 1950s, in a collaboration between John Bowlby and Mary Ainsworth that extended across many decades (Ainsworth & Bowlby, 1991; Bretherton, 1992), and subsequently supported by extensive longitudinal studies (see Grossman, Grossman & Waters, 2005), posits that humans seek the formation of close emotional bonds in order to survive, with resonance across the lifespan. As such, attachment style functions as an enduring mediator of an individual's emotional regulation system, and has been found to be predictive of emotional responses to major life events and traumata (Pietromonaco & Feldman Barrett, 2000). Attachment theory (Bowlby, 1959-80) aimed to offer an 'eclectic' (Hinde, 2005) theoretical framework that incorporated evolution, ethology, and Freudian psychoanalytic principles. At that time, these were prevalent in conceptualising human development and close relationships, linking unconsciously 'driven' infant-mother, and subsequent adult relationships (Freud, 1927). The theory introducing alternative cognitively constructed mental representations, termed 'internal working models', thought to be relatively stable but accommodating of new information, and reflective of both ordinary and traumatic experiences (Waters, Crowell, Elliott, Corcoran & Treboux, 2002).

The absolute dependence of a human infant on its primary care giver(s) links the inherent potential of each with the early care it receives (Winnicott, 1960). This characteristic confers complete vulnerability on the infant which relies for survival on encountering empathic (Stern, Borelli & Smiley, 2015), attuned (Tronick, 2007), and appropriately nurturing responses, which are adaptable to developmental needs (Grille, 2008; Hrdy, 2000), creating the necessary conditions for a secure form of attachment between the infant and primary caregiver (Ainsworth, 1973; Ainsworth & Bell, 1970; Bowlby, 1969, 1988). Evolutionary

adaptations impose an infant's own "agenda" (Hrdy, 2000, p.96), ensuring its survival and maximising opportunities for secure attachment by achieving "the set goal of proximity to mother" (Bowlby, 1972, p.301).

The enduringly influential theory of attachment continues to underpin contemporary conceptualisations of relationship formation, attracting ongoing research interest into the posited enduring effects on psychological wellbeing from adolescence to old age (e.g. Chopik, Edelstein & Fraley, 2013). Whilst conceptualisations or models of parenting aim to distil the essence from the range and complexity of what is paradoxically an everyday experience of transition, a persistent and compelling notion of successful parenting is underpinned by recognition of the significance of attachment as the strong and enduring emotional connection which characterises the 'secure' bond between infants and primary care givers. For decades within western culture the effects, both positive and negative, have been generally accepted as influential "from the cradle to the grave" (Ainsworth, 1973; Bowlby, 1969, p. 208).

For a significant number of women, the cognitive adjustment process pertaining to attachment between mother and infant is vulnerable to traumatic birth experiences, whether or not they are deemed clinically relevant (in terms of PTSD), and may be compounded by early postnatal separation of mothers and infants (Klaus & Kennell, 1970; Royal College of Midwives, 2010). Beyond birth, and mediated by parental capacity for reflective functioning, the aforementioned aspects of attunement and reciprocity (Brazleton et al., 1974) are supported by mirroring (Gergely & Watson, 1996) and containment (Bion, 1962) that demonstrate empathic understanding of the infant's painful physical sensations and developing emotions in order to foster agency of emotional management.

Clearly, according to attachment theory, the transition to becoming a parent has some reciprocity with the childhood one has experienced, which may be illuminated by much contemporary theoretical and philosophical underpinning concerned with patterns of development and life course events (Grille, 2008). The potential significance of the transition in terms of its connection to an individual's own experience of childhood is an area which warrants recognition and requires awareness on the part of psychotherapeutic practitioners

as the transition to becoming a parent is recognised as one of the most complex and challenging of the human experience. However, as stated earlier, mental health services have not traditionally recognised or addressed the needs of patients in terms of their identity and role as parents (Barlow et al, 2010).

The conceptualisation of the transition to parenthood, conventionally defined as occurring with the birth of a first child (Shannon et al., 2013), has evolved from a fairly brief period (Michaels & Goldberg, 1993) to the current paradigm of the critical 1001 days - conception to the child's second birthday - advocated by the First Three Years Movement (Macvarish, Lee & Lowe, 2014). The approach emphasises the significance of parental adjustments during this perinatal period, acknowledged as highly physically emotionally and psychologically challenging (Cowan & Cowan, 1992; 2000), to the emotional and psychological wellbeing of the child, parents and parental relationship (Early Intervention Foundation, 2015; Hogg et al., 2015). According to attachment theory, significant disruptions in the process are implicated as resulting in compromised and insecure attachment behaviours and styles, which, it has been suggested, have the potential to endure into adult relationships (George, Caplan & Main, 1985; Hazan & Shaver, 1987), with consequences for the development of subsequent parental relationships (Edelstein et al., 2004).

Difficulties arising from the template of early attachment are widely purported as predictive for a range of biopsychosocial outcomes (Cuthbert, Rayns & Stanley, 2011), however such views are increasingly disputed as overly deterministic and therapeutically unhelpful (e.g. Hipkin, 2017). Research, within primarily clinical populations, with a focus on attachment has elucidated links with maternal anxiety (Coplan, O'Neil & Arbeau, 2005), and reduced maternal warmth (Seymour et al., 2014), depressive symptoms, disengagement and increased irritability which are all found to negatively impact attachment style (Lovejoy, Graczyk, O'Hare & Neuman, 2000; Paulson et al., 2006). Children are therefore recognised as being especially vulnerable to maternal anxiety and depression with long term implications indicated by theoretical support for the facilitation of intergenerational transmission of disadvantage within this group (Turney, 2011). A report commissioned by

the Maternal Mental Health Alliance (London School of Economics & The Centre for Mental Health, 2014) represents a response to the perceived lack of engagement by policy and mental health stakeholders with the human costs associated with the issues associated with poor maternal mental health, and its potential effects on the secure attachment of infants. The report considers three major conditions recognised to affect around a fifth of women – perinatal depression, anxiety and psychosis, with more than half of sufferers unable to access specialist services (Demyttenaere et al., 2004; Wang, Aguilar-Gaxiola, Alonso et al, 2007). The MMHA report (2014) is the first of its type to consider indirect effects extending beyond the mother. The report relied on secondary data, and focussed on the financial costs with a central finding estimating that 72% of the financial costs are associated with “adverse impacts on the *child* rather than the mother” (p.4). Such impacts introduce risk within early development but may also extend to lifelong consequences regarding emotional, psychological, cognitive and physical wellbeing (Barlow et al., 2010; Pawlby, Hay, Sharp & O’Keane, 2008), with implications for conduct and behaviour (Hay, Pawlby, Angold, Harold & Sharp, 2003).

Contemporary notions of ‘good’ parenting are characterised in the Field (2010) report as securely attached, responsive and with clear boundaries in place. Good parenting, parental education and healthy cohesive family relationships within the first five years are widely identified as critical in terms of children’s life chances which are dependent on social and emotional wellbeing (Field, 2010), with emotional health in childhood considered to be the best predictor of positive outcomes in adult life, according to research conducted on the British Cohort Survey (Layard & Hagell, 2015, p.107). However, a recent UK government report indicates that 40% of children are insecurely attached, and only 52% are reaching a ‘good level of development at age 5’ (Public Health England, 2014, p.35), which suggests that the experience of many contemporary children of being parented is falling short of optimal for the development of their inherent potential. In turn, as previously outlined, their experiences may impact on their abilities to later effectively parent their own children.

Happiness as a measure of wellbeing dominates in some domains of international outcome estimates, with the first global World Happiness Report being produced in 2012 (Halliwell, Sachs & Layard, 2015). The current report asserts that “happiness is increasingly considered a proper measure of social progress and a goal of public policy” (p.2). Indicative of the prevailing paradigm this internationally commissioned report includes dedicated chapters on the neuroscience of happiness (Davidson & Schuyler, 2015) and identifies a role for the application of this knowledge in transforming the mental health and wellbeing of young people (Layard & Hagell, 2015). Summarising the mental health of young people in relation to their subjective wellbeing the report stresses the importance of investing early in the lives of children in order that they can grow into independent productive and happy adults. It highlights the significance of early relationships which set a precedent for attachment patterns which are recognised as key to the development of a healthy emotional life (Groh et al., 2014). It also draws attention to areas of current research interest within neuroscience, highlighting links between adverse childhood experiences and brain development (Lim, Radua & Rubia, 2014), increased vulnerability to disease in later life (Kelly-Irving et al., 2013), and between childhood trauma and development of dementia in older age (Burri, Maercker, Krammer & Simmen-Janevska, 2013; Sherwood, 2013). Although much research into the effects of childhood adversity (CA) reasonably focuses its attention on clinical populations (Walsh et al., 2014), the relevance of studying the ‘normal’ range of parenting behaviours is advocated in order to progress understanding of more common adversities of family discord (Belksy & de Haan, 2011).

In earlier decades, in the face of a perceived threat of increasing professional interference, the concept of ‘good enough’ parenting derived from the work of Winnicott (1973) arose as a response to unrealistically high parental expectations in recognition of the challenges routinely faced by parents. The concept was founded on “the sound instincts of normal parents...stable and healthy families” (Winnicott, 1973, p.173). Notwithstanding the attitudinal shifts in recent decades there is a recognised and uneven distribution in parenting approaches attributed in part to socio-economic factors (Demos, 2015), and availability of

support and high-quality education for parents which is recognised as a key area of under resourcing (Nolan, 2015a).

1.7 Unsettled infants, sleep disruption and effects on partner relationships

Literature is mostly about having sex and not much about having children.

Life is the other way around

Lodge (1965, p.120)

According to research focussing on heterosexual couples, relationship satisfaction often declines with the birth of a first child (Medina & Magnuson, 2009), however there is evidence to the contrary with a small proportion of couples indicating positive impacts (Roy, Walker, Jayyousi & Dayne, 2016). It has been suggested that around 14% of couples split before the birth of an expected baby, or babies do not live with both biological parents (Dex & Joshi, 2005). The stress of transition may be catalysed by a range of variables, relational, financial, economic, health, likely to influence the period of time over which the transition to parenthood unfolds (Early Intervention Foundation, 2014; Insana, Costello & Montgomery-Downs, 2011). The mental health and wellbeing of couples transitioning to become parents has been a well established area of research interest since the 1950s that has identified varying levels of disequilibrium experienced (Cowan & Cowan, 1988). Sleep disturbance, attributable to infant crying, impacts parental self efficacy, and ultimately is identified as the main contributing variable in the decline in relationship satisfaction (Medina et al., 2009; Medina & Magnussen, 2009; Meijer & van den Wittenboer, 2007). Early seminal research identified mothers as 'tired and distressed' (Le Masters, 1957), whilst anger, evidenced from men and women is recognised as commonly manifested, but highly challenging to accept and assimilate into the experience of new parenthood (Boots, 2013; Parfitt & Ayers, 2014). The 'sleepless nights' of early parenthood often alluded to anecdotally in western cultures, imply an expectation and

therefore by association some level of preparedness for the experience. Issues of nighttime disturbance necessarily impact on couple intimacy, with potential negative effects on sexual relationships (Parfitt & Ayers, 2014), which may in some cases affect decisions about having subsequent children.

Despite that most contemporary mothers are employed, recent findings indicate they still overwhelmingly take on 'traditional' gendered family roles and duties, despite prenatal expectations, in what may be a pragmatic response, identified as nevertheless highly influential in the experience and perception of transition (Roy et al., 2016). Discrepancies in role satisfaction have clear implications for the development of positive co-parenting and enhanced general health outcomes (Insana et al., 2011). In line with inequalities in the nature of caregiving more broadly that are perceived as within the female domain, nighttime sleep disruption amongst couples with children has been recognised and identified as a 'gendered' phenomenon, characterised by Hochschild (1989) as within "the second shift". The construct referred to the unpaid work undertaken by women within the home, additional to any employment outside it, as they sought to fulfill 'traditional, 'egalitarian' and 'transitional' roles within their partner relationships. Negative effects on couples, as women strove to fulfill all domains but inevitable felt they were failing, were reported to include feelings of guilt and inadequacy, lack of sleep and sexual interest, with resulting marital tension. (Hochschild, 1989). More recent data obtained for an Economic and Social Research Council (ESRC) funded, multi-disciplinary project, from audio sleep diaries and interviews with 26 couples, characterised the multiple roles undertaken by mothers as "the fourth shift" to reflect the numbers of women also employed outside of the home (Venn, Arber, Meadows & Hislop, 2008, p. 79). The findings reflected that mothers consistently undertook the majority of night time care of young children, and that this was not a matter of negotiation between parents (Venn et al., 2008).

However sleep disturbance has been implicated as a threat to the stability of couples whether postpartum or nonpostpartum (Medina et al., 2009; Medina & Magnussen, 2009). A recent sleep diary study of 68 newlyweds concluded the self regulatory resources that foster positive

evaluations of the relationship and underpin marital satisfaction are compromised by lack of sleep. The findings indicate a greater buffering effect in men, following more sleep, allowing them to overcome specific negative evaluations from the previous day thereby remaining more globally satisfied within the relationship (Maranges & McNulty, 2017). A meta-analysis (Nelson et al., 2014) considered data from three methodological approaches that studied comparisons between parents and non-parents, shifts in wellbeing across the transition to parenthood, and studies with a focus on daily activities with, and without their children, in order to move beyond the question of which group enjoy greater wellbeing, and identify mediating and moderating factors of parental wellbeing. The review findings reflected a highly complex interplay of variables, with parents experiencing greater unhappiness as a result of encountering relatively increased negative experiences such as sleep disturbance, negative emotions and troubled partner relationships. As a corollary, perhaps unsurprisingly, joyful and positive parenting experiences are seen to foster greater wellbeing and satisfaction (Nelson et al., 2014).

The sensitivity and responsiveness of parenting has been indicated as rooted in the levels of reciprocal support available in the parental partner relationship (Halford & Petch, 2010). However for some the struggles encountered as parents mirror deeper personal issues, residual from childhood, which may be unresolved and impact the relationship in both conscious and unconscious processes (Grille, 2008). One subjective factor, that exerts a significant influence on the health of relationships, is accuracy of partner perceptions, which are affected by lack of cognitive flexibility resulting from disturbed or restricted sleep. Insana et al (2011) evaluated objectively measured and self reported sleep and sleep disruption in premarital postpartum couples (n=21), and then explored perceptions of partners' sleep experiences within a framework of mood disturbance and relationship satisfaction. The authors conclude that clinicians and postpartum couples "should pay special attention to sleep...(it) may be a sentinel marker of relationship satisfaction", with planning and negotiation of nocturnal care of infants identified as area that could be the focus for development and maintenance of (Insana et al., 2011, p. 438). This assertion offers a clear indication of the

potential significant negative impacts of 'normal' sleep disturbance on partner relationships to those supporting parents during the transition.

1.8 Preparation for becoming a parent and postpartum interventions for support

...my well-worn soap-box:

we need high quality antenatal education and postnatal support for every family in the country, and extra education and support for those who want it or need it

Nolan (2015a)

The transition to parenthood has been explicated as encompassing a huge range of challenges which is partially characterised by ambiguity, both in terms of interpretation and meanings made of experiences that run counter to prenatal expectations, but also available advice for parents. The role for high quality parenting education is identified as key in achieving the widely-stated aspirations for optimising positive parental relationships and outcomes for children by leading parental education specialists (Barlow et al., 2010; Hogg et al., 2015; Nolan, 2015a).

Contemporary views of parenting, within western culture, are likely influenced by its high incidence, with many childfree individuals indicating an intention to become a parent (Yaremko & Lawson, 2007). The eternal universality with which childbearing and human reproductivity is regarded in contemporary society, characterised particularly in wealthy nations by an elongated childbearing temporal opportunity, belies the impact both conscious and unconscious of huge sociological and societal changes in recent decades (Raphael-Leff, 2009). The establishment of the NHS in 1948 saw the introduction of 'mothercraft' classes with a later shift to 'parentcraft' in response to familial changes and gender politics (Nolan, 2015b). Although a distinction has been made since the 1950s between parenting and childrearing, the concept of parenting popularised since the 1990s refers to a set of skills which may include adoption of a range of techniques or approaches posited as likely to enhance

child development and long-term potential, being variously supported by an expanding evidence base. The range may span ‘tough love’, characterised by warmth and consistency and promoting ‘sound character’ (Lexmond & Reeves, 2009), to ‘positive’ or ‘attachment parenting’ (Sears, 2001), which advocates an ‘authoritative’ rather than ‘authoritarian’ philosophy. This societal shift in identification of the function of parenting has coincided in recent years with a greater emphasis on the role of government policy and legislation in mediating the link between parent and child, with the underlying intention of safeguarding child welfare (Johnson, 2007; Monroe, 2011; Reece, 2006), which it has been argued ‘infantilises’ and undermines parents’ intuitive abilities whilst promoting expert-led support and advice (Macvarish, 2010).

Significant sources of both private and freely available, universal and targeted parental education are provided by national charities, such as the National Childbirth Charity Trust (NCT, 2015) and the Early Intervention Foundation (EIF, 2015). Targeted for parents identified as vulnerable, “hard to reach” (p. 2) or in need of enhanced levels of support to develop a positive relationship with their baby, the NSPCC Baby Steps has been offered in nine locations over the last three years (Hogg, Coster & Brookes, 2015). However, as identified earlier, not all parents are aware of or able to access support for a range of reasons. Despite a recent spending review pledge of £75 million for perinatal mental health (MMHA, 2015), government funded Sure Start Children’s Centres which offer open access to parenting advice and support have experienced mass closures in recent years, with official figures citing 99 closures in the first six months of 2015, equal to the total closures for 2014 (Brown, 2015).

Within the framework of early preventative intervention strategies, approaches to the transition to parenthood advocate educating prospective parents of the issues that may arise in the perinatal period and beyond (Early Intervention Foundation, 2015; Hogg, Coster & Brookes, 2015). Many professionals indicate a preference for an extension of the aforementioned critical 1001-day period in recognition of the significance of optimising healthy child development, particularly in light of issues and critical evaluation prompted by the ‘school

readiness' paradigm which assesses four-year olds according to personal, social and emotional developmental criteria (Whitebread & Bingham, 2011). National prevalence statistics suggest one in four children do not meet the criteria for school readiness with communities of greater economic deprivation identified as those with highest incidence (Early Intervention Foundation, 2015).

A comprehensive review of health led interventions intended to enhance infant and maternal mental health identified an enormous range of diversity, with for example 47 focussing on anticipatory guidance and instruction yielding evidence for improvements in infant sleep and parental confidence (Barlow et al., 2010). Due to the range and inconsistency of evidence the review authors concluded by advocating recommendations, subject to caveats of nonmaleficence, for interventions which seemed to promote positive gains even in the absence of conventionally acceptable evidence in the form of randomised controlled trials. It was their suggestion that interventions lacking a robust evidence base might be employed alongside established modes to extend the resources available to practitioners (Barlow et al., 2010).

Parental awareness of the impact of fatigue coupled with implications for the ability and likelihood of mothers to sustain self-care behaviours has underpinned the development of the Wide-Awake Parenting programme (Dunning et al., 2013; Giallo et al., 2012; Giallo et al., 2014). This intervention represents a significant shift in approach to tackle infant sleep difficulties as it is designed to address parental management of fatigue in contrast to combating infant sleeplessness, by a process of psychoeducation and supportive behavioural planning (Dunning et al., 2013; Giallo et al., 2014). It is informed by theories of planned behaviour (Ajzen, 1991) in relation to self-care behaviours and cognitive behavioural therapy (CBT) (Padesky & Greenberger, 1995). Although the telephone-based supportive intervention did not achieve significant results in an initial pilot scheme, a comprehensive account of the limitations and potential confounding factors that might have affected the clinical efficacy was provided (Giallo et al., 2014). It seems likely that further trials of this novel, low cost intervention are warranted.

Therapeutic approaches for perinatal wellbeing of particular relevance for counselling psychologists include compassion focused therapy, developed as a third wave CBT approach to address depression associated with high shame and self-criticism (Cree, 2015; Gilbert, 2010). The compassionate mind approach lends itself to group and individual working, offering a practical therapeutic framework, which addresses embodied experiences, underpinned by accessible neurobiological explanations of stress responses, in which the objective of self-care is a central tenet.

Despite NHS pledges to increase spending on mental health services there is regional variation, with some clinical commissioning groups planning to cut spending, meanwhile ongoing financial constraints have impacted service delivery models with a marked increase of groups, in preference to one-to-one working, in primary care (Pulse, 2017). It has been suggested that groups are less effective than one-to-one working with women experiencing symptoms of postnatal depression (Barlow et al., 2010), however it could be argued that groups provide the very social contact and support that many women lack, and that is recognised as key to postnatal wellbeing. An example of a postnatal wellbeing group – Finding Yourself Again (OSW, 2017), commissioned by Kernow Clinical Commissioning Group, offers five, weekly, two-hour sessions based on CBT principles, and psychoeducation, underpinned by the compassionate mind approach, delivered within a group therapeutic environment that encourages disclosure in order to validate and normalise women's experiences. It is also a practical course that aims to support women to develop strategies that foster and underpin self-care. Cornwall is an area of high social deprivation - groups are free to attend for mothers of children up to age 3, who can self-refer, although many are referred by health visitors, and do not meet a baseline clinical 'caseness' (IAPT, 2016), or via contact with the small regional specialist perinatal mental health team, which often indicates a recognised pre-existing mental health condition. Anecdotal evidence, supported by clinical measures (Patient Health Questionnaire-9, General Anxiety Disorder-7, Warwick-Edinburgh Wellbeing Scale) suggests marked improvements across a range of issues.

1.9 The current study: rationale and aims

Despite a proliferation of research studies and reports addressing maternal mental health, a gap exists in addressing the experience of women who, by failing to achieve 'caseness', despite experiencing considerable distress, are not identified according to psychiatric diagnostic labels, and therefore are non-clinical in terms of mental health services (Belsky & De Haan, 2011; IAPT, 2016). The twin challenges of sleep deprivation and high stress are accepted as within the 'normal' range of experience for postnatal women (NHS, 2015), when in other populations these experiences fulfil clinical significance. Whether the distress, that has been outlined here as 'normal' in response to the stress of sleep deprivation whilst taking care of a new baby, must be pathologised in order to legitimately attract support has been widely discussed. Whilst the women concerned often seek advice and support for their infant's sleep difficulties, many mothers do not seek help for their own distress, and having no overt or diagnosable mental health condition, go largely unidentified by support services. In a climate of austerity that has implemented cuts to universal services, it is this non-clinical population that was the focus of the current study, which may arguably represent a majority, who are likely to become more isolated within their own experience.

This study was interested in exploring the story of a lack of sleep in the journey to becoming a parent, both in real time and as part of a reflective process in a longer life narrative, and of considering the potential sequelae for infants and the child-parent relationship. The presenting source of the challenges was infant sleep difficulties with inevitable consequences for the parents' own fatigue, but also unforeseen, and often *undisclosed* impacts on a range of emotional and psychological functioning. The aim, in the first instant, was to explore the phenomenon of infant sleeplessness and its impacts, primarily, in this case, on mothers, and elucidate the range and variety of individual responses and coping strategies adopted by the women. It was intended that the scope of literature consulted would add further richness and depth to the complexity of the transition which is recognised as a period susceptible to disruption, with potentially severe consequences for children and maternal wellbeing. This study aimed to develop a substantive theory, focusing on the widespread experience of

mothers and infants, who are unrepresented by clinical presentations or identified vulnerable populations that are the focus of much research.

The model and theoretical framework translate readily to practice, and offer a point of departure from, and within which, to better identify, understand, and thereby raise awareness of the extent of the impacts of this 'normal' experience. The 'mask' model offers a visual representation of the seemingly eternal, widespread, yet intensely personal interplay of factors which are intensified, and even potentiated by lack of sleep. This may be utilised by clinicians in the collaborative formulation of women's experiences.

A subsequent goal is to inform mainstream clinical attitudes, reduce stigmatisation of women who *do* disclose their difficulties without seeking to pathologise their distress in order to apply clinical 'solutions'.

The overall aim of this study was to enable these women's voices to speak to others, in the spirit of sharing and recognition. This can make the difference between isolation, hidden shame, and feelings of difference, and add to an alternative discourse of shared struggle, hard earned experience and hope.

2. Methodology

Further to recent increased focus on perinatal mental health, and the well evidenced disparity between expectations and reality in the transition to parenthood, the present study aimed to explore the specific impacts of unanticipated consequences of ‘normal’ sleep difficulties in infants on mothers, and elucidate transitional coping strategies employed by interviewing mothers who were living through, or had lived through the experiences. Research findings will be pertinent to inform both ante-, and post-natal psychological wellbeing provision, with relevance for raising of awareness and training of those in contact with this group. The primary intention was to inform counselling, and other psychologists who may be working directly, or supporting other practitioners to work with mothers during the perinatal period and beyond.

Due to the wide range and complexity of variables that likely impact on the transitional period following childbirth, this study focussed on one aspect – sleeplessness in infants and its consequences for the adults who care for them. Much research into perinatal mental health refers to sleep deprivation, meanwhile for infants under 6 months old there is lack of available resolutions or clinically supported interventions. Accordingly, this was identified as an area that could benefit from the generation of additional substantive theory to inform work undertaken by those supporting mothers, in particular, in recognition of the issues which are, to a greater or lesser degree, an inescapable feature of early motherhood.

2.1 The role of the researcher in social constructivism

A qualitative methodology, grounded theory (GT), specifically a ‘constructivist’ variant (Charmaz, 2003, 2006, 2014), as distinct from the ‘classical’ GT approach in which objective theory was seen to ‘emerge’ from the data (Glaser, 1992; Glaser & Strauss, 1967; Ramalho, Adams, Huggard & Hoare, 2015), best met the research aims. It offered means to develop a substantive theory whilst simultaneously accounting for the role of the researcher as embedded within the co-construction of meaning with participants, and subsequent decisions that shape the research processes (Charmaz, 2006). The epistemological perspective of the researcher is therefore intrinsic within the process. The positions of

constructionism and constructivism, are often erroneously applied interchangeably, although they share a common central principle, that knowledge is constructed within a social setting. However, the difference lies in the specifics of 'how' and 'why'. In summary, the former assigns knowledge as emerging from social interactions, whilst the latter refers to meaning making from individuals' experiences (Davis, 2015). It could be argued that Charmaz's constructivist GT absorbs and utilises the two constructs without differentiation, positing that "[t]he constructivist approach places priority on the phenomena of study and sees both data and analysis as created from the shared experiences of researcher and participants and the researcher's relationships with participants" (Charmaz, 2003, p. 313). The epistemological position considers knowledge as "constructed in processes of social interchange" (Flick, 2014, p. 78), and largely "depending" on the view of the researcher as s/he "cannot stand outside of it" (Charmaz, 2014, p. 239). The methodology thereby accounted for my position, as a woman, mother and practitioner, as fundamental in the ensuing research undertaking. Participant interviews, a transactional source of data production, are subject to the shifting power dynamics present in all relationships, and have been referred to as a 'gift' (Mauss, 1954; Titmuss, 1970) provided by participants, resulting in "our story of their story" (Limerick, Burgess-Limerick & Grace, 1996, p. 450). Effectiveness of the products resulting from the handling of the data are largely dependent on the researcher's capacity for reflexivity that underpins sufficient scrutiny of the extent that their influence - "interests, positions and assumptions" (Charmaz, 2006, p. 188) impacts their deliberate commitment to prioritise participant data, over any other input, in the development of theory (Ramalho et al., 2015).

2.2 A justification and rationale for the selection of constructivist grounded theory

A constructivist GT perspective explicitly implicates the epistemological position and assumptions of the researcher as critical to the research undertaking, and therefore requiring early exploration (Ramalho et al., 2015). Accordingly, a point of departure for the research project addressed two questions - what does it mean to know something? And, in terms of theory development - how can we explain something? (May, 2011). A critical stance was

adopted in the decision-making process of selecting a research method, and this may, by extension, be considered to form part of the 'sensitising concepts' (Blumer, 1967) pertaining to the research endeavour which underpin and inform GT methods. Identifying a qualitative or interpretative research methodology as most appropriate to address the research question leads to the debate of justification and tribalism within the wider scientific research community rooted in logico-deductive positivism, within which researcher neutrality, passivity and objectivism is implied. Close consideration of criticisms, such as the debate provoked by journal articles published in the British Medical Journal (e.g. Paley & Lilford, 2011), usefully inform awareness of potential areas of weakness in adopting a qualitative research methodology.

The critical perspective referred to above posits objectivity as a "corrective strategy" (p. 957) necessitated by a human propensity for errors, imperfect recall and attribution biases, with 'meaning making' censured by reference to the unreliable or restricted ability of individuals to account for inner experiences (Paley & Lilford, 2011). Their critique suggests that a majority of qualitative researchers share a constructionist/constructivist approach towards knowledge which is at odds with the 'theoretical underpinnings' of quantitative methods (Kuper, Reeves & Levison, 2008). Paley and Lilford (2011) assert "the real test of a research study is not the extent to which it confirms the reader's preconceptions, but the extent to which the evidence confirms or disconfirms a theory" (p.957).

This criticism underpins a fundamental epistemological and ontological debate wherein counselling psychology assigns value to phenomenological experience, and acknowledges potential limitations of self-awareness in mediating for the effects of bias. Qualitative research is suited to tackle complex existential questions and provides well-founded methods to do so which rely often on data in the form of verbatim material generated via interviews (Smith, 2003). Interpretative methods, of which constructivist GT are one, acknowledge that the very flexibility which encourages interaction with the data produces findings that reflect *one* contextualised and constructed analysis which is open to reinterpretation (Willig, 2001). This reflects an inherent ambiguity which must be tolerated by both researcher and those who

evaluate the outcomes. However, a disconnect with 'empirical' methodologies which privilege a certainty that can 'correct' human error is understandable in light of pithy characterisations, including from within the field, of qualitative interviews as "on target while hanging loose" (Ruben & Ruben, 1995, p.42), suggesting focus yet degrees of flexibility, which acknowledge and accommodate uncertainty.

Rooted in symbolic interactionism (Goffman, 1959; Mead, 1934), GT methods offer means by which to explore human actions and interactions whereby meanings are communicated, and thus notions of reality constructed, by way of shared symbols, in particular language (Blumer, 1969; Charmaz, 2006; Fassinger, 2005; Sbaraini, Carter, Wendell Evans & Blinkhorn, 2011). GT methods have been seen as compatible with counselling, and counselling psychology, perspectives, which view therapy in terms of a change process defined by the client who is acknowledged as 'expert' about their own life (Barlow & Cairns, 1997). Since its inception, 'classical' GT (Glaser, 1992; Glaser & Strauss, 1967) methods have undergone review and differentiation, resulting in a 'family' of subtly diverse methodologies, all however with the objective to develop innovative and substantive, rather than formal theories, that are 'grounded' in - arising directly from - narrative, and maybe other supplementary data, exploring previously neglected psychosocial processes (Fassinger, 2005; Morse et al., 2009).

The characteristics of 'classical' GT (Glaser, 1992; Glaser & Strauss, 1967) that remain standard across the 'family' of GT methods, include the following elements: the aim of substantive theory arising from the data, inductive and abductive reasoning prevailing over deduction, the use of theoretical sampling with the goal of theoretical saturation, and simultaneous data collection and analysis founded on the constant comparative method, based on memo writing throughout the research process (Bryant & Charmaz, 2007). However, the function and timing of the literature review has been a much-disputed topic, with Glaser and Strauss (2006) arguing strongly against reviewing the literature in advance of data collection in order to preserve researcher naivety to extant theory. Charmaz is one of the GT theorists who advocates reviewing the literature "after developing an independent analysis" (Charmaz, 2006, p. 6). She and others provide a rationale that includes the prevention of

stifling creativity, and potentially undermining researcher's belief in their ability to generate theory due to feeling overwhelmed by the extent contributions in the field, and pragmatically, as a time-saving device due to the emergent nature of the process and lack of predictability of direction and therefore relevant literature in advance.

Constructivist GT follows a process that employs the fundamental GT tenets of an open research question informed by sensitising and disciplinary concepts, a coding process that develops levels of abstraction via memoing and constant comparisons within the data, and which aims for theoretical saturation, thus guiding theoretical sampling of participants (Charmaz, 2006). In contrast with the explicit methods of Glaser's (1992) 'classical' positivistic approach that, employs open, axial and selective coding, constructivist GT offers "systematic yet flexible guidelines" or heuristics rather than "mechanistic rules" (Bryant & Charmaz, 2007; Charmaz, 2006, p.10) to investigate social processes. Charmaz (2006) suggests that the degree of fragmentation required of the data by axial coding (Strauss & Corbin, 1998) detracts the research process from holistic contextual authenticity and nuance, whilst the "preset structure" (Charmaz, 2006, p.61) it provides may not most appropriately deal with overcoming issues of ambiguity by fitting the data into a predetermined form. Rather, she posits, that from a constructivist approach, ambiguities may be explored with greater cognitive and interpretative freedom, whereby narrative anomalies or apparent inconsistencies are analysed to reveal unexpected depths, and are accounted for within links made between categories and subcategories (Charmaz, 2006). The degree of adaptability yet depth that the method offers accommodates wide ranging methodological, ethical and philosophical perspectives inherent to the study of issues within a framework of social justice (Charmaz, 2011; Fassinger, 2005).

Charmaz (2000) advocates comparing not only data from different individuals, but that of the same individual at different points in their narrative, and the comparison of incidents with incidents, and categories with categories as part of a constant and iterative process. This was achieved in the current study by follow up email contact with the first two participants 12 months after the initial interview, following an enforced break in the research process. The potential rupture presented an opportunity to invite the two participants to recall their

experience during and after the research interview, assisted by a copy of the transcript if requested, and make any additional comments or reflections following the time elapsed. Both women provided written comments, which were labelled '2' (e.g. *Alice 2: 12*), and included within the analytic process.

A distinctive feature of a constructivist approach considers GT a "social action" (p.129) of co-constructed meanings and shared relationships within a dynamic research process, viewing the researcher as enmeshed within the phenomena under scrutiny (Charmaz, 2006), and seeking 'fairness' as opposed to claiming 'objectivity' (Charmaz, 2006). The intention of a constructivist method of GT is to address 'how' and 'why' questions in relation to the dynamic construction of meanings and actions bound within a context. When executed well Charmaz (2006) asserts that it represents a *tour de force* of reflective practice, as it aims to produce a theory based upon interpretations whilst recognising the fresh interpretative essence of the resultant theory, which is not intended as 'final' and remains contextually bound. The significance of values is seen as intrinsic to the research process from inception to theory generation, therefore a constructivist approach requires particular attention and awareness directed to preconceptions arising from sensitising concepts (Blumer, 1967).

Necessarily, constructivist GT assigns particular significance to the role and influence of the researcher in the process of co-creation of meanings and theoretical development in an interpretation of the data that, according to Henwood and Pigeon (1992), "can simultaneously liberate and discipline the theoretical imagination" (p.1), whilst researcher reflexivity is explicitly methodologically bound within the analytic audit process of theory generation (Fassinger, 2005). As a new mother twenty years ago, I had some experience of sleep difficulties with my first child, so therefore could not have positioned myself within this research study as an objective observer according to the classical GT approach. The philosophical perspective from which the constructionist/constructivist epistemology posits that reality is individually constructed through interactions, rather than existing as an objective reality to be observed, aligns with my own worldview, which also influenced the methodological selection.

During the planning process a comparative method, Interpretative Phenomenological Analysis (IPA), recognised as an interpretative development from thematic analysis (Hefferon & Gil-Rodriguez, 2011), was considered, with particular reference to a similar small-scale study into the transition to becoming a mother, conducted by the originator of the method (Smith, 1999). The longitudinal study of the impact of their experiences on the identity of four women, gathered data via interview and diaries, over a nine-month period from pregnancy to five months postpartum. Repertory grids were developed from data collected, allowing for comparisons between time points. Smith (1999) identified the strength of the IPA study was its focus on the interpretation of the phenomenological, or “particular account of the ... woman rather than the investigator’s” (p. 282), and in this case the investigator was male, by definition not a mother. Meanings were co-constructed with the researcher, who was not a “tabula rasa” (p.282), informed in this case by psychosocial models of identity development, but with no expectations of whether, or how, the transition to motherhood might be manifested in the women he interviewed. IPA methods were applied to this group but did not offer means of theory development, meanwhile GT provided a data handling and analytic process nested within another qualitative methodology. Smith (1999) employed IPA methods to produce “a theoretical model...grounded in...(the) data” (p.284). Specific signposting to proponents of GT, including to “Charmaz (1995)” (p.284), was indicated for clarification of the method. As a neophyte researcher seeking a single methodology, consideration of this example, in particular, led me to opt for constructivist GT methods directly in order to adhere to one specific approach from the outset. The current study was intending to interview participants only once, and constructivist methods expressly acknowledge, and facilitate accountability for the potential impacts on the research process, for any resonance with the mothers interviewed at a single time point.

A research aim within the present study, was to draw attention to a transition in a woman’s life that, despite having been extensively studied through the diverse lens of a range of disciplines often with an emphasis of the pathological or psychiatric (Smith, 1999), still appears to fall outside of the remit of mental health training and therefore clinical awareness of a great many

practitioners. Constructivist GT methods provided a flexible set of guidelines within which to formulate an interpretation of the experiences of the participants being interviewed, with the goal of inductive theory development from the researcher who necessarily brings to bear some personal values, opinions and influences to the process of meaning making. In the current study the philosophical and epistemological underpinning of constructivist GT methods offered opportunity to combine clinical experience and judgement developed prior to, and throughout training, whilst simultaneously accommodating and accounting for the influence of my own memories of first becoming a mother, and personal opinions of the role of mother and parent. My remembered experiences, that shared some commonality with theirs, informed the way in which I was able to approach and relate to the participants, and in turn this impacted how they responded to my questions, and ultimately how meanings were constructed between us during the interview, and necessarily influenced my analysis of the material.

Throughout the interview process, the clinical training gained in my therapeutic encounters informed a process of clarification and checking the meanings intended and inferred from the narratives offered by participants. Academic supervision encouraged separation from the data, by confirming and supporting the necessary bracketing of personal experience. Supervision also interrogated the data collection and analytic processes. Unique within GT methods, the constructivist approach employed this supporting framework of procedures to maintain a focus on the role and potential influences of the researcher within the overarching process of data gathering, selection, analysis and interpretation.

2.3 Design

A qualitative study design with data collected from five participants via one-to-one interviews and email correspondence, analysed by hand using a constructivist GT methodology (Charmaz, 2006).

2.4 Participants

2.4.1 Number of participants

A total of five women were interviewed.

Four participants were recruited as mothers who had experience of an infant with sleep difficulties, and one was recruited as a professional early intervention practitioner and antenatal educator.

2.4.2 Inclusion criteria and theoretical sampling process

As I had limited access to new parents at the time of participant recruitment, a private clinic offering chiropractic treatment to children as young as neonates, addressing a range of issues including sleep problems, was contacted in order to request their help in gaining access to potential participants to the study. The clinic provides assessment and treatment for young babies and children, and provided an initial source of recruitment of participants who were actively seeking private treatment for perceived sleep difficulties in their infants. A preliminary meeting was held with the lead practitioner, during which it was agreed that she would identify potentially appropriate mothers to introduce to the research topic, and once they expressed interest arrange for the researcher to make email contact with further information. The same initial email and safeguarding information was sent to all participants prior to consent being sought.

This purposive sampling recruitment strategy provided three potential volunteers, all women, who were contacted by the researcher, two of whom became participants and the third declined due to time constraints. Background information for the study and inclusion criteria (Appendix D) were emailed to prospective participants following initial contact. They were also

advised of the mental health safeguarding rationale for completing a depression screening scale with the researcher. After confirming their interest in participation an interview was arranged.

Only mothers who were identified as at low risk of post-natal depression and not currently being treated within a clinical setting were included, however a self-rating depression tool (Zung, 1965) was completed prior to the interview as a precautionary screening measure. Scores over 50/100 are deemed to be clinically indicative of depression (mild, moderate or severe), and any participants identified by this measure would have been excluded from the sample. The age of child was not set and duration of difficulties was not specified, but it was required that their infant had difficulties with sleeping identified soon after birth. Participants were not excluded if there were comorbid health difficulties presenting in their child, such as colic, or physical pain associated with perceived traumatic birth, as this is to be expected within the population of interest, however all the children were generally considered to be health and neurotypical at the time the mothers were interviewed.

Initial sampling (Charmaz, 2006, p.100) guided the primary inclusion criterion of mothers seeking private paediatric chiropractic for infants under six months old, who were identified by their parent as having sleep difficulties. However, in accordance with GT data collection methods, recruitment via theoretical sampling (Charmaz, 2006) expected that subsequent participant recruitment might likely deviate from parents seeking treatment for their infants. It was also recognised that this group were likely to be somewhat homogenous as they were able to access private treatment, and that this may reflect other similarities between them. In order to achieve theoretical saturation and explore the wider implications, it was necessary that the sampling focus would remain on parents of infants whom they felt had, or were having, sleep difficulties, which were having an impact on them. It was predicted that a range of professional and clinicians working to support mothers during the transition might also be recruited via theoretical sampling as the analytic process developed and made reference to their role in offering support and guidance.

Theoretical sampling sought to explore adaptations made, and development of coping strategies over time, but also the impacts on adults if sleep issues remained unresolved. Accordingly, these considerations guided the subsequent recruitment process, with the third and fourth participants contacted through word of mouth, and recruited independently by the researcher. These two mothers were older, one aged 40, with an 8-year-old daughter who was still experiencing disturbed sleep, and the other in her 50s with two young adult sons living independently. It was relevant to consider that these remembered retrospective accounts would necessarily be affected by the passage of time and imperfect recall for the specificity of events. However, the inclusion of women with the potential to reflect on their experiences after several years has been advocated in GT studies of the transition to motherhood (e.g. Choi et al., 2005; Laney, Hall, Anderson & Willingham, 2015; Wiggins, Austerberry, Sawtell & Oakley, 2013). As both women had self-selected to become involved in the study due to the personal salience of the topic it could be argued that their views represent a highly biased perspective, underpinned by selective, adapted, perhaps unreliable, memories. Additionally, both women had also separated from their respective partners and co-parents – one during the time under review, one many years later. However, as stated earlier, as the data collection and analytic process was concerned with subjective processes and the development of individual meaning making that considered the individual as ‘expert’ on their own experience, rather than seeking objective externally verifiable realities.

The retrospective accounts added diversity and richness to the data by introducing the voices of those who were making sense of how they had coped, and the wider impacts of the sleep disturbances on their lives. The shift in sampling turned the focus towards mothers who, whilst still clearly affected by their earlier experiences, were less vulnerable than those whose struggles were current.

As a response to the narratives of both the first and fourth participants, which referred directly to support from Early Intervention and ante-, and post-natal education, a selection of relevant practitioners (ante-, post-natal, Early Intervention, and health visitors) were contacted by

email. This resulted in just one response, from an ante-natal and Early Intervention educator who agreed to become a participant.

In such a small study, the inclusion of professionals with a range of experiences to share was intended to assist with theoretical saturation. The recruitment of an Early Intervention practitioner was also an opportunity for triangulation of findings (Thurmond, 1991), in order to support whether the experiences of participant mothers were common, when compared to her wider and more extensive professional exposure. Other health professionals, in particular two health visitors, were contacted but did not respond or were unable to participate within the time frame of the data collection.

The four mothers chose to be interviewed at home, and the fifth participant was interviewed at a university premises. Interviews lasted approximately one hour, with informed consent sought prior and opportunity to ask questions at the close of the session. Interviews were recorded using a primary and back up digital voice recorder.

Participants were assigned a pseudonym under which the recording and subsequent notes and memos were kept in order to ensure their anonymity, and these are used as identifiers in the following account.

2.4.3 Participant Characteristics

The first four participants, from a non-clinical population, shared some characteristics and socio-demographic similarities, bearing children in their 30s, although two were older, in their 40s and 50s, and giving retrospective accounts at the time of the interviews. All had perceived sleep problems in their infants and sought a range of help and support to address the issues. The women were all educated to degree level or equivalent, were employed prior to pregnancy, and in stable long-term heterosexual relationships at the time of conception and birth. They were home owners, or in one case between owned houses as a result of family relocation. They all discussed aspects of childbirth which they felt might have impacted the infant's sleep, and all expressed a desire to breastfeed their babies, although not all were successful. According to the methodological rationale in the previous section, the immediacy

of the experiences of recent mothers *Alice* and *Emma* contrasted with the memories and retrospections of *Kate* and *Natalie*, who offered insights and reflections formed over the time elapsed.

The fifth participant, *Helen*, introduced a voice which offered one perspective from a professional stance as she had spent many years supporting people preparing and transitioning to become parents. As she was also a mother it has to be borne in mind that her opinions were likely informed by own experiences as a parent.

The participants were interviewed in the following order:

1. *Alice*: aged 32, educated to A Level with subsequent musical instrument teaching qualifications, married to a chartered accountant, had a daughter aged three and a half, and a son of four months for whom she was seeking chiropractic treatment. She felt that the baby suffered a traumatic birth and noticed his sleeping pattern had altered abruptly at three weeks when “everything changed, he wouldn’t sleep, it was just awful” (*Alice*: 60). She was at home with this baby, but planning a return to work within the next six months as a self-employed peripatetic music teacher.
2. *Emma*: aged 33, a graduate, her husband worked in leisure and hospitality, had a son of two and a half, and a baby boy almost six months old. She was initially seeking treatment for her baby’s apparent physical pain associated with using a car seat, and a blocked tear duct, seeking advice for sleep issues subsequently. Her first child had regular routines and patterns so sleep issues with this baby had come as a complete surprise. She was at home with her children and beginning to accept some work as a freelance public relations and marketing specialist.
3. *Kate*: aged 53, divorced, graduate and deputy head teacher of a secondary school, reflected back on early motherhood 25 years before, describing experiences which were still able to evoke a very fresh sense of her struggles with a first child who she recalled had slept very little for the first two years. A professional who later became the principal earner in the family, she took maternity leave with her first pregnancy.

She and her then long-term partner, later ex-husband, went on to have a second child who was a 'textbook' baby in terms of sleep patterns.

4. *Natalie*: aged 40, studied for a degree as a mature student before completing a teaching diploma in order to gain greater financial security. She became a single parent when her daughter was 16 months old - the breakdown of the relationship was acrimonious and had impacted her daughter's sleep patterns. She also ran a small business and had recently given up her teaching commitments to spend more time with her 8-year-old daughter who appeared to need very little sleep, and was referred to a sleep clinic aged 5. *Natalie's* new partner had moved in with her and her daughter for several months at the time of the interview.

Helen: aged 34, had completed post-graduate training as an ante-natal educator, and group facilitator, and had recently accepted a new post in Early Intervention, funded by a local authority, with a remit to provide targeted support to families with young children who have been recognised as in need of additional help. She clarified her experiences of working with new parents as "not just mothers, but I've mostly worked with mothers postnatally" (*Helen*: 24). She was married, and a mother of two teenage children who she described as being relatively 'normal' in terms of their sleep as infants.

Some relevant characteristics of the four participants recruited to represent their experiences as mothers, and their children, and the problems encountered are presented in Table 1.

Table 1: Participant characteristics (mothers & infants)

Participant pseudonym	Zung rating score (25-49=normal)	Childbirth experience	Infant breastfed (by age in months)	Age of infant when difficulties presented	Main concerns	Interventions sought for infant
<i>Alice</i>	42	Assisted (forceps) – cord around baby’s neck	Exclusively at 4 months	3 weeks’ old	Frequent night waking, suspected fractured skull	Chiropractic assessment & treatment
<i>Emma</i>	43	Natural – no pain relief	Exclusively at 6 months	Soon after birth	Pain in back & neck. Lack of routine- feeding, sleeping, frequent night waking	Chiropractic assessment & treatment
<i>Kate</i>	25	Natural	Bottle fed at 10 weeks	Birth to age 2 years	Crying and disturbed sleep	Sleep medication

<i>Natalie</i>	24	Natural – cord around baby's neck	Breastfed until weaned	Birth to age 8 years	Disturbed sleep and behavioural concerns (aggression)	Cranial osteopathy, homeopathy, sleep clinic, sleep medication, sleep training, Early Intervention
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The table omits the fifth participant, *Helen*, who was interviewed with an emphasis on her insights from her professional practice supporting parents, rather than on her own experiences as a mother. She was the sole professional recruited within the time constraints of the research project. However, her data were considered relevant and valuable in providing insight from a practitioner, offering an alternative, 'insider's' perspective, on the mothers' interpretations of the role and input of professionals. It was intended that *Helen's* account offered *one* opportunity to introduce and explore the "gaps, unanswered questions or underdeveloped ideas" (Fassinger, 2005, p.162) which might pertain to the professional side of the debate within an area acknowledged as failing to meet the psychological and emotional needs of women, resulting in many seeking alternative private sources of help (Royal College of Obstetricians and Gynaecologists, 2017).

2.5 Ethical approval and considerations

Ethical approval for this study was obtained from the University of Wolverhampton's Behavioural Science Ethics Committee. The potential participants were not deemed a vulnerable group and therefore no particular considerations were recommended, and it is relevant to note that none had sought support for themselves during their periods of distress. The researcher's professional ethics were guided by the British Psychological Society's Code of Research Ethics (BPS, 2010) and Code of Ethics and Conduct (BPS, 2009).

Prior to interview prospective participants received an information sheet which provided details of the course of study and contact details for the supervisory team (Appendix D). It also suggested that the topics covered during the course of the interview might include revisiting the participants' own childhood. At the interview meeting participants were introduced to the boundaries and limits of the research interview as distinct from a therapeutic encounter. They were assured that the interview material would be handled sensitively, that all identifiers would be removed or altered and that confidentiality of their material would be maintained. In accordance with ethical and professional guidelines (BPS, 2010) participants were made

aware of the limits of confidentiality in the case of safeguarding issues and their consent was confirmed as informed by signature (Appendix D). At the conclusion of the interview a copy of the transcription was offered to be emailed when completed and the time limit within which to withdraw consent should they wish was advised. Throughout the recruitment and interview process I was guided by personal and professional ethical principles which informed the interactions, with respect, sensitivity and mindful awareness of the power differentials within the encounter.

Although the academic ethical approval procedure did not identify the group as vulnerable, the interview process did highlight some inconsistencies with this recommendation, with particular reference to the necessary containment, but also subsequent potential emotional and psychological impacts for participants regarding the extent and degree of unexpected self-disclosures. These issues will be further explored within the Discussion section.

2.6 Materials

The Zung Self-Rating Depression Scale (ZSDS, 1965) (Appendix, C) was completed and scored during the interview process and the results discussed with the four participants recruited as mothers, as a safeguarding screening procedure. No participant was excluded as a result of completing the screening tool. Safeguarding screening for vulnerability was not deemed relevant with potential professional participants, therefore *Helen* was not asked to complete the scale.

The Zung is a 20 item self-rating scale designed to assess level of depression across four common characteristics: pervasive and physiological effects, and psychomotor and other disturbances. Ten positively and ten negatively worded statements (e.g. *I feel hopeful about the future*, and, *I have crying spells or feel like it*) are assigned a score (1-4) indicating level of agreement (1=*a little of the time*, 4=*most of the time*), producing a total score ranging from 25-100. Total scores across the range are interpreted according to bands: normal (25-49), mildly depressed (50-59), moderately depressed (60-69), severely depressed (70-100).

The validity and sensitivity of the screening tool within a clinical population has been established for research purposes (Biggs, Wylie & Ziegler, 1978).

2.7 Procedure

2.7.1 Data collection

A semi-structured interview protocol formed the basis to explore the experience of the mothers and this was adapted slightly throughout the data collection process, in accordance with GT constant comparative methods, to elicit data to address gaps which emerged from previous interviews (Appendix E). An adapted version of the interview schedule was used for the fifth participant to reflect her professional role (Appendix F). The core questions were open-ended, and the discussion tended to flow from them as a starting point. Participants were encouraged to expand on issues they felt were relevant, and the interviews were characterised by a narrative stream which was guided by the research question in broad terms. It was felt that this approach encouraged reflection and depth to be achieved. The first interview overran the intended time and although the data was used it was treated as a pilot to inform subsequent time management and direct the flow of information.

At the conclusion of the interview participants were reminded of the research question and asked whether they felt the topic had been fully explored by the process. Later opportunity to review the analytic findings was offered explaining that this would be a valuable contribution to the analysis, and consent to be re-contacted was obtained verbally. Initial memos were made immediately after each interview.

Due to a break of 12 months in the data collection process between interviews 2 and 3, the first two participants were contacted by email to advise them of the delay and offered the opportunity to reflect on the experiences that were discussed at interview and reply with any insights or observations which they might wish to add retrospectively. The additional material was incorporated into the analysis and the same process repeated when participants reviewed the analysis at draft stage.

Interviews were transcribed verbatim and the dialogue numbered by turn of speaker. Participants were given pseudonyms, names and other personal identifiers were removed or altered at the point of transcription to preserve anonymity. Participants were offered a copy of the transcription and reminded of the period, within which they could withdraw consent or redact any content, following the interview according to GT requirements of comparative analysis (King & Horrocks, 2010). Transcriptions were identified by number and digital materials were stored on password protected software. Physical data was also stored securely in a locked file drawer.

2.7.2 Member checking

Within the range of GT methods there is no specific guidance to checking analytic outcomes with participants for their confirmation. Whilst advocates insist that it uniquely ensures accuracy, credibility and consistency (Fassinger, 2005; Riley, 1996), it has been suggested that it contradicts the spirit of observations which intend to reveal analytic depth of a “snapshot” of a co-constructed reality at a moment in time (M. Sque, personal communication, February 27, 2014). Charmaz (2006) suggests that planning for member checking may assist in gaining ethical approval for research due to an increasing literature advocating this as a form of validation which may employ diverse strategies.

As indicated at the conclusion of the interviews, in addition to offering a copy of the transcribed interview, participants had the opportunity to review the analysis when nearing a completed draft. Mindful of participant burden, both in terms of time and of the possibility that some might not wish to revisit the material, the email (Appendix K) offered the option of maintaining silence which would be interpreted as declining to be involved. Three of five reviewed the analysis, with feedback confirming credibility and resonance, reporting that their feelings and experiences had been well represented. Usefulness could also be inferred as they reported that it encouraged further positive reflection not only on their experiences but on being involved in a research process which sought to validate and raise awareness of the challenges which they had experienced.

2.7.3 Data quality

Charmaz (2006) outlines the criteria of credibility, originality, resonance and usefulness, as a means of assessing the worth of a study, and these guiding principles have been held in mind throughout the research process. The intention was to present the experiences of the women “clearly and effectively’ in order that ‘practical benefits might ensue” (Fassinger, 2005, p. 158). Credibility is reflected in the depth and range of observations evidenced in the analytic process, which supports the logical integration of concepts and generation of the theoretical model. Originality is present in the unique voices of the participants who responded to the opportunity to explore their experiences with candour and honesty, which on occasion revealed aspects of themselves which were unexpected. This study adds immediacy to the current focus on maternal mental health by a different perspective, from a non-clinical sample of mothers who reveal the profound and sometimes long-term effects of their experiences whilst caring for very young children. It offers insights into a period that has been extensively explored across disciplines including autobiographic literature (e.g. Cusk, 2001; Maushart, 1999), nursing and midwifery (e.g. Barclay et al., 1996; Mercer, 2004) and sociology (e.g. Miller, 2005; Oakley, 1979), and is replete with psychological theoretical explanations (e.g. Goffman, 1959; Higgins, 1987), and yet whose findings often resist translation to inform broader multidisciplinary awareness, and seem not to ‘trickle down’ to enlighten the lived experience of women.

It is felt that the resonance of the study was encouraged and facilitated by clinical training and experience which informed development of ‘relational depth’ (Mearns & Cooper, 2005) in engagement with the data throughout the process. Much consideration was given to the interpretations presented within the data analysis, in comparison to those tentatively offered in therapeutic encounters. Issues of power resonated through the decision-making process of interpretative data handling, and these informed the selection and presentation of material. The usefulness of the study is, firstly, that it was deemed a useful exercise by participants in that it offered an opportunity to talk about experiences that had often been largely undisclosed, and this was reported to have been helpful both in real time and retrospectively. Additionally,

the theoretical model that was developed has subsequently evidenced its clinical and therapeutic relevance. It has since been applied, by the author, in clinical settings and has been well received, and provided a useful tool to aid mothers' conceptualisation of their experiences, both in groups and individual sessions.

2.8 Analytic strategy

The data sources for analysis included the transcripts and additional reflective material provided in research diaries and subsequent participant emails. The data were supplemented and developed in the analytic procedure outlined by Charmaz (2006) via memo-writing, initial coding, identification of focussed codes and raising of conceptual categories (Charmaz, 2006), and guided by her advocacy of "theoretical agnosticism" (Henwood & Pidgeon, 2003, p.138). In accordance with GT theoretical sampling methods comparative analysis occurred on a constant ongoing basis as data was gathered and reviewed in light of previous and subsequent data forming an iterative analytic process.

For each transcript, initial in-line coding was first performed focusing on social and psychological processes rather than topics or themes, following Charmaz (2000). Codes were added in-line in a coloured font (red) for ease of distinction and identification and attempted to preserve the active voice inherent in the meaning making and underlying assumptions (see Appendix G for an example of a coded transcript). Gerunds were employed wherever possible in order to embed the action within the codes, and verbatim "*in vivo*" (p.55) codes maintained researcher adherence to the participant's voice (Charmaz, 2006; Glaser, 1978). For example, when *Emma* (L: 14 & 16) emphasised her feeling that the sleep challenges served to strengthen the relationship with her husband "...erm...I think in some respects we're stronger than ever..." and later "... I think it's made us stronger" this is coded as *recognising strength of relationship*.

Significant events and actions were also coded according to their impact on the narrative within each interview. At this point the first interview data was compared with the second and a process of focussed coding began to emerge which grouped the identified codes according

to emergent themes for each transcript (Appendix H). Focussed codes emerged from repeating, or salient, themes coded within the data which began to provide early indications of theoretical saturation and significance within the individual narratives. As an example of the scope of the emerging focussed codes following comparative analysis, between the first two data sets twenty-six which were produced. As they emerged focussed codes were entered into a table with corresponding verbatim material alongside. Clarity and ease of data handling and sorting was assisted by colour-coding each participant's material with an identifying coloured font (*Alice*: black, *Emma*: blue, *Kate*: red, *Natalie*: green, *Helen*: purple). Amendments to the focussed codes arising from the comparative analytical observation and memoing were then added in the colour corresponding to the relevant participant (Appendix I). In this way, an audit trail was established in the scaling up of focussed codes into categories.

The comparative process grew in complexity as the data set grew and tacit beliefs and meanings were identified and interrogated (Charmaz, 2006). Focussed codes were explored, adapted and refined with the addition of each data set, or were subsumed into other groupings. With the addition of data emergent concepts grew in strength allowing analytic identification and interrogation. As mentioned earlier, whilst frequency of themes did inevitably provide evidence for their potential significance, theoretical saturation requires engagement with the data at a level of abstraction which provides distance and a critical perspective from which to view and review the emerging concepts. In turn, the links which emerge between categories enabling the development of theory derived from the data may also be subjected to critical assessment and evaluation via memos which define, compare, interrogate and thereby raise further questions of the data. As a complement to the written analytic process integrative diagrams (Strauss, 1987) inspired an initial mapping of the nascent theoretical model which offered a fresh perspective. A rubric of the proposed analytical categories (Appendix J) provided the framework for the process of drafting the analysis. This process in turn provided further refinement as selection of verbatim material for inclusion began to develop and drive a

compelling narrative which prompted ongoing reviewing of the robustness of the analytic categories and provided tests to the emerging theory.

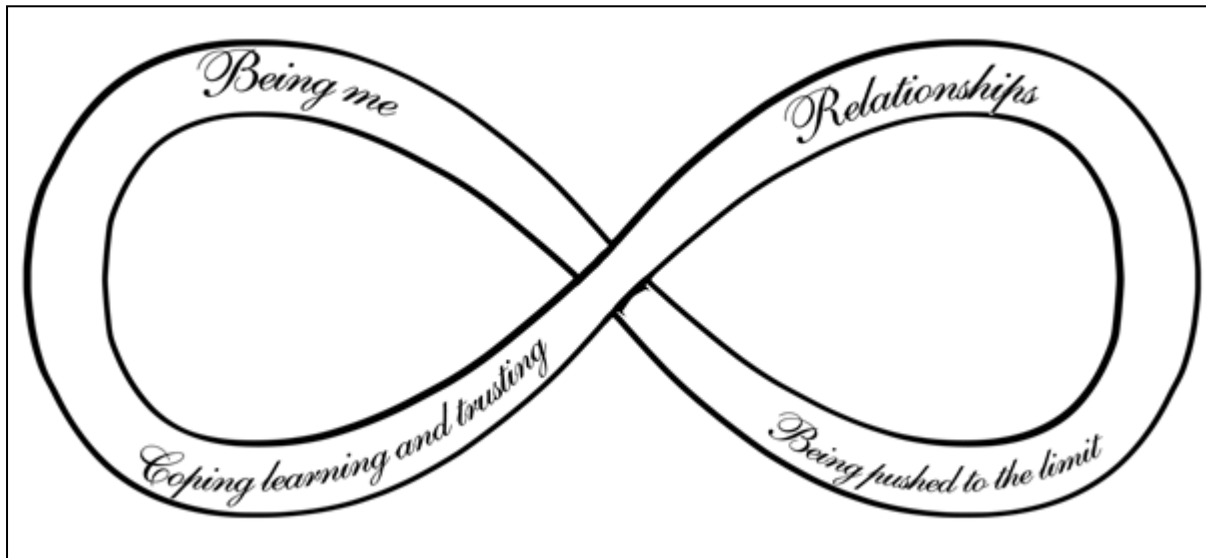
3. Analysis

3.1 Introduction to the theoretical model: description and explanation of categories and subcategories

This small study sought to explore the experiences of four mothers, who identified their child's sleep difficulties as significant in their transition to becoming mothers and parents, and a fifth woman, trained to support parents during the transition, via how they communicated and made sense of the challenges lived through. In accordance with constructivist grounded theory (Charmaz, 2006; Ramalho et al., 2015), the following analytic process and theory development offers interpretations of the words and actions of the five women and their making of meanings, acknowledged as the product of a reflexive research process. The process seeks to offer depth and breadth of understanding to what could be seen as ubiquitous, or even "mundane" parenting experiences relating to the often unwelcome sleeping patterns and habits of infants and small children (Charmaz, 2006, p. 152). It is hoped that the compelling nature of mothers' accounts of distress will illuminate a time of transition which, whilst indeed routine, is presented here as a source of significant, if silent, despair. In addition, it offers an opportunity to reflect on mothers' experiences across a span of two decades and to highlight an ongoing paucity of recognition and support, particularly within the first 6 months in the absence of advocated sleep interventions for infants, despite well recognised implications for the psychological and emotional wellbeing of the adults caring for them (Netmums & Children's Sleep Charity, 2016). The interviews and subsequent analytic process attempted to preserve the individuality of the meaning making whilst seeking to develop a deeper understanding of the processes which underlie the development, maintenance and change of expectations, attitudes and strategies. Due to the complex nature of some identified themes, only material that seemed to directly illuminate the research question was included. Inevitably, however, this very complexity has required consideration within the analytic process. Guided by the philosophical underpinnings of counselling psychology any interpretations made have been offered tentatively in order to

explicate the findings within this context. Set against a backdrop of the wide-ranging impacts of prolonged sleep disturbance and eventual deprivation a central narrative of 'the wearing mask of transition' was developed.

Figure 2: The wearing mask of transition



The model is represented by means of a visual cipher, the lemniscate or infinity symbol, depicting a plane curve consisting of two loops with a central meeting point, which finds wide application in contemporary culture. Its application within this theoretical context offers visual and allegorical interpretations – indicating both a sleep mask, but also a disguise. During the course of the analysis it came to provide a useful visual representation of the perpetual nature of transition throughout the human lifespan, whilst as a conceptual framework supporting the iterative nature of the constant comparative method. Further exploration of algebraic geometry, the branch of mathematics to which the symbol pertains, added resonance to the application of the transition model, as both are concerned with exploring the range of properties of the possible solutions within a system, rather than necessarily finding specific solutions.

Both literal and allegorical references to masks and masking appear throughout the transition to motherhood literature (e.g. Barclay & Lloyd, 1996; Barclay et al., 1997; Maushart, 1999; Cree, 2015), and the concept was mentioned earlier in the context of stress and distress in

relation to the emotional labour of midwives (Raiment, 2015). The current version – ‘the wearing mask’, deliberately distinct from ‘wearing the mask’ - hopes to offer an opportunity within its construction to sensitively personalise and identify the fatigue induced by disguising whilst coping with the challenges of transition, within the specific context of sleep deprivation. The data provide direct references to “put(ting) on a front” (Kate: 145) and choosing to conceal distress from others, driven by urges to disguise difficult emotions and experiences, and present an image which is congruent with expectations, both internal and external. The interview data and auxiliary sources offer substantial evidence of processes surrounding childbirth and early parenting in which the masking of emotional distress is commonplace. Masks are ubiquitous and arguably useful across human social interactions and times of transition allowing for coping strategies to become established, as most notably presented in Goffman’s (1959) dramaturgical model of presentations of self. When resilience is compromised, perhaps due to physical, emotional and psychological demands as wrought by sleep deprivation, a ‘coping mask’ may be an available shortcut which can be felt to satisfy the needs of those around. However, as the data reveal, this form of emotional management does little to address the psychological and emotional needs of the mother or her baby, and indeed may exert long term negative effects on satisfactory integration of the period into a coherent and acceptable life narrative. The retrospective data obtained suggests that alternative, help seeking approaches are deemed preferable, however it is the reluctance of women to reach out which this study aims to address by offering a conceptual framework that encourages identification, validation and normalisation of these experiences which can lead to disclosure, acceptance and reduction in shame and isolation.

Accordingly, when offered a safe space via the interview process to explore some of the issues they were confronting it was felt that participants allowed some valuable insights ‘behind the mask’. It is these insights which have underpinned and directed the data handling process and ultimate development of four analytic categories: ‘being me’, ‘being pushed to the limit’, ‘relationships’ and ‘coping, learning and trusting’. The categories comprise sub-categories, the exploration of which are integral in the substantiation and explication of the analysis (Table

2). The following analysis explores each category by way of its subcategories, with *italics* used to identify words which labelled focussed codes earlier in the analytic process. Notably the subcategory 'my own childhood' extends influence across all four categories, indicating the potential re-emergence of parents' experiences of having been parented.

The first category, 'being me', organised what are very complex data into four subcategories in a descriptive manner, which is then both synthesised and expanded to incorporate deeper psychological and interpretative treatment across the three subcategories which comprise the second category 'being pushed to the limit'. The third category, 'relationships', sorted the data via straightforward references to partners, family, friends and others. This initially convenient and simplistic approach to establishing a category did not preclude the development of complex interplay between particularly *partner relationships* and the other categories. A notable if deliberate exception from this category was the relationship between the mother and child(ren) as this pivotal relationship was examined across the remaining three categories. The final category 'coping, learning and trusting' identified diverse strategies identified as supporting mothers through the transition, and factors which block coping, linking inevitably back to the category 'being me'. The iterative and circular nature of the categorical distinctions thereby reflects the flow of the visual cipher.

Illustrative quotes are included with reference to line numbers, and all transcribed material is available in the confidential attachment.

Table 2: Analytic categories and component subcategories with illustrative quotes

Being me	Being pushed to the limit	Relationships	Coping, learning & trusting
<p>Expectations of parenthood</p> <p>“I just always thought – that I’d be a really good mum and it would be really easy” (Kate: 10)</p>	<p>Living sleep deprived</p> <p>“I lost control because I’m knackered” (Alice: 287)</p>	<p>Noticing changes – highlighting differences</p> <p>“I’m prepared to give up my social life but I don’t think (husband) is” (Alice: 287)</p>	<p>Gaining confidence to parent intuitively</p> <p>“...people have said...you need to wean them early...I still don’t think that’s the issue, I think he just needs to try to learn to settle himself” (Alice:84)</p>
<p>Increasing self knowledge</p> <p>“I probably put myself under quite a lot of pressure to be doing stuff” (Emma: 103)</p>	<p>Feeling alone with responsibility</p> <p>“most days I feel quite frazzled” (Emma:134)</p>	<p>Valuing & maintaining partnerships</p> <p>“I am getting back up...he will back me up on her sleep as well” (Natalie: 338)</p>	<p>Making sense of sleep issues</p> <p>“for the parents...to be able to see things from their baby’s point of view...you’re sleep deprived, he’s not trying to annoy me... it might just be that he needs to be held” (Helen: 124)</p>
<p>Juggling roles</p> <p>“a lot of women I think have very high expectations of themselves – that they still have to do everything and have a baby” (Helen: 24)</p>	<p>Experiencing conflicted emotions</p> <p>“I felt completely low, I felt isolated, I felt alone and incredibly resentful...and also incredibly guilty for feeling like that” (Kate: 28)</p>	<p>Seeking & accepting support from others</p> <p>“what resolved (baby’s) sleeping issues...came from accepting more help from my husband during the night; something I know that I hadn’t been very good at asking for or accepting...” (Emma 3:1)</p>	<p>Seeking solutions – being open to alternatives</p> <p>“the positive outcomes from the alternative therapies are about more than the treatment alone...valuing being supported and...listened to...” (Helen 2:2)</p>
<p>My own childhood</p> <p>“when you become a parent...start looking at...the way that you were parented...a lot of reassessing...re-evaluating.....it can be a very challenging time for people” (Helen: 87)</p>	→	→	→

3.2 **Being me**

A bold title, selected deliberately to highlight the phenomenological diversity present in the four mothers' accounts, and augmented by illustrative examples from *Helen's* professional experiences. Clearly a category entitled 'being me' evokes a strong sense of identity, and links with a lifespan narrative approach to making sense of these every day and yet profound experiences. This category provides a foundation for the entire analytic development, via the ambitious task of attempting to convey the many and diverse ways these mothers identify, know, and inevitably, compare themselves to others, in addition to comparing and contrasting their experiences with that from *Helen's* work with transitioning parents. This category aims thereby to attempt to account for and explore the processes which establish, maintain and change mothers' understanding of themselves both before and during their transitioning experiences as impacted by lack of sleep. It takes account of the conditions that affect their self-concept and seeks to explore the processes by which aspects remain constant or are altered.

In the absence of relevant psychometric assessment measures, but if seeking to characterise the mothers interviewed in the categorical terms of 'types', it would be tempting to use personality descriptors such as 'conscientious' (Costa & McCrae, 2005). Their accounts indicated high expectations of self and competence, which likely extended beyond their attitudes towards parenting to wider perspectives on functioning in life, portrayed unequivocally by *Emma* as "I don't want to do anything unless I can do it to the best of my ability" (Emma: 230), and given a different interpretation by *Alice* "I'm one of those people...I will just break my back for anybody, and do anything they ask" (Alice: 237).

A category that focuses on the individual, and understanding their internal and external processes, clearly has implications for and offers underpinning interpretations which inform the remaining categories. Accordingly, links between these often highly interwoven and interdependent categories will be identified and accounted for within the analysis then coalesced in a concluding summary.

The four participants, *Alice*, *Emma*, *Kate* and *Natalie*, who were recruited due to their current or prior experience of coping with infant sleep difficulties, recounted narratives which, whilst having elements in common, unsurprisingly revealed wide ranging individual differences in expectation, attitudes and approaches to the challenges faced. Their accounts were accompanied by a contrasting perspective offered by *Helen*, the fifth participant, whose professional opinions were informed from working with and supporting many mothers in their transition to becoming a parent, as well as her own experiences as a mother. The category 'being me' was developed from the following four subcategories which attempt to order and understand the data in terms of the broader context of these women's lives – emotional, practical and psychological.

3.2.1 Expectations of motherhood

Alice, *Emma*, *Kate* and *Natalie* anticipated motherhood with pleasure, and planning for a family formed a significant part of their life ambitions, encapsulated by *Kate* "I was always really clear that whatever my path my life was going to be I always knew I wanted children" (Kate: 10), and poignantly recalled by *Natalie* "(I) felt incredibly lucky...I've only got a very small chance of getting pregnant... (I have) really bad endometriosis" (Natalie:16). Pregnancy therefore, although not always straightforward or planned in every case, had been anticipated with partners and the practical aspects of the women's lives were felt sufficiently stable to support a child.

Notwithstanding careful planning in many cases, as evidenced above, *Helen* offered her reflection that the reality of becoming a parent takes many by surprise: "a lot of the parents I have worked with are really...unprepared for what life is going to be like when they have their babies" (Helen: 24). This was exemplified by *Kate*, "I just always thought – that I'd be a really good mum and it would be really easy, and it was the hardest thing I'd ever...done" (Kate: 10), "having a baby is supposed to complete you, isn't it? It's supposed to be the wonderful thing, but I found it really hard, *really* hard" (Kate: 30).

Furthermore, *Helen* talked about how the prevailing cultural norms that frame parental expectations of child rearing may in some ways underestimate the impact of babies' dependence on new parents. According to her observations, she finds a lack of awareness of practical issues, for examples, normal patterns of "regression" (Helen: 173) associated with the establishment of sleep routines:

"some people seem to be quite surprised...how dependent their babies are - I think there's a kind of undercurrent in our culture...we want babies to be independent from a very early age...we do their nurseries up before they're born with this idea that they're going to go to sleep in the nursery" (Helen: 26).

Predictability of sleep routine that afforded parents some control was equated with the temperamental characterisation of placid babies, as 'easy'. *Emma* reminisced about her first child "he was just...very predictable, he was just very easy really" (Emma: 87), and *Kate* fondly described her second baby "he used to feed and sleep, feed and sleep, he was like textbooks say babies do" (Kate: 10). Links between predictability and control were supported early in some interviews as the women confirmed a desire for a feeling of being in control, "I am probably a little bit of a control freak" (Emma: 16), "as I've got older I've got worse but I have to be in control of things" (Kate: 10). This contrasted with insights offered by *Alice*, "I'm one of those people, I want to get every angle and all the information" (Alice: 44). *Natalie* characterised her expectations of motherhood as 'naive', which suggested her self-confessed acceptance of unpredictability was somehow simplistic, or perhaps unrealistic in light of the complex challenges to come, "...it sounds really naïve, I thought you got a child, and as long as you fed it, loved it...you just had to go along with it all, and your child would do what it did" (Natalie: 326).

The sub-category 'expectations of motherhood' comprised earlier focussed codes, including one entitled *impact of unplanned events*, which identified and explored occurrences and reactions relating to conception, pregnancy, labour and birth, in addition to the unforeseen issues presented by sleeplessness, which had been anticipated, if greatly underestimated, by *Kate*, "I thought the first couple of weeks... I might not have much sleep...but not two years"

(Kate: 41). Reluctance to repeat the challenging experiences significantly affected her attitude towards subsequent pregnancies, “I don’t know why I did have another one – I think I did it because I didn’t want him to be on his own...he was three and a half when we had (second child)” (Kate: 24), and caused significant anticipatory distress in her second pregnancy

“a week before I had (second child) I can remember getting very tearful and upset, saying I don’t want to do it, I just don’t want to do it, because I just knew it would go back to how it had been...well, that’s what I thought – I thought it would go back, and it was just so awful, the thought of going back” (Kate: 105).

The impact of disturbed sleep, extending into periods of sleep deprivation were thus referenced from the early stages in the interviews. The key issues identified centre on the lack of concordance between expectation and reality, with the mothers reflecting differing aspects of awareness and acceptance of the lack of predictability the new baby had brought into their lives.

Although ante-natal education was seen as potentially offering insight into how expectant parents manage their expectations for child rearing practice, *Helen* was realistic about the impossibility of be prepared for the overwhelming impacts of sleep disruption:

“we talk about sleep a lot in ante-natal classes...everybody knows they’re not going to get any sleep...‘you’re never going to sleep again’...but...you can’t ever really be prepared for that...absolute exhaustion...I think a lot of it’s to do with...expectations...and how realistically you can be prepared?” (Helen: 26).

This statement takes account of the lack of opportunity to recover from labour which is compounded by meeting the needs of the new infant. The mothers indicated individual differences in their need for sleep and preparedness to cope with broken sleep, which was informed in the case of *Alice* and *Emma*, by previous experience, whilst *Natalie*’s approach was one of acceptance reframed as ‘naivety’. However, as the accounts indicate, their present experiences represent a significant deviation from what they had been prepared for.

Helen identified a pivotal responsibility for parenting education in providing accessibly presented evidence-based information about arguably poorly understood basic developmental concepts that most new parents might not have anticipated.

“most babies don’t have any idea about the difference between day and night until they’re about 10 weeks old...there is an end to it, but you don’t know where that end is...the concept of my baby sleeping through the night actually only means between...midnight and five” (*Helen*: 169).

Despite some having attended ante-natal classes, the mothers made no reference to having any specific knowledge of the infant’s likely sleep patterns, beyond, in the case of *Emma* and *Alice*, their experiences with previous babies. Therefore, *Helen*’s observations reveal an important opportunity to convey to expectant parents that sleep pattern in early infancy is likely to be disorganised until babies establish their circadian rhythm. Informing parents of the rapidity of the infant sleep cycle in contrast to their own would help to counter unrealistic expectations of what constitutes ‘sleeping through the night’, and this might then mitigate for the fatigue and anxiety arising in new parents from a sense of pathologising the perceived lack of sleep in their infant.

The generalised anxiety and impacts on psychological wellbeing of lack of sleep can be further exacerbated by unanticipated medical complications, in pregnancy, labour, and beyond into the early weeks and months, even when babies are born ‘healthy’. For *Natalie* and her baby this took the form of a traumatic late stage of labour and delivery: “it was during birth that they realised it was the cord – around her neck, going tight, loose...” (*Natalie*: 46), and for *Alice* it was the suspected fracturing of her baby’s skull during a forceps delivery: “he had the cord wrapped round him twice and was quite blue... (his face is) quite bruised...(chiropractor) thinks they’ve cracked his skull...”(*Alice*: 32). *Emma*’s baby experienced a repeat of her first child’s blocked tear duct, potentially requiring surgical intervention, causing her anticipatory anxiety “...(baby) going under general anaesthetic’s a bit kinda scary” (*Emma*: 75).

The women’s awareness of their own sleep before having children was explored, “I never had any problem sleeping at all, and I don’t think I’ve ever got that back” (*Kate*: 47), “(sleep) was

good... (but) I've always been a real light sleeper" (Natalie: 69). They were prepared for, and anticipating, their own resilience in the face of 'normal' sleep disruption in the early period of motherhood, as indicated by *Alice's* assertion, "I can cope with broken sleep" (Alice: 84), an assertion tempered by the previous experiences with her first child before a routine was established. However, these four participants acknowledged that having a baby who was seemingly experiencing sleep difficulties had impacted, or was impacting, not only their lives but also their sense of self to a significant degree "it did feel like it would be manageable, but obviously...it's very different" (Emma: 32).

As mentioned earlier, for *Emma*, and to a lesser degree *Alice*, expectations of infant sleep were mediated by predictions based on prior experiences with previous babies who had been 'good' sleepers, "(first baby) was a brilliant sleeper, a really good sleeper, he was kind of textbook...he slept through from quite early on as well, so he was a very easy child" (Emma: 32), "(this time) I thought that by 6 months...established a bit more of a routine, but I haven't" (Emma: 42). Her first experience was characterised as perhaps unusually straightforward "my mum kept saying to me, you're not going to have the same child, I hope you realise this, you're not..." (Emma: 85).

A range of responses to the impact of unformed, unmet or altered 'expectations of parenthood' relating specifically to the issue of infant sleep pattern and duration was evidenced. An expectation of competency based on self-concept, which will be explored in detail in the category 'being pushed to the limit', was present in *Kate's* retrospection on her struggles with her first baby's lack of settling and the impact on her sense of identity, confidence and competence "I wasn't this 'earth mother' liked I'd hoped I'd be" (Kate: 10), "the biggest thing for me – the biggest feeling I had – was just a complete sense of failure" (Kate: 16). Her expectations had some basis in prior observation of mothers and babies, and attributions of competence while preparing for motherhood, which her own experiences failed to meet

“you have somebody else’s baby and they start crying you give them back, and they always stop, don’t they, when they go back to their mum they stop crying – it seems easy – the mum’ll give them a cuddle and they’ll be fine” (Kate: 33).

In line with her previous philosophical remark, *Natalie* was accepting and felt reassured that her daughter was happy and thriving despite an erratic sleep pattern, “she just never really went to sleep – but I can’t remember it ever bothering me until she got to about five, no four...I just thought that’s what babies did – I just didn’t think they slept...mine was always awake... (day and night)” (Natalie: 52) - a concept which she later qualified,

“I knew that they were *supposed* to sleep, just that mine didn’t, but it wasn’t an issue really because she was always happy...so I just thought well it’s not a problem then...she’d fall asleep if we went for walks, and she’d fall asleep in the car a little bit...she obviously *did* sleep, but not like those big stretches that people talk about” (Natalie: 63).

At the other extreme *Kate* experienced the early weeks dominated by her baby’s lack of sleep to be highly destabilising

“he just didn’t sleep and I had all sorts of different feelings...I felt I couldn’t do it, I felt I should be able to do it and I couldn’t, I felt there must be something wrong with either him or me” (Kate: 10).

Coping with the practicalities of early motherhood seemed to be broadly understood and anticipated by the participants to be an all-encompassing undertaking, of which sleep deprivation formed an integral part – this will be explored in more detail in the category ‘living sleep deprived’. Although the mothers were at home without support for the majority of the day, some with an older child were able to access nursery places for part of the week. Childminders and grandparental childcare support formed part of the later plans to allow the mothers to return to work.

As time progressed, routines and duties became established and when sleep difficulties remained unresolved for some resentment built “I just couldn’t do anything – I couldn’t do anything I wanted to do” (Kate: 16). The lack of time for self-care, or even time just to sleep,

reinforcing the sense of isolation and resentment, often towards partners, was recalled by *Kate* “(he) lay there all night snoring, and was completely unaffected by it, and he’d go off to work the next day and I’d be left drained, because I hadn’t slept all night, with more of the same all day” (Kate: 10). Whereas the role of primary carer was presented as a ‘natural’ choice for some “if there’s a problem I’m the one who wants to be looking after the boys...I’ll be the one who gets up in the night, because it’s just in my nature to do that really” (Emma: 16). Issues of gender roles and expectations of partner support to facilitate respite for mothers did not appear to have been considered in prior planning for these mothers and their partners, and will be considered further in ‘relationships’.

3.2.2 Increasing self-knowledge

Participants engaged in reflections on their current life, often contrasting it with the past, both in terms of their own childhood, and adult life prior to becoming a mother. The subcategory ‘increasing self-knowledge’ was informed by differential awareness of their reactions to the lack of predictability in their lives which was underpinned by their baby’s sleep habits. For example *Alice* described greater self-reliance since becoming a mother, “I am now a lot bolder” (Alice: 243), whilst *Emma*, looking after a toddler and baby, reflected on the motive and function of her self-imposed busy daily routine, which often relied on them being dressed and out of the house early in the morning: “maybe I’m doing it for me, I don’t know – I feel like I’m doing it for them, or I’m doing it for all of us because I need it as much as they do” (Emma: 105). She was candid in disclosing that the routine helped her to manage her own needs and those of her two children

“maybe some days (older child) would be more happy to crash around here and actually would like to sit in front of the TV in his pyjamas, or just play with games, but I kinda think, well, because of (my lack of) sleep, I think we just need to get out” (Emma: 128).

Helen meanwhile appeared critical of a coping style characterised by cramming many activities into life with young infants, which she feels is at odds with what babies need to thrive.

Although this sentiment was not voiced overtly by *Emma* in her earlier statement, *Helen* offered personal reflections on such 'busy' behaviour, which she suggests is rooted on a lack of confidence and ease in 'being' with babies,

"I know a lot of women who...go to a lot of groups...they need to be out of the house...they're not comfortable just being with their babies...and also, a feeling that they *need* to be stimulating them, that they need to be *socialising* them...*small* babies...so I think there's a lack of understanding really, about babies' needs and development" (Helen: 34).

Such an approach was observed by *Helen* as increasingly accepted as a norm, perhaps particularly for those who can access, and afford to engage, in specific baby-focussed activities.

Kate's recall of her first child's sleep issues, and the associated challenges that followed, have necessarily been influenced by the passage of 20 years. However, she expressed an enduring sense of unhappiness and lack of fulfilment or sense of mastery during the early years with her first child. She still maintained uncertainty towards the processes by which she had overcome her challenges, "I honestly don't know how I got through it" (Kate: 24). The passage of time allowed her, for the first time, to disclose 'putting on a front' in the early years of motherhood, by masking what would have been too painful for her to acknowledge at the time, "I'd put on a front, and be – ooh, it's marvellous, it's wonderful – because I wouldn't want anybody to see it wasn't" (Kate: 141).

Although her current perspective offered insights prompting her to reflect on the positive impact she felt reaching out to seek help might have offered in terms of supporting her psychological and emotional wellbeing and mental health "the biggest lesson I learnt from it really would be not to be so stubborn, and to tell somebody – to actually have found help myself" (Kate: 153), awareness of her coping strategy at the time informed her anticipated caution in responding to others in the same position

Researcher: “I wonder how you’d feel now; say if you were talking to...someone...experiencing these problems...how would you feel you could approach it – would you feel that you’d want to help them?” (Kate: 134)

Kate: “I think I’d tread carefully because I think if somebody had come and approached me when I was feeling the way I felt, and said that they’d noticed...I think that would have made me feel worse, because it’s somebody else thinking, or somebody else noticing, that I’m a failure” (Kate: 135)

Here *Kate* offers a valuable insight into both her state of mind at the time and the extent of her empathy towards those who may employ and rely on similar masking as a means of coping.

3.2.3 Juggling roles

The development of this subcategory reflected that all of the women interviewed were anticipating a return to work outside of the home. *Emma* and *Natalie* appeared to identify their work roles as contiguous with their identity as mothers, stating early in the interviews “I’m self-employed” (Emma: 6), “I’ve got my own business” (Natalie: 4).

Returning to work after eight months, “I started a new job when he was 8 months old and he went to a childminder” (Kate 2: 3), *Kate* took maternity leave with her first child but reflected on the impact of sleep deprivation and coping with her challenging experience of early motherhood on her general functioning outside of the home with a sense of loss “I wasn’t the person (I was before) ...that part of me had gone” (Kate: 28).

Both *Alice* and *Emma* expressed a determination to return to work within six months, underpinned by a financial imperative “it always was that I’d go back to work quite soon because of money” (Alice: 178). There was also some evidence of tension between balancing identity needs which were linked to self-confidence and feelings of agency. For *Alice* who was enjoying spending longer at home with her second child, there was a tentative acknowledgement of the impact of her work on her self-confidence “I suppose if I don’t go back to work I might...lose confidence in myself...I’m gonna doubt my own abilities again” (Alice: 112).

Although there appeared to be no special consideration given for the sleep issues and fatigue that mothers were experiencing, after several years *Natalie* made a link between her daughter's sleeplessness and her own impaired functioning that prompted her to seek help, a concept which will be explored further in a following category - 'seeking and accepting support from others' - "because I was working a lot more...and I...was starting to get really short-tempered, and I started realising that, actually, I'm way way over-tired...you've got to do something about it, cos it was affecting *me* more than her" (Natalie: 95).

Emma illustrated the dilemma of the self-employed in feeling some pressure to accept offers of work before being really able to cope lest a refusal jeopardised future opportunities

"I've just started doing a little bit of work again...I'm thinking it's probably a bit early really...so I'm trying to squeeze that in somewhere...something's gotta give...when you look at your priorities really they're with the children, but in the long term you realise you've got to do the work...otherwise you're not going to have a job" (Emma: 164-166).

This statement indicates some unwelcome pressure to juggle her mothering role with self-employment outside of the home, whilst it also is implicit in its identification of the round-the-clock nature of the role and its responsibilities which have to be 'juggled' by many as a matter of necessity, if not immediately following the birth of their baby. The sense of juggling tasks and roles is exemplified by *Natalie* describing that she had continued running her small business, and when her relationship broke down began a degree to improve her employment opportunities

"when her dad left, that's when I did my degree...couldn't afford to pay the mortgage on my own, just having my shop and the little teaching job...so I had two years...working two jobs...degree, and...a child that didn't sleep" (Natalie: 99).

Helen offered her candid personal insights, which although indicating empathy, also sounded a note of censure for those parents whose enduring value of routines and high expectations of themselves are often challenged in novel ways with the arrival of a baby,

"...the professionals, they've probably waited a bit longer in life to have their babies, they've got careers...they're used to being in control of their lives...knowing exactly

what they're doing...suddenly they don't know anything...they really struggle with that...the reality of what it's like to have a baby...all sorts of issues about identity...what the expectations are of them, and what they think everybody expects them to be doing – a lot of women I think have very high expectations of themselves – that they still have to do everything and have a baby...whereas, of course, having a baby is, that is your job, a 24 hour, 7 day a week job for however long” (Helen: 24).

Recognising that this statement is specifically addressed to middle-class, ‘professional, working women, with implicit expectations of being able to plan, and perhaps manage their families as an extension of the way in which they might their careers, it would be over-simplistic and crass to disregard the financial burdens faced by most, if not all, families, who are not represented within this small study. Employment outside of the home offers much besides financial reward in terms of alternative types of fulfilment and validation, and it is perhaps well worn to reflect on the apparent lack of status afforded to the “unpaid work” (Alice: 267) of mothering, which it could be argued is alluded to in this description.

3.2.4 My own childhood

This subcategory was the most difficult to title adequately in order to reflect the range of experiences it encompassed. Reference to the focussed codes which informed this category offers an indication of the range of complexity in the data, from *re-experiencing the impact of childhood trauma*, to *reflecting on own experience of being a child, or being parented*. The methodological issue of achieving saturation of the category, whilst partially fulfilled due to the variability of individual reference to childhood, could not hope to do justice to the diversity of experience presented. The relevance of this material for the research question is to consider that sleep deprivation has the potential to increase susceptibility to negative or self-judgmental interpretations based on unresolved issues from the mother's past. It was summarised sensitively by *Helen*, “when you become a parent...start looking at...the way that you were

parented, I think you do a lot of reassessing...re-evaluating...it can be a very challenging time for people” (Helen: 87).

As participants offered insights from the narrative of their own childhoods, *Kate* recalled “my sister was...the easy baby...I was the not easy baby” (Kate: 147), “my mum says I was about eight before I slept through the night” (Kate: 179). *Kate* also acknowledged her mother’s perceived masking strategy “she does present an image, my mother does” (Kate: 183). Meanwhile *Alice* disclosed “throughout my childhood...I didn’t feel secure” (Alice: 194), “...I was begging my mum to send me to the boarding school she went to...I didn’t want to be at home...for an 11-12-year-old to be doing that is quite sad really (*laughs*)” (Alice: 219).

Childhood was also referred to in relation to plans and aspirations for their own children. *Alice* who had not enjoyed school, being identified relatively late as having dyslexia and experiencing bullying, even within the family, recalled “my parents, well my mum and my step-dad...they would always knock me down” (Alice: 126), “even my dad, I mean, bless him, I always remember him saying, why are you doing (A Level subject), cos you will fail?” (Alice: 132). She spoke of her hopes of being a role model for her daughter, “it’s only really been since having (older child) I’ve thought, right, how am I going to teach her to stand on her own two feet, and be confident, and do these things if I’m not?” (Alice: 112). By contrast *Natalie*, separated from her daughter’s father, considered her own experience of growing up after her parents divorced, “I just have a lovely memory of growing up with lots of parents – two families – that really loved me, so I tried to carry that on” (Natalie: 167).

The women offered insights into desires to consciously address issues from their own childhood experiences, with links to a later category ‘gaining confidence to parent intuitively’,

“I didn’t have that as a child, and I didn’t have a loving relationship – I don’t remember my mum cuddling me, or kissing me, or anything like that... I always remember talking to one of the ladies at the Children’s Centre...she was like – you never can give your child too much love, you know it’s normal, it’s fine” (Alice: 131).

Alice also identified a cause for her reluctance to accept offers of child care support “...that stems from my mum, she never worked but we always had au pairs, and I always think why

didn't you bring us up?...I always think we were palmed off" (Alice: 92), whilst demonstrating insight into and compassion for her mother's formative experiences

"she lost her mum when she was eight and just got sent off to boarding school, so I have to keep in my...reasoning, well mum doesn't know how to be a mum – she always wanted a big family, but I kind of think because she wanted to feel loved, but I don't know she actually knows how to give love really" (Alice: 203).

She acknowledged the influence of her mother's depression on how she anticipated her own ability to parent. She expressed the relief of instantly feeling love for her first baby "just giving birth I felt that instant – wow" (Alice: 205). Meanwhile awareness of her husband's concerns regarding her family history were evident, indicating an undercurrent of perceived vulnerability regarding her mental health by others

"he's always thought I'm gonna get post-natal depression because depression is in the family...my mum used to be on all sorts of anti-depressants when we were kids...she does flip in and out of depression...he was like, oh, you're gonna get post-natal depression, and my sister also had it with two of hers, and is still on anti-depressants" (Alice: 144)

This awareness was countered by her sense of being stronger and more supported in her relationship "I didn't really (worry), I think because I am stronger" (Alice: 146), "...no, not stronger, I think I have a stronger relationship with (husband) than my sister does with her husband and I know (he) would support me... (Alice: 148). However, his comments had a stinging tone which she was reluctant to address "I don't want to bring it up with him" (Alice: 158), as she recounted from their ante-natal conversations

"...he always used to say, oh you only want children to prove you're a better mother than your own mother...I obviously wanted to make sure I was a better mom, but...I didn't feel like it was going to turn into a competition" (Alice: 148).

The power dynamics of intimate relationships is apparent in *Alice's* husband's perception of her vulnerability, as the result of her own experience of being parented. The potential impacts

on her transitioning to motherhood will be further addressed in a later category, 'gaining confidence to parent intuitively'.

Helen provided a complementary example from a group she had facilitated, "(group member) started...assessing the kind of impact of the in-laws parenting of her partner, so she was beginning to understand him now as...a product of the way he was parented" (*Helen*: 98). Wittingly or unwittingly, reciprocal psychological exploration of influences from their past and their values in child rearing is undertaken by partners in their transition to parenthood.

3.3 Being pushed to the limit

This category was elevated from a subcategory in earlier analysis, which emerged from candid and compelling accounts of the impact of sleep deprivation on women's ability to manage the daily demands placed upon them. Participants made disclosures, frequently for the first time, of feelings, thoughts and actions, which challenged not only their self-concept, but their developing sense of self as mothers and parents. These disclosures were, at times, almost confessional in tone, and the women occasionally voiced concern at how their utterances would be received. The most apparent themes in this category were *coping*, or feelings of *failing to cope*, particularly with the *unanticipated effects* of an infant whose sleep seemed disturbed, and *feeling overwhelmed* and *alone with the responsibility of a baby*, especially if *breastfeeding*.

3.3.1 Living sleep deprived

The primary feelings conveyed by recent mothers *Alice* and *Emma* were, perhaps unsurprisingly, those of struggling to do the best for their babies and young children against a backdrop of sleep deprivation, and concomitant emotional distress and physical and psychological fatigue. Neither were primiparous mothers and both were experiencing very different times with their second children, particularly due to the sleeping patterns and

difficulties in settling the infants “I suppose in a way it’s more my mood and temperament towards (older child) with me being tired” (Alice: 273).

As their partners worked, participants relied on finding time to rest when their babies slept, however the demands of another child often prevented this, “I used to just dread the Thursday and the Friday thinking, how am I going to cope as these are the two days that...I have (older child), and she’s already tired from nursery, so her behaviour can be up and down” (Alice: 84), “it’s tough because you can’t do that - when they sleep, you sleep - because there is no period of time when they are both sleeping together” (Emma: 97), “with two, no, you can’t sleep anywhere anytime, you’ve still got the second one...I think that’s why it’s affecting...moods and everything now” (Alice: 361).

Although finding time and motivation for effective self-care is recognised as fundamental to underpinning emotional, psychological and physical wellbeing especially when sleep is deprived, in common with many new mothers the participants struggled to prioritise their needs. Time when they were not attending to the needs of their baby or other child was anticipated as valuably spent reconnecting with their partners, often at the sublimation of physical self-care, “I’ve got between half seven and eleven, and that’s probably when I should be going to bed and sleeping, but that’s the only time I have with my husband” (Emma: 180), these themes will be revisited in ‘relationships’.

The arguably culturally popular notion of ubiquitous entitlement to ‘me’ time, appeared in *Helen’s* light-hearted reference to her own mother’s comments, an insight which could also be considered within the category ‘my own childhood’ as it reveals her own mother’s philosophy, “...my mum always says, I don’t know what...mums these days are always going on about ‘me’ time...you don’t get ‘me’ time when you have babies” (Helen: 44).

Aspirations for ‘me’ time were not evident in the interview data collected from these mothers beyond time to sleep. *Natalie* spoke of the reaction from her daughter’s psychologist when she had referenced her responses to the ongoing restrictions in her life, “(she) couldn’t believe I hadn’t been out...what happens when you go out with your friends and socialise? I don’t go...why?...cos I don’t” (Natalie: 290).

Participants often became emotional when recounting the frequent distress of dealing with a baby who was unsettled – perhaps crying a great deal - and not sleeping for significant periods of time during the day or night. For them, and recalled by *Kate* from years earlier, this pattern had become a regular challenge felt keenly during the night, but also with repercussions on their family life during the day, “I do dread them (evenings) – I have to admit” (Alice: 88), “the sleeping is much harder than I thought it would be, (Emma: 42), “he just didn’t sleep” (Kate: 10), “it is a long time ago, but I still remember the bleak, lonely feelings” (Kate: 193).

The potential impact of sleep deprivation on mood in mothers recovering from labour and adjusting to the demands of a new baby, as will be explored, was referenced by all participants. *Helen’s* summary below provides an overview of the common experience that highlights the complexity and relentlessness of the demands placed on mothers in the post-natal period:

“sleep deprivation is awful...you’re going to be tired anyway, even if you have a baby that does sleep...it is overwhelmingly emotionally tiring...and then when you add actually not sleeping to that...the impact on your relationship...and functioning in the day...how do you pull yourself out of that low mood?” (Helen: 56).

Participants became sometimes visibly distressed when reflecting on and recounting occasions when they had felt ‘pushed to the limit’. At the extreme such occasions resulted in smacking an older child, which was identified as a consequence of sleep deprivation limiting resilience to find preferable coping strategies in the face of provocation

“I have hit her twice...second time I just cried myself to sleep that evening...sleep deprivation...now I’m losing my control, whereas before I was very calm and I could solve the situation – I feel like I’m losing it really” (Alice: 275).

Alice went on to criticise her reactions as “weak” (Alice: 283), indicating a lack of “brain power” (Alice: 275), and explaining in one instance to her husband “I lost control because I’m knackered” (Alice: 287) - a justification which failed to prevent her from imagining his response. With explicit links to ‘my own childhood’, her reflections posit catastrophised internalised consequences as a result of her sleep deprived and stressed state,

“...going back to my parents, growing up I was hit with a shoe, on bare bottom...I was growing up being hit and slapped...that night - not that (husband) would ever do it – I was actually dreading him hitting me, going - see how you like it” (Alice: 283).

Kate described an emotional and distressing memory from many years earlier when her first child was very young and she was in despair due to lack of sleep. She recalled a thought, or perhaps a verbalised statement – ‘I can’t deal with you anymore’, putting the baby down ‘with force’, leaving him there, and them both crying. Exploration of her question, ‘what have I done?’, which was not pursued within the research interview, might have yielded deeper insights within a therapeutic encounter,

“he was six or eight months old...I didn’t throw him in his cot...I put him down with some force in his cot...I can’t deal with you anymore...walked out and shut the door...he was crying...I was on the landing crying, thinking what have I done?” (Kate: 111).

Natalie recalled her struggles to gain some physical separation, in order to manage her conflicted emotions towards her child, which she recognised as underpinned by sleep deprivation - her reference to the added impact of working outside the home echoes those seen earlier in ‘juggling career and work’, “there have been times when I’ve sat in my bedroom and rocked on my hands... if I get off my hands I don’t know what I’ll do...no sleep for like four nights, then working...” (Natalie: 366).

The feeling of being pushed to the limit by competing pressures was sometimes linked directly to attributions of character, as alluded to earlier by *Alice*, which were then qualified in the case of *Emma* coping with a six-month-old infant and a two-and-a-half-year-old, describing herself as “I’m probably quite a tearful person...just tired” (Emma: 101). She later demonstrated more explicit awareness of the effects of sleep deprivation on her abilities to manage her reactions to everyday environmental stressors,

“it’s just hard to be...rational sometimes when you’re tired or when...you find yourself crying over...squash on the floor, or the house being a mess, or whatever, and you’ve actually got to just put those things on one side and think, it really doesn’t matter in the scheme of things, but...it does feel quite stressful...when you’re tired” (Emma: 234).

For *Kate*, her son's lack of sleep induced a sense of incompetence, reflecting that her unmet expectations of motherhood challenged her sense of self, causing her to feel "cheated" (Kate: 133), and directly influencing her developing relationship with him, "the fact that he was crying so much all the time, and not settling reflected on me...that he didn't like me (Kate: 20), "...why he wouldn't do what I wanted him to do...felt that it was a complete reflection on me...that I wasn't a good mum" (Kate: 67).

These insights indicate the salience of a range of powerful emotions that may be attributable in no small part to sleep deprivation, and are highly influential on the women's experiences, with immediate and long term consequences during this time of transition. This will be further explored in the category 'experiencing conflicted emotions'. The lack of a safe means to acknowledge, recognise, reconcile, accept, disclose or assimilate, in some cases novel, overwhelming, and not necessarily positive emotions was indicated as a source of considerable pressure, guilt, shame and loneliness. *Kate* candidly expressed this conflict retrospectively "I felt resentment, I felt I wish I hadn't had him – I feel awful now saying that, but I did, I felt having him had ruined my life" (Kate:10).

Negative emotions, identified within earlier focussed codes as *guilt*, *shame*, *interpretation of events*, and *feeling judged* were often cited as exacerbated by the effects of sleep deprivation to precipitate *feeling overwhelmed*. Seeking an explanation and solution to her baby's night waking, *Emma* blamed herself for creating the 'habit', "he's in our room, which is possibly the issue...probably a habit that I've kind of created...I suspect that's my fault really, he's in this routine, or lack of routine" (Emma: 46). She expressed guilt, often towards the compromise she felt her children faced because of her fatigue, "I do want to give them my all, but I'm not sure how much I've got in the bank because I'm just so tired, so yes that's hard, cos you get guilty" (Emma: 103,) and also towards her husband, "I feel quite bad and actually, when he walks through the door, I should probably be a bit more like, how are you feeling?" (Emma: 208). Inevitable comparisons with her previous experience of motherhood arose - a flicker of a sense of anticipatory retribution perhaps adding to the pressure of her current unexpected

situation, “I just think from that experience (first child) I just...realised that I was pretty lucky...and people kept telling me as well” (Emma: 89).

Additional to comparisons of previous experiences mothers also confronted idealised interpretations of the lives of others “...they have textbook babies and it’s all perfectly fine...you know, but if you have a baby that doesn’t sleep it is torture, it really is...torture. It’s the only word I can use, isn’t that awful, but it’s true” (Kate: 151). Such comparisons with the perceived lives of others are explored in ‘relationships’.

3.3.2 Feeling alone with responsibility

This subcategory absorbed the preliminary focussed code, *feeling overwhelmed*, and originally included the emphasis, *especially if breastfeeding*, as it was highly influenced by the method of feeding being employed by the mothers. The four mothers had the intention of breastfeeding their babies, and whatever their preconceptions quickly became aware of the unique requirements of this method. The practical demands of breastfeeding, often for continuous periods, or at least several times throughout the night, contributing to mothers feelings of isolation, meanwhile partners were often portrayed as feeling helpless.

The practical and emotional challenges routinely encountered by women motivated to do what they believed to be the best for their baby by breastfeeding, if all goes well, results in positive outcomes for mothers and babies: “I enjoy it, and...I feel like I’m giving (baby) the best start that I could” (Alice: 148). However, *Helen* referred to a literature that indicates links between unsuccessful breastfeeding and impacts on maternal mental health. This insight suggests a dilemma for those supporting women at this time, as some women quest for knowledge and solutions to their problems, whilst awareness of the implications of failure may undermine or compromise their confidence and motivation to breastfeed their baby,

“I’ve supported women who have put themselves through absolute hell to try and establish breastfeeding...we also know that women that want to breastfeed and don’t are also at more risk of post-natal depression...for individual women, they (can) feel really, massively pressured” (Helen: 81).

Her words connect with *Kate* recalling her waning confidence due to a lack of success with breastfeeding,

“he didn’t feed very well and I’d really wanted to feed him myself and by the time he was about...ten weeks old, I think, I’d swapped onto bottles because he wasn’t gaining weight and I felt like I’d failed there (too)” (Kate: 10).

As already mentioned, the establishment of successful breastfeeding is beneficial, not only to the child’s development but also the mother’s confidence and wellbeing, as attested to by the ease and convenience that *Natalie* described

“...she had to fit in with my life cos I had to go back to work so she fitted in with me...Day 2 when she came home, I took her...shopping and didn’t really think about where I’d stop to breastfeed her, she’s always just fitted in with me” (Natalie: 326).

However, for some it came at a price, reflecting the dilemma and compromise encountered by the mothers as they sought to balance the competing demands on them. Feelings of isolation and overwhelming responsibility came through the new mother’s accounts, with *Alice* early in the interview characterising her life managing two young children, and a husband who was fully employed and working on improving their house at weekends, as “it’s kind of me really” (Alice: 6), emphasising her sense of isolation in her responsibilities towards the children.

Emma demonstrated sensitivity towards the dilemma her husband encountered in wanting to support her as she struggled to settle their baby throughout the night, “it’s tough for (husband) because he can’t really do what he’d like to do as I’m feeding myself...so at night when (baby’s) not sleeping, and I’m kind of tired and cranky...he’s a bit helpless really...it’s tough” (Emma: 14).

Conversely, the lack of wholehearted support from a partner added to a sense of isolation, as illustrated by *Alice* as she provided an insight into the potential divisiveness of what felt a rigorous feeding routine - these issues will be explored in more detail in the category ‘relationships’. She felt proud of having achieved something that her sisters were unable to, but recounted feeling her husband’s lack of support for a routine which he identified as creating problems for them in settling their new baby to sleep with his accusation “...you’re only

breastfeeding to prove a point – that you can...that hurt me” (Alice: 148). She too was looking for a way out of her isolation, hoping that her efforts to change the routine would be recognised “I’ve been trying to give him a bottle every single day, and he just doesn’t accept it, I think (husband) has seen this, so without me having to talk to him about it he knows I’ve tried” (Alice: 152).

Emma’s subsequent reflections after several months, about the night time routine she and her baby had developed, offered some rationalisation tempered with self-blame for the pattern of night waking which she felt responsible for perpetuating,

“in hindsight...(I) should have been much stronger earlier on...feeding on demand during the night was a short-term solution to settling him quickly when I was extremely tired and I thought he needed comforting...now aware that it didn’t help either of us in the long run (Emma: 2:40).

Helen indicated sensitivity towards the competing demands of managing parental expectations of breastfeeding and sleeping, with awareness of meeting the infant’s developmental needs. She recognised that her position of ‘in supporting the development of mothers’ ad hoc coping strategies as potentially at odds with alternative advice, or opinion, on the matter of using breastfeeding as a way of settling the baby to sleep:

“if you’re breastfeeding you may want to just stick the baby on the breast to keep them quiet, but people have told you not to do that...don’t let your baby fall asleep on the breast – your baby’s only ‘comfort feeding’ – your baby can’t possibly be hungry...so you pace with your screaming baby...the stress that you’re putting yourself through, by not just doing whatever you need to do that night to get through the night” (Helen: 52).

Helen’s personal view, which validates some of the practices that the mothers adapted to ‘get through’ their nights, may well reflect a pragmatism which is widespread amongst professionals supporting women at this time. However, the mothers appeared to have internalised notions of judgment and incompetence from the outset, particularly with reference to babies’ sleeping and feeding patterns. Anticipating negative judgment of her actions, *Alice’s* justifying statement revealed an expectation of censure and reflects perceived societal

pressure to leave infants alone unless they require feeding according to the time of their last feed “last night I picked him up, cos I *genuinely* thought he needed food...when I looked at the time I was like, hello...?” (Alice: 86).

Mothers felt they were exacerbating, or even causing their babies sleep disturbances by responding to their night time ‘demands’ for food, or perhaps, as suggested earlier by *Emma*, just ‘comfort’ (Emma: 2:40). Developing their instinctive responses and beginning to trust their own successful experiences, as described by *Alice*, grew their confidence, as will be further detailed in ‘coping, learning and trusting’,

“so I kind of put him back down and held his hand...gently sort of held him...you need to calm...that’s when he kind of thought, yeah, well I suppose I’m not that hungry and fell back to sleep for another forty minutes” (Alice: 86).

Notable within the data were references to a desire for control, explored in ‘being me’, which was felt to have been lost, and with it the comforting potential for regaining some sense of ‘normal’ life. These mothers were confronted daily, and nightly, by a dynamic and changing situation that would not yield to their control, and which continued to challenge their expectation, evoking a sense of disorientation elucidated by *Helen*, “if your first baby did sleep, and your second baby doesn’t it’s a huge shock...you thought you must have been doing something right the first time and it’s not working now” (Helen: 60). The overwhelming sense of sole responsibility was portrayed starkly by *Emma*, who, even when feeling well supported by family at other times, acknowledged with breastfeeding “there’s not much they can do at eleven o’clock at night...between kind of eleven and...seven” (Emma: 160). Participants however demonstrated adaptability and resourcefulness in developing and implementing strategies, as will be explored in ‘coping, learning and trusting’.

The vexed issue of bedsharing provoked an almost confessional disclosure from *Alice*, whilst her justification of the decision to do so was simply to ‘cope’ with the rest of life

“for me, just to cope with the everyday life...I have brought him into bed and co-slept with him...I didn’t start that at the beginning...I’ve probably made the habit...I needed

my sleep and brought him in with me, and now he's like, ooh, I quite like this, so I am trying to break it" (Alice:82).

Natalie maintained a deep-seated fear of bedsharing, despite her child being eight years old, referring to advice given years earlier, meanwhile questioning of the rationality of her fears

"she would sleep in my bed, and then I don't sleep at all...if she gets into my bed at any point I just don't sleep...even though she's eight...oh my God, no, they can't sleep with you...if she could sleep with me she'd sleep all night long, but I didn't sleep...some nights I would just do that so I'd know she would be okay for school" (Natalie: 260).

Both responses express anxieties connected directly to the decision to bedshare, which is confronted on a nightly basis by the mothers acting as principal carers, often acting without deliberate or conscious motive due to their sleep deprived condition.

3.3.3 Experiencing conflicted emotions

The complexity and conflicting nature of expressed emotions is captured by this subcategory, which also highlights participants' processes as they experienced, struggled with, and found ways to reconcile conflicted feelings. Issues of *validation* and *normalisation*, subcategories that informed the development of this category will be further explored in 'relationships'. Against a backdrop of sleep deprivation, isolation, and lack of time for themselves they, unsurprisingly, seemed not to know how to manage their emotions, which become portrayed as somewhat 'stuck'. Whilst the data suggested a great diversity in the range and accessibility of the conflicted feelings experienced, themes of reaching out, asking for, and accepting help, or not, and the reality of not living up to expectations appear to be common.

The *compromise* involved in *reaching out* and *accepting help*, represented a dilemma for *Alice* describing her feelings around somewhat reluctantly accepting an offer of free child care support from her husband's parents. Dependent upon this support to be able to return to work, she was nevertheless uncomfortable with their style of relating to her children, and to her children's reactions to them, "(they) mean well...but (daughter) isn't that forthcoming to them..." (Alice: 8). She reflected on experiences from her own childhood and drew on a

recent experience of therapy, which had increased her assertiveness, whilst trying to make sense of her discomfort towards her father in law's tendency to discipline her daughter, "(therapist) taught me to say no" (Alice: 237). Her dilemma was unresolved as she remained aware of the sensitivity of addressing the problem with those towards whom she felt conflicted. Despite her recent increases in confidence and self-assertion she found herself unable to voice her misgivings "he's always shouting at her, pointing the finger...I didn't like the way he was sort of telling her off" (Alice: 94). Her anticipatory anxiety at the potential impacts on her children was negatively affecting her already compromised emotions about returning to work, identified earlier as more a matter of duty to maintain her self-confidence.

The dilemma of craving help, but being unwilling to accept it, was acknowledged as being compounded by fatigue as highlighted by *Emma*

"it probably doesn't help when I'm arguing and I'm tired and my husband says oh, I'll take them off, and I say, no, no, I'll take them off...it's just that some days are harder than others, that's all, just depending on the sleep really" (Emma: 194).

In a paradox perhaps familiar to many parents, she missed being with her children if she accepted help, "I feel like I've lost a bit of a limb when I'm not with them" (Emma: 160).

Reflecting back on experiences 25 years earlier *Kate* voiced sentiments perhaps made more accessible due to the time elapsed. She described feeling 'cheated' in terms of her experience of being a first-time mother – a role that she was compelled to fulfil despite her unmet expectations, "I felt cheated...it wasn't what I'd expected, I felt cheated that I hadn't had the motherly experience that I thought it was going to be" (Kate: 133). She was able to compare this time retrospectively with the markedly different and more pleasurable experience of having a second child, "I wouldn't want to say that I love (second child) more than (eldest), I don't think I do, I have fonder memories of (second child) than I do of (eldest) because of how he was as a baby" (Kate: 99). She evoked the depth of her conflicted feelings which, as she recalled, persisted for the first two years, maintained by the seeming relentless disappointment and challenge of her experiences with her first child,

“I just felt that (eldest) had completely taken over my life, and I felt...I had this leech on me – isn’t that an awful thing to say about your own child? I honestly felt like I had this thing, sucking the life out of me...and I’ve always loved (eldest)...but, I didn’t like him...because I just felt...taken over (Kate: 24)

and which she felt had continued to exert their effects throughout the development of their relationship,

“(eldest) and I were at loggerheads all the time...now he’s grown up fine, but probably from his early teens...it was a difficult relationship...I think partly that’s because of my early relationship with him...my feelings of motherliness, and the lovely baby feelings are linked to (second child) and not to (eldest) (Kate: 99).

Despite the challenges and complex emotions, time brought resolution as *Kate* reflected

“having my boys has been the best thing that ever happened in my life, I look at them now as young men and I’m so proud of both of them, they have, without a shadow of a doubt, been the best thing I have ever done in my life” (Kate: 151).

As described earlier, for *Natalie* having a baby that slept very little did not challenge her expectations, however the impacts on her of her daughter’s extended sleep difficulties caused her to reflect on those who are unable to call for help, invoking the significance of supportive relationships, “...(I would) call my mum...I need you to come down...I hate myself for thinking it...I can really see how somebody slightly on the edge would lash out, and that’s horrendous but that’s just from no sleep” (Natalie: 366).

Natalie also had to reconcile her feelings towards continuity and consistency of care for her daughter following the separation from her father, becoming visibly distressed during the interview at the recollection of this ‘hard time’ several years earlier, “it was very *very* hard...but I couldn’t stop him coming, cos he was her dad...that was a really *really* hard time” (Natalie: 21). She confronted managing active hostility from her partner – a reality which at odds with her own experience and projected hopes for co-parenting, recalling bleakly “her dad constantly told me that I was crap” (Natalie: 200).

Although she did not seek help at the time *Kate* questioned her mental health during the period, “I was very tearful...I was sometimes irrational...I can remember worrying about things that were just stupid things to worry about...fixating on things that were really not important” (Kate: 71), recognising retrospectively her persistent low mood, anxiety and distress were linked to her state of fatigue from which she felt no opportunity to recover

“I don’t know whether I had depression...because I know I had irrational thoughts, and I can remember once being so, so tired one night...never considered harming him, or killing him, or whatever, but wishing I hadn’t done it...because of everything that was ahead of him in his life, and how my life had changed” (Kate: 157).

She never discussed her feelings with her ex-husband but gauged his likely responses, highlighting her interpretation of the dissonance between their individual experiences over the period

“I’ve never talked to (ex-) about it...– I think he’d be really quite shocked, if he thought that he’d made me feel so isolated...I think he’d be shocked, cos if you asked him what sort of dad he was, he’d say he was a hands-on dad...but certainly as babies, he wasn’t...I think he’d be really surprised” (Kate: 171).

Perhaps due to the temporal distance from the events, and doubtless influenced by the impacts on her relationship, *Kate* articulated in the present, the depth and confronting complexity of her feelings towards her partner and her baby more than 20 years earlier, “I felt completely low, I felt isolated, I felt alone and incredibly resentful towards the two of them and also incredibly guilty for feeling like that” (Kate: 28). Although she experienced feelings of isolation and resentment towards the felt lack of engagement or shared responsibility from her partner, and her experience of motherhood in the broadest sense, she felt unable or unwilling to disclose her vulnerability to him at her time of greatest distress.

The accounts suggested that these mothers routinely struggled to reconcile conflicted and often complex feelings towards not only their babies, and other children, but also, in some cases, their co-parents, yet lack of access to sources of professional support for parents who do not reach clinical thresholds for treatment is not universally addressed in current mental

health provision, as identified by *Helen*, “there is a massive gap” (Helen 2:11), “(there is a) clinical pathway...but...there are thresholds...whereas a lot of women might benefit from...counselling or some psychotherapy...the vast majority of women aren’t going to be able to access that” (Helen: 104). She highlighted this non-clinical population as representing a potentially significant point of early preventative intervention in terms of safeguarding mental health and wellbeing

“there isn’t space provided for people to talk...I think...people...really could do with...some proper counselling, some real unpicking of what’s gone on in their own lives, in order to better parent their children, or understand them” (Helen: 98).

3.4 Relationships

The majority of interview data informing this category unsurprisingly related to the parental partner although the women were in diverse relationship situations at the time of the interviews, with two having since separated from their co-parent. The category was expanded from solely *partner relationships* to include others who, as a group, were seen to represent significant sources of support and, in some cases challenge and conflict.

3.4.1 Noticing changes...highlighting differences

The impact of becoming a parent caused often dramatic shifts in the original partnership as it adapted to include and accept babies, and this was experienced very differently by both parents, whilst the passage of time and individual differences likely affected how this extended period of transition was experienced and interpreted. By means of both descriptive and reflective data, and clearly dependent on the previous categories, this subcategory attempted to capture the relationship dynamics at play in what were long-standing relationships at the time of becoming parents.

The four mothers described long term partnerships prior to having their children, “we’ve been together since school” (Alice: 140), “I’ve been with him a long time...known him since I was

18” (Emma: 18), “we started going out together when I was 15, but we had times apart” (Kate: 31), “(daughter’s) dad I was with for six years I think we decided to try for a family after five...(I) fell pregnant straight away” (Natalie: 16).

Unsurprisingly, approaches to planning a family differed within these relationships. *Alice* recalled her husband’s life plan superseding her own, but reflected that it had worked, “we got married at 23, and he said, no, we’re not having children until we’re 30...actually really pleased we waited” (Alice: 168). Meanwhile *Emma* reflecting on the rapport with her husband, “I’ve been with him a long time...we know how each other kind of click, and he knows when to just steer clear” (Emma: 18), described planning their second baby with consideration for their first child, “it was a nice age gap” (Emma: 12), “I just thought it was a nice time for him to have a little mate” (Emma: 32).

Despite a general desire and expectation of having children, *Kate* recounted the impact of her first pregnancy which was unplanned

“(we) talked about having children, at some point, but (eldest) wasn’t planned, we were using contraception when I got pregnant...I was in a complete state of disbelief...I think it wrong-footed me a bit...I think one of the big things for me when I had (eldest) was I hadn’t been in control of that because it had just happened” (Kate: 10).

This subcategory explored the changes which the journey to motherhood and becoming a parent bring to bear on the relationship, linking with earlier subcategories of ‘expectations of motherhood’ and the *impact of unplanned events*. In some cases, partners had discussed how they would deal with unplanned events, “the only thing we discussed...we both agreed we wouldn’t have a Downs (baby)...I think that’s another hang-up (husband) had with a child...you can’t 100 percent guarantee there’s not going to be something wrong with (babies)...” (Alice:168). They also planned practical matters “the only thing we did was that we cooked a load of meals and put them in the freezer...(he) wouldn’t expect me to iron his shirts and things...(but) I think he was hoping I’d do it” (Alice:178).

There was little evidence from the women interviewed that they had discussions with partners in anticipation of how they would negotiate sleep difficulties in their infants. As participants

found their new circumstances, including coping with a child sleeping less than they had anticipated, elicited different and perhaps unexpected reactions from their partners, other differences became highlighted. *Alice* recalled how differently she and her husband reacted to the consequences of their baby's recent traumatic birth which she described as "quite a 'One Born Every Minute' moment" (*Alice*: 34), whereas "my husband, you know wasn't even concerned...he was a bit blasé about it" (*Alice*: 142).

Natalie assigned the breakdown of her relationship to her ex-partner's expectations of the impact of having a child - "she would have been about 16 months – I think he blamed me, well he did blame me cos I was giving her attention and not him" (*Natalie*: 61). Although she enjoyed great support from him in the early period she went on to identify the negative impact on their daughter of maintaining a bedtime routine after their separation,

"he'd get up, he'd change her, he'd give her me to feed, he'd put her back to bed, but when we separated he would still come back – that was the hardest thing – he came back every night to bath her and put her to bed...and then that's where (some problems began) ...she's under a...child psychologist now" (*Natalie*: 123).

The changes wrought by the transition to parenthood magnified existing difficulties in the relationship, "he's drink dependent...I don't like alcohol around children...I was used to him drinking a lot, once he'd gone I was like, oh I can't stand anything like that" (*Natalie*: 155), leaving *Natalie* to contemplate the effects on her daughter of the relationship breakdown and the ensuing conflict enacted frequently at bedtime - "it was after her dad left...the sleep...was worse then, but I couldn't tell you if it was because I was taking full responsibility for her night-time...waking up with her, or whether she was just worse" (*Natalie*: 119), which has had long term effects which she faces alone, "he won't take responsibility for...I don't want to call it problems, but he won't - for any of her little issues - he won't take responsibility" (*Natalie*: 169). As time passed *Kate* recalled that comparisons with her partner's life only served to highlight perceived imbalances in their experiences of becoming a parent, as the limitations and restrictions on her life became more apparent, "he'd go out with (friends) and leave me, and I

wasn't feeding him any more – I was bottle feeding him, so, why can't I go? Why can't I go and you stay...never even an option" (Kate: 26).

Finding a balance between individual needs of maintaining a social life and interests outside of a young family were also raised by *Alice*, mindful of the effects on her children's sleep routines,

"I'm prepared to give up my social life but I don't think (husband) is, so when it does come to sort of going out with friends with children he's harder to drag away...I'm having a good time why spoil it, whereas as a mum...I know the repercussions" (Alice: 287).

In recognising and prioritising their needs, and those of their babies and toddlers for routine and sleep, participants highlighted differences which did not exist when they were a couple, as *Kate* reminisced, "we'd been real social (animals) – we used to go out all the time (Kate: 10). By means of retrospection she was able to offer a fresh perspective on how life was for her and her partner after their first child was born, identifying the impact of her low mood on her behaviour and demeanour, "I was not happy at all, I wasn't sociable – I didn't go out for months...I was very moody, I don't think I was very nice to live with" (Kate: 73). Later in the interview she expanded on her feelings of unremitting despair which eventually subsided over time as "things did come back",

"I just believed that it would be different, I didn't believe that my life was going to be a crying baby, no sleep, and that was it, and a husband in name, but everything we'd had before we'd had (eldest), and before we got married, had gone...it didn't last, and things did come back, but in that period of time I can remember thinking, what have I done? This is now my life, and it's not what I want, and despairing, if I'm honest" (Kate: 123).

From her current perspective *Kate* offered an evaluation of the situation, redefining her ex-husband's intentions and development of his parental involvement, "I felt completely abandoned...if I told (ex-husband) that he'd be really upset that he had made me feel like that...that was never his intention, as the boys were older...he was a great dad" (Kate: 115).

3.4.2 Valuing and maintaining partner relationships

Maintaining the partner relationship emerged as a priority from the interviews conducted in 'real time' with both *Alice* and *Emma*. Both recognised that they were trying to fulfil many of the roles that existed before the arrival of the new baby, perhaps in accordance with their existing identities and expectations as already experienced mothers and wives, "I'm trying to be the ideal wife-keeping up with the washing, home cooking every night..." (Alice: 84). She described adaptations to their sleeping arrangements designed to facilitate her husband's sleep

"(husband) is in the other room, bless him...he had tried to come back in our room when he tried to feed once, I think cos he felt guilty...I said to him, look, you've got an important job...lots of responsibilities, you need your sleep" (Alice: 88).

Despite attitudes and expressions of resignation "we've got to do what we've got to do really" (Alice: 88), the current challenges of coping with a baby whose sleeping pattern was impacting seriously on mothers' own levels of fatigue caused *Emma* to reflect on her form of responding to her husband "at night when he's not sleeping, and I'm kind of tired and cranky he's a bit helpless really...it's tough really - I appreciate that, even if I don't necessarily tell him" (Emma: 14). She showed awareness of the complex and shifting dynamics as their relationship adapted to the current challenges as she reflected on the practical and emotional support her husband offered with quiet concern "I don't want him to feel he's being...pushed aside" (Emma: 168), "I am conscious I'm not kind of taking him for granted" (Emma: 208).

The women articulated empathy for their husband's inability to 'rescue' them from their current challenges and expressed gratitude for their partners' support, "at the moment he's being quite understanding, so I guess I'm quite lucky" (Alice: 188), and, "it's just when I've had a shocker and he just is my sounding board really – I'm not really having a go at him, I just let him know if I'm struggling, or I can't really function" (Emma: 99). She identified times of masking her distress by being light-hearted "when I am being kind of rational... (I say) I am really sorry for being such a witch these mornings (*laughs*), I mean it's not even being a witch it's just, I'm probably quite tearful" (Emma: 210). Meanwhile evidence of negotiation was apparent in

Alice's disclosure "I said to (husband) do you mind me going to bed? I always feel like I need to ask him (*laughs*) – can I go to bed early please? He was like, no, it's fine" (*Alice*: 88).

Aside from a desire to nurture their intimate partner relationship, *Alice* reflected in some depth on her wish to support her husband's feelings of connectedness to the process and development of his relationship with the new baby, despite the gulf seemingly created by her breastfeeding, "...could be (husband) thinking he's not building a relationship with (baby)...I've seen a change when (husband) comes home and (baby) smiles...you can tell he's quite chuffed with that" (*Alice*: 148). She describes her deliberate efforts to include and encourage his involvement "the one time he actually put (baby) down for a sleep in his cot he slept for three to four hours, and I said – you couldn't do that again? You've got the special touch" (*Alice*: 182).

Adapting to and prioritising family life when both partners share similar meanings, values and expectations offers a rewarding counterbalance to the challenges of fatigue and anxiety, as *Emma* described, "I think in some respects we're stronger than ever...(even) when you're tired and you're irritable you tend to bicker slightly more...you have to remind yourself...our best interests is kind of what's right for the boys" (*Emma*: 14). Desire to demonstrate empathy and share her struggles with her partner was evident in *Alice's* reflections

"(daughter) is at the age where she's pushing all my buttons at the moment...I'm quite aware when (husband) walks in from the door...probably seven out of ten times it's not a happy household...I do sort of say...I do really feel for you, when you've worked really hard all day in the office, and you must think what am I walking home to tonight...I actually texted him saying – you'll be pleased to hear you're coming home to a happy household tonight, so you know, I'm hoping he sort of feels better that I am aware that it's not rosy all the time...(Alice: 88).

By contrast, in recollecting these times, *Kate* described feeling unable to share her vulnerabilities with her ex-partner for fear of unmasking her feelings of inadequacy, thereby compounding her loneliness,

“I hid it from (ex-husband) ... I didn't want him to see the extent it was because if he understood, or recognised or realised how dreadful some days I felt, I thought it would make him feel differently about me... I wanted him to think I could do it, and be a good mother... it's a real complex layering of trying to hide it and protect it... whereas, if you were just more open about it, it might have been easier (Kate: 163-165).

In a new relationship with a partner whom her daughter “absolutely adores” (Natalie: 336) *Natalie* felt supported, appreciating her new partner's backing in the on-going sleep regulation issues “I am getting back up... he will back me up on her sleep as well” (Natalie: 338).

Interview data revealed the women's attitude to maintaining an intimate life with partners as they struggled to reconcile this with their need for sleep. Following earlier remarks that she forfeited time early in the evening when she might be sleeping to be with her husband, *Emma's* desire for contact was evident,

“my downtime is when they're both in bed at half seven that's the only time I have with my husband... to chat, and just to have dinner... cos otherwise we'd just be like passing ships... and I like that time to hang out with him really...” (Emma: 180).

Alice candidly disclosed her ambivalence towards sex at this time when she was feeling such fatigue, but balanced this with the need to maintain a satisfactory intimate relationship,

“I'm torn...(husband's) like, can we have sex tonight? Sleep's more important, and I'm quite aware of that affecting us... and you know, there's occasions when I just think, oh, go on then, but deep down I'm like, I need my bed” (Alice: 361).

All sexual desire was gone for *Kate* at this time, compounded by a fear of becoming unexpectedly pregnant for a second time,

“we had no sex life at all... it didn't exist, whereas before we had (baby) we'd had a very good sex life, that had just completely disintegrated... when we did start having sex again I went on the pill, but I also made (ex-husband) use condoms as well, cos I was so worried about getting pregnant” (Kate: 71).

A statement that reinforces her sense of their previous life being lost with little consolation, and her only method of controlling the future to abstain from intimacy with her partner by imposing a wary contraceptive regime.

3.4.3 Seeking and accepting support from others

Pregnancy, birth and childrearing attract wide ranging opinions, and although parents often sought advice and support, not all was solicited or evidence-based. Meanwhile the transition to parenthood is illustrated through these accounts as a time of considerable stress and anxiety, when vulnerability to mental ill health may be precipitated, with sleep deprivation identified by the women interviewed as a singularly significant contributing factor. Despite this identification of need, appropriate and adequate universal support services, for those prepared to seek them, have remained lacking across decades, whilst traditional sources of support via family continue to decline in modern UK society (Netmums & Child Sleep Charity, 2016).

There also appeared to be a conflict between the participants' phenomenological accounts and self, or externally imposed expectations of what might be considered 'normal' experiences. *Helen's* commentary, informed by observing many parents in the transition, suggests that such disparity, and the ensuing challenges, are commonly encountered in her work. She also highlighted potentially valuable missed opportunities in identifying need and supporting parents at this time, "I don't think our country's very good at all at supporting families...when they start out...there's a lot that could be done to protect new parents' mental health...not waiting until they're suffering" (Helen: 16), a position echoed in current concerns raised within service provision (Khan, 2015). There is also a tone of frustration in the perceived limitations within the service that *Helen* works, notwithstanding her professional awareness that here are other barriers that might prevent the mothers taking up support made available to them. She spoke of the potential costs to society and health services that might be avoided by a co-ordinated and routinely accessible early support system for families: "there's been quite a lot of rhetoric...if we spent, something like 1.8 million pounds on protecting parents' mental health we would save eight billion...based on mental health

problems in the children later, alcohol, drugs, juvenile detention, prison..." (Helen: 10), "you think about how much you would save in the long run for the NHS, if they put just a little bit into it at the beginning" (Helen: 201).

Valuing the support available via her local Children's Centre, *Alice* however found that restrictions on older children attending with mothers and babies meant she was unable to access some courses,

"with having (older child) I'm a bit restricted in the clubs I can do with (baby), cos they don't like little ones coming along, so we haven't been able to baby massage and things like that, but the Children's Centre have been really good, and they've said we'll come and do a home visit and show you how to do it, and I thought, well, that's nice..." (Alice: 46).

With the awareness of groups which she valued with her first child but was now unable to attend, she reflected sadly,

"...that's where I went with (older child)...they do drop ins...and things like that...I'd love to do (a group) with (baby), but it's just the wrong time..." (Alice: 50),

which, despite the offer to visit her at home, potentially increased her sense of isolation as a previously relied upon source of external support was no longer available. The sense of isolation and uncertainty which suffuse the data remained a compelling focus.

Notwithstanding the support and understanding which may have been available from partner, family and other friendships, the reluctance of some to ask for help, even from partners, was a recurring theme for *Emma*, *Kate*, and to a lesser extent *Alice*, with *Emma* reflecting two years after the interview,

"what resolved (baby's) sleeping issues...came from accepting more help from my husband during the night; something I know that I hadn't been very good at asking for or accepting...as I mum, I felt I should have all the answers and I'm sure there was some sense of failure on my part that I couldn't settle him myself...on reflection, I don't see this as a failure but as a result...we were all getting more sleep and were a much happier family for it" (Emma 3:1).

By contrast *Kate* recalled one instance of appealing to her partner,

“I didn’t say much to him at all...something had happened...I was very tearful when he came home from work – I’d been crying before he came home...and when he came home from work he asked me what was wrong, and I said – I can’t cope, I can’t cope, I can’t do it...” (Kate: 117)

which was met by his perceived inability to offer emotional support “...(he) was never very good at...emotion...if ever there were tears or deeper emotion, or discussing your feelings, he couldn’t do it, couldn’t cope with it...I could talk *at* him, but I’d get nothing back” (Kate: 117). *Helen* emphasised the importance of access to sources of support that can allow women to normalise their experiences. Issues such as those arising from disturbed sleep, and breastfeeding which, whilst challenging, are quite common, can otherwise be misinterpreted as indicative of problems in infants, or inadequacy in themselves, by anxious parents, “(disturbed sleep) it’s normal...the worry that there’s something wrong...the same with breastfeeding...if people know...that it’s actually normal, then they’re slightly better placed to cope with it” (Helen: 165).

The heightened sense of isolation experienced by these mothers may have been attributable in part to the amount of time the women were spending alone awake during the night with their babies, leaving them sleep deprived and vulnerable to anxiety. Whilst exploring *Alice’s* support network, the following exchange highlighted her sense of being alone with her struggles,

R: “...I’m wondering what kind of support network do you have around you that are telling you that you’re doing a great job?” (Alice: 91)

P: “...I can’t think of anybody else who’s actually said I’m doing a great job, to be fair...” (Alice: 92),

Kate also reflected a sense of feeling unsupported throughout the difficult time so many years earlier, “I don’t think I had any support, if I’m honest” (Kate: 59).

Perhaps influenced by their sense of self, as explored in ‘being me’, for some their fatigue might have reduced their likelihood of seeking out group activities, whilst friendships

represented paradoxical challenges of self-comparison. For example, *Kate* suffered inevitable but invidious comparisons within her close family,

“my sister had a baby at the same time...she lives 200 miles away, so I didn’t use to see her, but I used to hear – oh he’s marvellous, oh he’s wonderful, oh, he slept eight hours last night, and I’m thinking – he slept eight minutes last night...so there was that comparison” (Kate: 209)

and friends whose apparently uncomplicated experiences emphasised her difficulties,

“some friends...who had children older than ours...had said...it doesn’t change your life at all, you just do what you’ve always done, the baby just fits in, I thought, oh, it’s going to be a piece of cake, but obviously, their life hadn’t been turned upside down - their babies had fitted in” (Kate: 79).

Her isolation was compounded by a reluctance to disclose vulnerability to those closest to her, offering insights which, whilst beyond the scope of the purpose of this study, are nevertheless indicative of complexity in family and relationship dynamics which are in no way unusual,

“I spoke to a friend...I never told my mother – I would never tell my mother, even now, the age I am now, I would never tell my mother anything...I found it difficult talking to (friend) cos she was pregnant, and then she had (baby), who was the perfect baby, and she couldn’t understand, I mean, she was sympathetic, but she couldn’t understand” (Kate: 125).

By contrast *Natalie* described an interaction, marked by the tenderness of her parents’ responses, who intervened when she seemed unable to care for herself, “(my dad) picked (daughter) up (saying) I’ll bring her back tomorrow...I sat on the step and rocked until my mum came and put me into bed” (Natalie: 290).

The data evidenced advice coming in many different forms, which often trivialised the problem, sought to reassure, or over-simplified the solution, “people kept giving me different advice – do this, do that – and the fact that I had no control over it – I’d feed him, wind him, hope he’d go to sleep...he wouldn’t go to sleep” (Kate: 10). *Natalie* was however receptive to the

numerous ideas suggested by her customers, offering a range of alternatives to be explored, “I used to have a book with all their ideas in it, and I used to slowly work my way through it” (Natalie: 117). Myriad suggestions, for those who are receptive and can afford to respond, may offer a sense of possibility and agency, but may conversely reinforce feelings of desperation underpinned by a sense of a uniquely insoluble problem in the long run. In her case *Natalie* found that no solution seemed to prove effective in the long term “she responds well (to homeopathic remedies) but nothing lasts long with (daughter)...” (Natalie: 112).

Alice, Emma, Natalie and *Kate* all sought varying degrees of professional support to address the sleep issues, ranging from paediatric chiropractic, and cranial osteopathic assessment and treatment for their children, pharmacological intervention, sleep training, sleep clinic and Early Intervention support work. However some resistance, and understandable reluctance to be judged as ‘failing’, prevented *Kate* from seeking advice from her GP, “I never actually went to my doctor and asked for help, and looking back, I think that’s partly me not wanting to admit that I couldn’t do it, you know, I felt that I wasn’t a good mother” (Kate: 61), or support for herself from friends “I didn’t really see any of my friendship group, occasionally they’d pop round but I made no effort to be sociable with anybody” (Kate: 71).

The effect of meeting others in a supportive environment was described by *Alice* as opening up her emotionality “I went to post-natal group yesterday...and all they had to just sort of say was the odd question and I just burst into tears” (Alice: 84), a response which elucidates the significant role that supportive relationships play in psychologically and emotionally holding a mother, who, in turn is sustained to provide attuned and compassionate care for her baby.

Helen indicated her perception of the importance and benefits of being able to share something of daily struggles candidly, and concerns for those who do not feel able to do so,

“when you talk to other people and they feel like that sometimes, it makes you feel better...a lot of the negative feelings that mums have towards their babies, which are normal...they feel so guilty about feeling that about their baby...just validating it...” (Helen: 136)

whilst remaining mindful of the safeguarding issues which create the framework within which any professional receives disclosures,

“...if you think like you want to harm your baby that’s different, but it’s okay to be really annoyed with your baby, to be really cross, to feel like at the end of your tether...it’s okay to put your baby down – leave your baby to cry, go out the room, take some breaths, do whatever you need to do, until you’re better able to cope with them” (Helen: 136).

Helen described the privately-run groups which she facilitates as offering a safe and contained space for women to share and receive validation of their experiences, “groups...that bring those women together, and having it facilitated...led and it’s held safely...the feedback I’ve had from those groups have been really positive...women have said, I really needed it and I didn’t realise” (Helen: 104).

3.5 Coping, learning and trusting

The subcategories which comprise this analytic category develop themes emerging from the previous categories and aim to identify specific processes associated with coping with the daily shifting challenges which have been highlighted.

3.5.1 Gaining confidence to parent intuitively

Processes, underpinned by attitudes and approaches which promote learning, and by extension, learning to trust intuitive parenting abilities to respond appropriately to babies’ cues, were identified as areas in which to support parents to feel empowered, self-reliant and *develop trust* in their capabilities. Within these processes, developing a sense of the state of their own mental health, especially in light of the impacts of sleep deprivation, enabling parents to trust their own judgment, is the foundation of the successful development of intuition. Accommodation of pre-existing relationships with other children impacted the family dynamics as well as their development of relationships with the new baby. Necessarily, personal

differences in seeking reassurances or the opinion of others was demonstrated, however parents also strove to develop the confidence and sense of agency required to navigate the plethora of available 'expert', and often conflicting, advice. Characteristics such as *being flexible*, and *adapting situations for their own needs* via a willingness to adapt their plans and expectations in response to reality, were highlighted as mediating factors in facilitating intuitive parenting abilities. An ability to tolerate assaults to self-concept and identity, rendered via compromised performance due to sleep deprivation, was seen to underpin the development of more helpfully realistic expectations.

Whilst *Emma* was explaining, in simple terms, the impact and extent of her current sleep deprivation, "I'm just tired, I think, I'm just a bit tired...and everything's just a bit harder to do...just functioning, having a kind of a conversation, it's sometimes a bit of a struggle (Emma: 95), her comment also caused the researcher to reflect, with a sense of responsibility, on the participant burden inherent in the interview process which was underway - taking up time and potentially creating additional anxiety. *Emma* also recognised the effect her fatigue was having on her abilities to maintain a realistic perspective, "it's hard to keep things in perspective when you're tired, so you can't think, well, I'm doing my best, I'm doing everything I can" (Emma: 103). Linking with an earlier subcategory she demonstrated *self-awareness* and evidence of being able support herself cognitively by acknowledging her daily achievements, "I'm just trying to keep my head above water...as long as I've got them both in the car at the end of the day and they're both through the door, then I feel like I've done my job for the day" (Emma: 152). There was a suggestion of irony, that this level of functioning was less than she desired – possibly that it presented a challenge to her preferred norms and expectations from her first experience of motherhood – yet she was allowing her instinctive coping strategies to lead her through the challenges in ways that were functional, and the most acceptable to her, now that she was managing two children.

Seeking reassurances regarding her mental health, and competence in her parenting abilities and instincts, *Alice* cited her husband as an important source of support "he's a very calming influence, and if ever got at all stressy he'd bring me back" (Alice: 148). Whilst adapting to the

demands of a new baby she reflected on a clash with her 3-year-old daughter, “I hope it wasn’t a power trip cos I’m not that type of person” (Alice: 295). Her rhetorical question seems to indicate fluctuating levels of self-awareness in line with her fluctuating sense of parental competence in response to the new demands of mothering two children. *Helen* suggested that with subsequent children parents may feel less inhibited in relation to adopting their own strategies for coping,

“...you’ve already got through it that first time...increases your confidence...knowing that what you did was okay...I don’t really care...I’m gonna do it this way...that’s where you get comfortable parents...that probably has a big impact on the children as well” (Helen: 215)

However, this assertion presupposes some consistency between children’s demands and effective parental responses, whereas the reality as experienced by *Emma* and *Kate*, in particular, differed significantly. As demonstrated in earlier categories, when situations failed to match expectations parents felt deskilled. Moreover, these feelings were often compounded by a sense of shame or self-doubt arising from expectations of competence based on previous experiences. In direct contrast to *Helen’s* statement, challenging her identity developed from a more straightforward experience with her first child, was proving hard for *Emma* “it’s almost like being a first-time mum really, because it’s not the way it was before, and it’s hard” (Emma: 38).

Arguably, by virtue of her profession, occupying, or at least being perceived, by parents she helps, in the position of ‘expert’, *Helen* suggested an inverse relationship between parental confidence and the role of the ‘expert’,

“maybe it came with...the advent of the ‘expert’...I think there is a huge lack of instinctive trust or self-trust about parenting...people have been so disempowered...people don’t know that they can just trust themselves to sort things out, and they can make mistakes, and that’s okay” (Helen: 46)

later referring to the paradigm shift in parenting education towards the inclusion of findings from neuroscience and the necessity for appropriate translation from research to inform practice,

“...there’s quite a lot of kind of lay science about how babies develop, and the damage of stress...this kind of half understanding...for some people that have that... understanding of neurodevelopment...that’s another area that needs handling very carefully” (Helen: 112)

going on to emphasise her philosophical and professional agenda as one of reinforcing permission for parents to trust their own developing instincts,

“I try and include...in all my ante-natal work...some understanding of what babies actually need, and what they don’t need...the parents who actually want to pick up their baby, when their baby cries...their natural instinct is telling them to...someone’s telling them not to because they’ll make a rod for their own back and they need to toughen their babies up...gives them the permission to actually parent instinctively” (Helen: 116).

Whether or not informed by expert opinion, contemporary parents are able to access overwhelming amounts of information of varying degrees of reliability, which may be a source of both comfort and confusion, with potentially significant added costs to some parents, as *Natalie* recalled in the efforts she had gone to find a solution to the sleep issues

P: “I’ve even bought her a special sleep pillow and sleep duvet, that was hundreds of pounds – I could have gone and bought a twenty quid one from Matalan, but, you know, anything that had the word ‘sleep’ attached to it I was like a magpie to it – I bought it...” (Natalie:115)

R: “So you were researching, were you? On the Internet..?”

P: “...everywhere” (Natalie:117)

Aside from vast commercial marketing opportunities in baby care and solutions to parenting dilemmas, advice that claims to be evidence-based may be inconsistent or seem contradictory,

“everybody’s telling them what to do – there’s a thousand different guidelines – don’t do this, do this, eat this (*laughs*)...and that’s constant, and it’s so accessible by the media and the Internet...there’s just so much information” (Helen: 46).

Even where there is specific guidance, such as in relation to bedsharing, *Helen’s* comments reflect her awareness of a lack of adherence to guidance, which she perceives as less about ignoring advice, but rather of finding ways to settle babies to sleep, in spite of the cognitive dissonance, and subsequent anxiety this may cause parents,

“there’s so much fear around bringing your baby into bed with you...yet most people will find that actually that’s where their babies are going to settle and not cry all night, so that everybody gets more sleep, but they’re afraid of doing it, or they’ve read things in the media, or their health visitors have literally ticked a box saying that we’ve talked about the dangers of bed sharing, and people are afraid” (Helen: 52).

She cited feedback from bedsharing parents she had supported to respond intuitively, that is by responding to their baby’s cues in ways that feel natural and instinctive, indicated empowerment and relief as their instinctive responding was validated “a lot of the feedback I get is from those people saying, I’m glad I knew that because it made me feel better about responding to my baby” (Helen: 118).

Participants in this study, it could be argued, were adopting similar strategies but lacking the validation required to lend them the support needed to reinforce their confidence. As mentioned in other categories, mothers described bedsharing, and feeding their babies on demand, but their accounts were tinged with guilt or self-blame. Notwithstanding the effectiveness of the approaches, aspects of cognitive dissonance undermined the mother’s belief in the validity or appropriateness of their responding.

Parents’ experiences of encountering inconsistencies in advice from professionals, or even losing trust in medical opinion during the perinatal journey, may account for the readiness with which some were prepared to seek solutions within the realm of alternative therapies. This is despite many, such as chiropractic, being criticised from within the mainstream, for a lack of scientifically rigorous evidence base for their efficacy claims. This may reflect a lack of

confidence to challenge medical professionals, as indicated by Alice, following her traumatic labour, “I didn’t really ask questions...now I feel like I want to ask questions, especially like, why did you let me go on for that long, and why wasn’t there an emergency C-section?” (Alice: 36).

3.5.2 Making sense of sleep issues

The meanings that mothers made about their child’s sleeplessness as they reflected upon the issues were seen to take into account their *developing relationship* with the new child. *Emma* who was unprepared for sleepless nights following her first child admitted “you hear about ‘sleepless nights’ and it seemed a bit of an alien concept really, to me” (Emma: 287), but despite her current challenges found a positive interpretation, cognitively reframing the time spent during the night with her baby awake as welcome “quality time” which otherwise would not be possible for them to be alone together

“I don’t really mind kind of getting up in the night with him...it’s the only time I actually get on my own with him...I don’t mind doing it because it’s quite nice quality time, cos he’s not crying, he’s not grizzly, he’s just hungry, or it’s habit” (Emma: 95).

Alice also offered positive interpretations of the motives for her baby’s waking during the night “I think he just likes me too much” (Alice: 58), attributing his behaviour to his attachment to her “he’s just thinking, no, I need my mom, to get me back to sleep...now he’s like, ooh, I quite like this” (Alice: 82).

Being able to empathise with their babies clearly helped these mothers to reframe their nocturnal experiences, and was further elucidated by *Helen* as a characteristic which, in turn, enables parents to gain the perspective necessary to support balanced responding,

“for the parents...to be able to see things from their baby’s point of view...when you’re in it, and you’re sleep deprived, and you have a baby that’s crying...it’s quite easy...to feel...it’s personal...feel very cross with your baby...can be helpful just to think...he needs something – he’s not crying for no reason, I might not know what the reason is,

but he's not trying to annoy me – he does need something, and it might just be that he needs to be held" (Helen: 124).

Kate, by contrast, felt unable to identify with her baby "both (ex-husband) and I are quite relaxed people but we had this demanding baby" (Kate: 79). This characterisation of her baby as "demanding" links with the earlier categories of 'expectations of parenthood' and 'my own childhood' which identified the labelling of 'easy' and 'difficult' babies.

Mothers adopted strategies only to be left marvelling at their baby's apparent resistance to succumb to sleep, as *Kate* recalled many years later,

"I can remember one night, taking the pram upstairs and putting him in the pram, standing at the foot of my bed rocking him and thinking, at midnight he'll go to sleep, at one o'clock he'll go to sleep, and I just stood there all night rocking the pram" (Kate: 10).

How could parents maintain their trust and confidence to be able to cope when faced with such apparently relentless challenges with very young babies?

Kate rationalised the magnified effect of negative thoughts and feelings when "at night time everything's ten times worse" (Kate: 159), reflecting on the shared experience of others she has encountered over the intervening years, that part of managing these challenges is anticipating, or at least hoping for better times ahead. This suggested that hopes of making meaning had dissolved, replaced with survival instincts "... (other parents with) similar experiences to mine... they've just soldiered on through it like I did, you know, just hoping things will get better" (Kate: 169).

Children growing older, and developing conversational skills, provides mothers opportunities to discuss their sleep behaviour, and gain different understandings which inform the meanings made, as in the case of *Natalie's* daughter, "it's only now that she's eight that (daughter) will say to me, I think I feel tired... she doesn't even really know what it is" (Natalie: 81). She mentioned other children with similar experiences prompting a conversation "she said, oh I'm just like so and so at school because we've got sleeping problems... do you think you've got a sleeping problem then? Well yes, cos I don't sleep all night" (Natalie: 276). Meanwhile she

identified a reciprocal relationship between her daughter's sleep pattern with her on-going concerns, indicating a belief that an effective solution would address the behavioural issues, "all her behaviour is all, still all around sleep...if she started to sleep really well, I think her behaviour would be better" (Natalie: 252).

Although *Kate* felt unable to discuss the problems at the time they were occurring, she was motivated by the lingering significance of her experiences, and a desire to exorcise the past, to disclose her struggles to her eldest son, now an adult, in an effort to make meanings with him

"I can't help how I felt...I can't go back and change how I felt...I have worked hard on my adult relationship with (eldest)... actually in the last couple of years I've talked to him about it...he's been such a lovely young man...to reaffirm my feelings towards him...I told him exactly how I felt when he was little...I feel ashamed of how I felt when he was very little" (Kate: 111).

Her ongoing need to resolve her conflicted feelings indicates the extent to which the negativity of the interpretations made of her son's sleeplessness in the early years impacted her ability to bond with him initially, but also her relationship with him in the long term.

3.5.3 Seeking solutions: being open to alternatives

Whilst it is beyond the scope of this study to evaluate the following interventions, most women in this study (*Alice, Emma and Natalie and Helen*) subjectively assessed benefits resulted from seeking alternative treatment approaches to address babies' pain and distress. Such treatments are generally accessed via the private sector, and referrals tend to be on a personal basis from within social networks. Clearly positive experiences "I think both of them really benefitted from the treatment" (Emma: 71) encourage referrals, "I have since recommended (clinic) to other new parents who have also been very happy with the treatment received and noticed improvements in their own children" (Emma 2:43), and reconsultation, but as *Alice* asserted, the price of accessing private treatment, in this case chiropractic, can be prohibitive

“it’s expensive, the outlay, but I think, if you’re forewarned...and possibly save for it than it isn’t so much of a shock...I think people are scared with the price, and think well is it really going to work - it’s a trust element as well really...” (Alice: 74).

Alice’s own prior experience of chiropractic treatment “I’d had a bad car accident...seven years ago...pilates, and (specific) chiropractic...got me through” (Alice: 52) had led her to consult a paediatric chiropractor as her first baby seemed to be in pain,

“as soon as (first baby) was born it was just apparent, as soon as we just lay her down to try and change her nappy she’d just scream with pain, she’d never sleep on her back...so I think she saw (chiropractor) in the first week, and I saw a change in her straight away...and she...gave me exercises to do and...we could get her to sleep...so that was a real achievement” (Alice: 52).

Thus her own prior positive experiences informed her confidence to seek treatment for her second child “...I knew (from first baby) (chiropractor) has gotta be able to do something” (Alice:74). Although notwithstanding her earlier positive experiences she did not seek assessment immediately following his birth,

“even with the forceps birth he seemed a dream baby...I’d feed and feed and feed him and then he’d sleep for four hours...I was like, my goodness I can cope with this, so I didn’t feel at that stage that I needed (chiropractor)...at three weeks everything changed, he wouldn’t sleep, it was just awful...I got to about five or six weeks with him, and thought, enough’s enough...I’ve got to take him...I think I got him in at about eight or nine weeks” (Alice: 60),

a delay which she later regretted, assigning the continuation of her baby’s perceived pain to her lack of seeking earlier intervention “half of me kicks myself for not going straight away, but I didn’t feel I needed to then...” (Alice: 60). She referred to her practitioner with great warmth and gratitude for the positive impact she feels she has had in the lives and development of both her children “I used to call her (chiropractor) the ‘magic lady’” (Alice: 54), offering her opinion that many mothers and babies who are currently unaware of or unable to afford to access treatment would benefit from the range of issues that had been addressed by the

treatment, “(breastfeeding) was quite painful...she did something to (baby’s) jaw and stopped it hurting...I always remember thinking that’s just incredible, and so many mums give up because it hurts” (Alice: 52).

Emma had also sought help for her baby’s apparent pain

“...it was to do with his blocked tear duct initially, and he had terrible fear of the car seat, initially – any time I went near the car seat he would scream - it would just be piercing, so they did quite a lot of work on his back and neck, I think it all got squished when he was inside me, so they just had to release his back, and he’s like a different child since, so that’s been amazing” (Emma: 63).

For these parents, accessing chiropractic treatment for their baby’s pain empowered them to feel that a solution was accessible. Even if the sleep problem was not ‘solved’ they felt reassured that their baby has been “checked out” (Alice: 52) - assessed with what they believed and perceived to be subtle and gentle adjustments, made by practitioners often claiming to identify issues of which parents felt they would otherwise have been unaware

“with (first child) I think she had more problems around her hips, and spine, and jaw, oh and we had to do some exercises around her nose, as well, whereas (baby) is more about three nerves that weren’t working because of the birth, and one of them was even his eyebrows...I’d never noticed it...but he’d never move his eyebrows” (Alice: 52).

Notwithstanding their reliance on conventional medical expertise and care during pregnancy and labour, a private treatment which paid such close attention to the delicacy and detail of their infants’ tiny body and their responses to the treatment they receive, was a source of comfort as *Alice* recalled her older child responding to the practitioner,

“she’d be really fractious...then (chiropractor) would lie her on the bed and she’d be, in a way, kind of hypnotised, and it was just as if (she) knew (chiropractor) was helping her, even as a real young child...she’d just lie on the bed and gaze up at her...it was really kind of fascinating to watch actually, the connection...” (Alice: 54),

and recalling the practitioner's interaction with her new baby "when I went the last time she said, right I'm gonna finish here cos he's kinda telling me I've had enough" (Alice: 58).

In addition to addressing the presenting problem, parents established a relationship with the specialist practitioner who became a source of more general support and advice offering techniques and exercises enabling them to take a more proactive role in comforting their infant. As treatment tended to span several sessions parents were able to consult or anticipate consultation support as problems arose "I didn't go to them about the sleep problems...we are seeing them maybe next week...so it might be something I'll mention...see if they can shed any light..." (Emma: 69).

Helen drew parallels between her role in ante-natal education and other sources of support "the positive outcomes from the alternative therapies are about more than the treatment alone...valuing being supported and...listened to, which I experience in my job roles every day" (Helen 2:2). Citing her own experience, and that of speaking to alternative practitioners "...cranial osteopathy is...the thing that I know most about...it makes sense to me...I'm sure that chiropractic is similar" (Helen:185), she offered her personal support for their claims to offer helpful and effective treatment to mothers and babies to be given greater credence,

"I have spoken to cranial osteopaths who really believe...they should be on the labour ward, or the post-natal ward, at least, just doing a bit of easing out after the births...so many births aren't really normal...women (too) don't recover, post-natally...they just think they need to keep quiet, and put up with their aches and pains" (Helen: 199).

As mentioned earlier, *Natalie's* daughter was treated following a conversation with a customer, also a practitioner, who suggested intervention following the baby's traumatic delivery,

"when she was born she didn't do that cry...I didn't realise it was really important...and one of my clients did (cranial osteopathy)...(baby) let out this awful scream, and she said that's what she should have done in birth" (Natalie: 38).

In her efforts to explore solutions to her daughter's persistent sleep problems *Natalie* later consulted a counsellor, at the request of her ex-partner, who proposed a sleep training programme,

“(counsellor) wanted me to do ‘controlled crying’, which I hadn’t tried – I’d read about it... I think she was nearly two, so they said it was a good age to start...she gave me a programme of what to do, and it was quite harsh” (Natalie: 135).

Emma has disregarded sleep training as an option for her baby due to the disruption to her older child, “I was anxious that my older son wasn’t disturbed during the night...played a part in my reluctance to go down the ‘controlled crying’ route” (Emma 2:41).

Despite her misgivings *Natalie* persevered with a regime which required the previously agreed presence of her ex-partner each evening, yielding unexpected early positive results which quickly turned to disappointment and confusion as the situation became unsustainable due to the requirements of the programme,

“the first night she slept...(I thought) why didn’t I know about this in the beginning? She slept all night, and the next night she cried for less time and slept all night, and the third night he just said, oh she’s cured, I’m going, and she woke up – that was it, I did what it said on the paper...and she didn’t sleep” (Natalie: 137).

She remembered the distress and disruption caused during the ensuing weeks “she used to scream for him to come back...it was horrible...he used to put her to bed then have a go at me and leave” (Natalie: 127), reflecting regretfully on an intervention which she felt pressured into attempting, and which had unintended impacts on her daughter’s bedtime routine “I think, for a little child she’s just got used to seeing him here again, which I think was worse really – I think I should have been left to do it myself” (Natalie: 145). She disclosed a pattern of masking her emotions, intended to protect her daughter from witnessing the conflict,

“when I think about how it used to be with her dad, at the door, at bedtime, I used to find that quite horrific, so she must have found it awful...I used to stand with my back to her crying for him, and I used to wipe all the tears away and pretend to talk to the door he’d slammed, and say (*brightly*) right, see you tomorrow, bye, oh, come on, let’s get you back into bed, but subconsciously I’m sure...she knew that inside I was really upset by what had just happened” (Natalie: 352).

The prevailing circumstances of this family at the time reflect a level of complexity which were compounded rather than addressed by the sleep training routine. Characterising her daughter's current sleep, "there's no pattern...the slightest thing can throw her off" (Natalie: 311), it is tempting to impose a range of interpretations on her disturbed responses, which *Natalie* had explored with her daughter's psychologist, "she came back saying that (daughter) only really needed three to four hours sleep a night...and that they'd put a lot of it down to her dad going" (Natalie: 127).

By the time her daughter started school *Natalie* sought support for the sleep issues, which were ongoing, and associated behavioural concerns,

"I actually thought...I'm not gonna carry on and think this is normal, so I went into school...asked to speak to somebody...she was from the Early Intervention Scheme...she was really...lovely – she made me feel like I wasn't doing a bad job, she was amazing, she was probably the first person ever that made me feel I was being okay...she worked with me for six months, and she was absolutely brilliant" (Natalie: 181).

Speaking candidly *Natalie* acknowledged the potential stigma associated with accepting formalised support, indicating others she knew and felt would benefit from supportive intervention, but recognising their reluctance to invite that which they feel might potentiate scrutiny and loss of autonomy, "there should be more people like...(Early Intervention support worker)...I've got friends I believe need...support...(they) say 'no - next step is Social Services'" (Natalie: 370).

Seeking help brought a range of responses as *Natalie* and her daughter were also referred to a sleep clinic, and prescribed medication which she decided not to continue to administer,

"it frightened me to death the first night...I was reading her a story, and then she just went...and her head...it was like nodding...that worked – for three nights...and I phoned them to say it's not working anymore and they said, up it to two, but that's an adult dose...I don't give them to her anymore, because...they would make her go to

sleep beautifully, but she'd be awake by half ten, eleven, and I thought, what is that doing to her body?...so I just stopped giving them" (Natalie: 264).

More than two decades earlier *Kate* was advised to leave her baby to cry himself to sleep, recalling that it yielded no positive results, but still wondering "...maybe I didn't leave it for long enough, leaving him to cry I found really difficult...I think the longest I ever left him to cry was about 40 minutes, and by the time I went in he'd been sick" (Kate: 61). That she questioned her adherence to a method which seemed to lack a sense of structure or containment, and which provoked such distress in her infant reflected a state of desperation and self-doubt, coupled with a lack of any other sources of solution for her at that time.

Conversely for her, following a recommendation at a time when such interventions were more routinely suggested, medication signalled a turning point in establishing a sleep routine for her son, "by the time (eldest) was about two somebody said to me...you can buy something called 'Phenergan' which will make them sleep...just use this until he gets into a pattern of sleeping" (Kate: 91). Initially causing her concern - "the first night he slept I didn't sleep because I thought he was dead" (Kate: 43), the decision was contentious, offering relief from sleeplessness yet causing consternation at the time, and some lingering guilt even in the retrospection, "I used it for weeks...weeks, because as soon as he had started sleeping I didn't want him to stop" (Kate: 24) "...I think I used it for about two or three months...awful" (Kate: 91).

Ante natal classes represent a valuable source of information, and are voluntary and an opportunity to engage with practical and conceptual aspects in preparation for parenthood at a time when prospective parents are highly receptive. As *Helen* asserted, "there's so much opportunity, people are so ready to learn things and do the best by their children" (Helen: 18). However traditional classes are being phased out due to austerity measures, "a lot more could be done ante-natally...ante-natal education is...being stopped...NHS classes that most people expect to go to, they're no longer provided (locally)" (Helen: 18). Also parents may be motivated to attend in first but not subsequent pregnancies, often due to local availability or childcare issues,

“I didn’t do any of the classes building up to it – I did with (oldest child)...the NCT and the NHS one...I’m doing the post-natal lessons with him cos I just thought it’s really important for me to refresh, you know, the weaning and things like that” (Alice: 44).

Refreshing knowledge in this way counteracts the issue of salience, identified by *Helen* as mediating the effect of ante-natal education, impacting the likelihood of parents recalling and accessing prior information sometime later when it might be most relevant, as she reflected, “one of the biggest problems with ante-natal education is what’s salient at the time” (Helen:177).

Recognising the significant role for comprehensive ante- and post-natal education, *Helen* raised a key issue arising from the current study,

“the women I work with either access my support through antenatal education, which they pay for...or...health visitors identify women ‘at risk’ of post-natal depression and refer them to me for additional support...theoretically this is ‘early intervention’...however this depends on women being able to identify their own need for additional support...something not necessarily clear or acceptable to women - and being able to discuss this with their health visitor...the majority cope (to a greater or lesser degree) alone or with ad hoc support...there is a massive gap”

(Helen: 2:11).

Identifying herself as self-reliant, reluctant during our interview to suggest any vulnerability, and doing her utmost to manage her young family, meanwhile trying to show appreciation to her husband and nurture their relationship, and accepting some freelance work of her own, *Emma*’s description of her long day evokes a lonely image

“the other day we were up and out and we were in (town) by 9 o’clock in the morning...we could go to the park – obviously, there are no (opening) hours...I mean, a lot of these play centres only open at 10, so sometimes that feels like a long while away” (Emma: 118).

Even in the midst of extensive social networks, “we’ve got a lot of family and friends close by...which is, erm, lovely” (Emma: 4), as attested to earlier, isolation was at times preferable

for women masking their emotions as part of a coping strategy. But as characterised by *Kate*, still trying to reconcile herself decades later to the pretence she came to rely upon, “you end up living a lie, just to save your own face” (Kate: 203). The testament of loneliness, anxiety and isolation, during what may be a relatively brief and transient period, provided through the accounts presented within this study was nowhere more poignantly revealed.

3.6 Summary of findings

Although presented in an ordinal fashion, the intention was not to produce a linear taxonomy of categories with which to explain the experiences of mothers during the time of transition. The interdependent nature of the analytic categories and the concepts which they represent is evident, with much potential for overlap indicated both within and between categories and their component subcategories. Within the category of ‘being me’ prior expectations and ways of responding to unforeseen challenges were analysed as being enmeshed. Unmet expectations required revisiting and reconceptualising of plans, along with concomitant cognitive and emotional readjustments. The underlying appraisal processes which facilitated or hindered adaptation to the unforeseen circumstances became understood as highly significant in the exploration of the impact of infant sleeplessness on the transition to motherhood. Dissonance in mothers’ expectations of competence, when confronted by the challenges they faced, often resulted in concealment and masking of their emotions and distress. Resilience supported by self-care, cognitive flexibility and adaptive coping strategies to accommodate any additional challenges were seen to become strained or ineffectual as a consequence of sleep deprivation. The development of the interplay of these issues was explored in the category ‘being pushed to the limit’ which offered some emotionally charged and revealing material indicating the extent and frequency of distress, coupled with the complexity of emotional turbulence, evidenced in this small, non-clinical group. The category ‘relationships’ considered and explored the inherent dynamics across a range of relationships from supportive to challenging, intimate to professional. Insights into partnerships, which

anticipated one form of parenthood to then face an unexpected reality, illuminated a time of transition which can result in significant stress for parents, but also with implications for the developing parent-child relationship. 'Coping, learning and trusting' offered some understanding of the means by which mothers employed personal resources, or encountered personal blocks to adapting, echoing features identified across the other categories. Significant in this category was the identification of general, perhaps cultural blocks to contemporary intuitive parenting, and the adoption of privately funded alternative therapies by those with access to, and confidence in, such approaches as early intervention for sleep issues, despite a lack of endorsement by conventional medical opinion.

Key concepts which emerge from the analysis, include the range and variability of the 'normal' experience of transition to motherhood within the non-clinical demographic under consideration, the impact of sleep deprivation, and the severity of distress which characterises this transition for some mothers being often completely and deliberately concealed. The lack of acknowledgment by mothers, and those around them, of the extent of the challenges reflects an apparent cultural blindness to a form of distress which, whilst potentially impacting adversely the mental, emotional and psychological health and wellbeing of mothers and children, lacks recognition and therefore social relevance as it fails to fulfil current clinical criteria for treatment.

This small study indicates unmet needs for emotional and psychological support in the mothers it interviewed, whose experiences, despite spanning more than 20 years, suggest a continuity of issues. It is hoped that this study will encourage these women's voices to be heard, thereby raising awareness of the issues amongst mental health practitioners in primary care settings - arguably those most likely to encounter parents - who may feel they currently lack specialist knowledge of perinatal issues, or the impact of sleep deprivation. Awareness raising would include identifying approaches to address the lack of willingness in mothers to disclose distress. Importantly, increased interdisciplinary awareness of the issues would also inform the development of universal early support interventions for parents, including coping with sleep difficulties. A shift from the current emphasis on perinatal women's' mental ill

health, to greater recognition of the complexity of the stressors within this transition would reduce stigma and encourage more women to seek support earlier, perhaps avoiding any escalation of their 'normal' distress. To paraphrase Oakley's (1979, p.143) summary of findings from interviews with 60 mothers - in any other context where a person was confronted with a complex new job, but one of unique personal and societal significance, to be undertaken in social isolation, without pay, holidays, or perhaps any breaks, 24 hours a day, seven days a week, without training, *whilst sleep deprived*, a reasonable response would likely include recognition of the unique pressures being brought to bear on the individual. It would be unlikely that their mental health was immediately called into question. However, unfortunately, women's experiences that equate to the given scenario, but include an infant or small child as the source of sleep deprivation, still remain vulnerable to being pathologised within services and stigmatised within society.

4. Discussion

The proposed pluralistic theoretical model, 'the wearing mask of transition', synthesises a wide range of resources to inform a biopsychosocial conceptualisation that emphasises the complex, flowing and eternal nature of the processes involved in the transition to motherhood and parenthood. In this study, the model accounts for effects arising specifically from infant sleeplessness, but has potential for broader clinical applicability across a range of issues that might be addressed therapeutically within the context of the transition. It is hoped that the model may find application as a clinically and therapeutically relevant tool for practitioners and mothers in making meaning of their experiences. Additionally, for those involved in supporting mothers who are presenting as sleep deprived, an underpinning awareness of the physiological significance of sleep, and its disturbance or deprivation in adults, seems highly relevant. This is an area that is becoming more fully understood via functional neuroimaging techniques which provide explanations of the neural mechanisms underpinning the complex homeostatic functionality of brain energy recovery during the stages of sleep (Dang-Vu et al., 2010).

The lemniscate, or infinity symbol, which the model employs is widely referenced in contemporary culture. During the course of the analysis it came to provide a useful visual representation of the iterative analytic process, in addition to reflecting the perpetual nature of transitions throughout the human lifespan. Further exploration of algebraic geometry, the branch of mathematics to which the symbol pertains, seemingly added resonance to the application of the symbol to the transition model, as both are concerned with exploring the range of properties of the possibilities within a system, rather than necessarily finding specific solutions. In what may seem a paradoxical ambition to increase the specificity whilst broadening the scope, by incorporation of extant models and theories of transition, the model aims to improve understanding of the complexity and interplay of factors during the time of transition. It also seeks to characterise the transition of coping with infant sleeplessness as an extended and reiterative process, which more accurately echoes the development of sleep patterns in some children, rather than a purely stage conceptualisation

that implies a point of resolution and finality. The mothers interviewed in this study appeared to lack knowledge about 'normal' sleep patterns in infants, relying rather on previous experiences for those with older children. By contrast, *Helen* demonstrated a professional awareness of the issues which she aimed to share with expectant parents as integral to the ante-natal education she provided. Although all the mothers voiced daily impairment to their functioning due to sleep deprivation, their accounts did not indicate any broad awareness of the wider impacts on adult mental health, including lack of opportunity for restoration following traumatic birth experiences in some cases. These examples seemed to reveal the complexity of the apparently longstanding and enduring issues surrounding parental education, and translation from research to practice, by means that find the relevant audience, and at a time when the information is salient.

The anticipation of the type of mother a woman wants to be, can only be informed by ideals that are then shaped, or perhaps completely distorted, by women's lived experience, which in turn gives rise to a potential for reflexive capacity (Miller, 2005). The allegorical reference to 'the mask', intends to engender sensitive recognition of disguising whilst coping with the challenges of transition. Masks are ubiquitous and arguably useful across human social interactions and times of transition, allowing for coping strategies to become established, as most notably presented in Goffman's (1959) dramaturgical model of presentations of self. They have also been referred to specifically within the transition to motherhood literature (e.g. "The Mask of Motherhood", Maushart, 1999), and yet the accounts from the women in this study spanning twenty years, reflect continuing lack of awareness of these issues. Despite having been widely explored and identified for many decades, within the research literature of nursing, midwifery and sociology in particular, findings appear to resist dissemination to inform practitioners beyond those immediately involved with expectant and new mothers. However, as the field of perinatal wellbeing extends, encompassing the emergent national Specialist Perinatal Mental Health Services, it is increasingly pressing for those practitioners involved to address any existing and perpetuating discontinuities in knowledge and expertise.

When resilience is compromised due to physical, emotional and psychological demands such as those wrought by sleep deprivation, a 'coping mask' may be an available shortcut which can be felt to satisfy the expectations of women, their partners, families and society. The 'wearing mask' model incorporates concepts from transition to motherhood and parenthood, in addition to systemic, role, dialectical and general theories of transition, in order to provide a framework to make meaning of the lived experiences. The model also offers specific reflective space for the impact of parents' own experiences of having been parented, and draws from evolutionary, developmental and neuroscientific perspectives, enriching the psychoeducational possibilities for postnatal support and comprehension of the issues. The model emphasises the relevance of 'one's own childhood' in the transition to parenthood in light of the acknowledged significance of the impact of parenting behaviours on the development of the parent-child relationship, and subsequent emotional and psychological development of children who in turn become parents (Early Intervention Foundation, 2015; National Scientific Council on the Developing Child, 2004). In so doing it intends to encourage reflection on past events, which may be neglected within primary care service provision within IAPT, with its focus on the 'here and now', in order to prevent intergenerational transmission of perhaps subtle, but unexamined issues. Underpinning all else is the need to integrate the plethora of unmet expectations and unmatched predictions that challenge the individual's sense of culturally and socially acceptable narrative. Self-reflexivity is compromised by the chaos (Frank, 1995) that new mothers can feel their lives have become, yet women must strive to find means to assimilate their experiences into a coherent and ego syntonic narrative. The complexity of the struggle is implied within *Kate's* explicit insight into to her own mother's masking ("she does present an image, my mother", *Kate*: 183), but also in her doubt that she would hypothetically extend support to a mother she might perceive to be struggling for fear of exposing the vulnerability that she went to lengths to mask in herself.

Interpretations made of the mothers' coping by assuming a mask include *Alice* concealing her feelings of discomfort towards her father-in-law's reactions to her daughter, presented as

not wishing to “rock the boat” (Alice: 94). However, her return to self-employment, about which she appeared to feel ambivalent at best, was dependent upon childcare being provided by her in-laws. *Emma* elected not to receive a transcription of the interview as she did not want to hear comments she anticipated sounding negative towards her husband – “I’d hate to listen back and sound like I was really slating him or being awful...” (Emma: 256). *Kate* disclosed frequently, and deliberately, concealing her distress and deeply conflicted emotions from all those around her, and *Natalie* revealed the extent of her attempts to obscure the abusive conflict she experienced with her ex-partner by forcing a smiling cheerful exterior presentation for her daughter (Natalie: 352). However, as the data reveal this form of short term coping did not address the emotional and psychological needs of the mothers or their babies, despite in some cases becoming engrained as a strategy, in the absence of being able to disclose distress or explore alternative coping strategies. The retrospective data obtained suggested that alternative, help seeking approaches were deemed preferable; however, these were not enacted for a variety of reasons associated for some with the compromise involved in not being able to excel, or at least feel competent in their role as mother, wife, partner or woman. Essentialist expectations of the transition to motherhood as engaging with a “core self” (Miller, 2005, p.15), that she described as “an Earth mother” (Kate: 10) remained unmet in *Kate*’s first experience of becoming a mother with the result that she felt cheated and resentful throughout the first two years of her son’s life. Conflicted emotions seemingly underpinned by a sense of anxiety and shame attached to identity discrepancy, coupled with coping mechanisms relying on masking distress, rendering some unwilling to seek help to manage their feelings.

Offering valuable insights ‘behind the mask’ that were dependant on individual differences in willingness to self-disclose, the category ‘being me’ developed initially as a subcategory in response to inclusion in the data of specific references to personal characteristics. Raised to a category comprising a number of focussed codes that revealed insights about the self-talk which these women were able to access and articulate, such as *self-criticism*, *feeling judged* or *guilty*, it underpinned the subsequent analytic and theoretical development. Although there

was no intention to question the women directly about their personalities, the language that they employed revealed aspects of themselves which, via further exploration, illuminated both the meanings they made, and informed the interpretations the researcher formulated from their experiences.

Each mother told a different, but similar story, with all four indicated distressing impacts of sleep deprivation on their individual capacities and self-concept, whilst *Helen's* account served to offer wider and more numerous examples recalled from her practice, and informed by engagement with relevant professional debates. *Alice* and *Emma* described efforts to regulate their babies' sleep-wake cycles, which was influenced by the requirements of breastfeeding, whilst both mothers were unable to catch up on sleep by napping, or sleeping later in the morning, due to having a toddler who needed their attention.

The mothers had all taken breaks from their paid employment and described adopting 'traditional' gendered family roles whilst at home with their babies. It is relevant to note that the retrospective accounts, such as *Kate's*, echoed the crisis model of transition with her emphasis on a felt lack of partner support (Dyer, 1963; Le Masters, 1959), confirming evidence suggesting the passage of time allows for disclosure of experiences that are dissonant with cultural scripts of 'normal', or arguably 'perfect', life with a baby (Choi et al., 2005; Miller, 2005; Nicholson, 1998).

Kate and *Natalie's* retrospections both offered insights into the effects of the transition to parenthood and sleep disturbance on the partner relationship, with the consequence that both women had separated from their children's father. Whilst it would be simplistic to ascribe these outcomes purely to the transition, *Natalie* was explicit in linking her ex-partner's feelings of rejection with the arrival of their daughter. A more recent retrospection, such as *Emma's* reflections on her management of the sleep and feeding routine the previous year, sought to reframe the experiences by rationalising and self-blame for establishing and maintaining her baby's night waking by breastfeeding on demand. It could be argued that these differential cognitive responses arose from a desire to resolve

discrepancies in self-concept (Higgins, 1987), by reflecting on a preferable approach which would likely inform any future experiences.

Emma's retrospective comments illuminate a complex and significant dichotomy which exists between evidence-based principles and parenting practices. She breastfed on demand, in response, she felt, to her infant's need for 'comforting', and in order to achieve sleep for herself by whatever means were effective. She later reflected that this was a mistaken short-term solution which she felt prolonged their shared sleep difficulties, the salient issue at the time. However, both forms of responding represented her adapting to the unique requirements of the baby whose patterns and lack of routine represented an unexpected source of challenge. The unique challenges of breastfeeding were revealed in *Alice's* account of working with her baby's night time waking and implementation of alternative soothing by stroking (*Alice*: 86). Despite the tenderness of the interaction she described, *Alice's* specificity in recalling the length of time gained in sleep ("forty minutes") was poignant testimony to the ongoing struggle to balance the mother's own needs with her sensitive attunement (Tronick, 1981) to the needs of her baby.

Natalie's child, aged 8, was the oldest in this study, and although she expressed fewer prenatal expectations and less personal concern for a felt need for control, the sleep disruption she experienced was the longest lived, for which she sought and accepted all help, including eventually external formalised support. The links she made with her own and her daughter's experiences of the trauma surrounding the breakdown of her relationship were evidently still painful years later.

By these isolated examples from the accounts, it can be seen that the lived experience of challenging times of transition became assimilated into the personal narrative in highly individual ways, and according to the proximity to events. In sharing the story with friends, family or new mothers seeking advice, to what extent will their experiences support or refute the societal myths surrounding motherhood?

A range of issues arising in the data arguably from "received wisdom" (Burgard, 2010, p.2), or perpetuated by myths, included the concept of 'easy' or "text book" (*Emma*: 32; *Kate*: 10)

babies, seemingly widely recognised, and used by participants both about themselves (Kate: 147), and their infants (Emma: 32; Kate: 99). Such characterisation lent potential for impacts of unmet expectations such as disappointment, self-blame, and feeling cheated and possible resentment if a baby did not conform to the ideal. Other sources of confusion and anxiety were evidenced to include dichotomies and ambiguity in the information available to parents (e.g. colic). Although bed sharing is commonplace in many societies, UK guidelines are relatively unequivocal, however evaluation of the associated risks is ultimately assigned the responsibility of parents. The current study supports that, in practice, the weight of the responsibility for this decision falls to the (breastfeeding) mother attending to the baby throughout the night, or, more realistically, the decision is not consciously made but she awakes to find the baby in her bed having fallen asleep whilst feeding. Thus, perhaps on a nightly basis, mothers face what they might believe to be potentially life endangering choices that they alone have to make, revealing a considerable additional source of unrecognised stress.

Participants often indicated that they were surprised at the level of personal engagement they felt with the interview process, which was described as the first opportunity they had for disclosing and reflecting on their experiences, and with their emotional reaction on reading the analysis which offered insights into the shared nature of their experiences. These responses resonate with the earlier presented case for the relevance and clinical significance of sources of early support for parents with unmet and unrecognised needs. The extent and degree of unexpected self-disclosures which were captured in the category 'being pushed to the limit', introduced anticipated issues, referred to by Fine (2004), as "the ethics of involvement and the ethics of detachment" (p. 75). Decisions relating to the boundaries required to maintain an interview as a research undertaking, and avoid straying into quasi-therapeutic territory were made simultaneously in line with clinical judgment. Where necessary, time was taken at the close of the interview, and after the recording had finished, to ensure that participants felt reassured that their disclosures were contextualised, validated, and safely held, as far as possible. Equally challenging were disclosures that later

appeared to be regretted due to their negative portrayal of the women's circumstances, such as the earlier example given of *Emma* refusing a copy of the transcript, as she did not want to hear herself sounding critical of her husband. In some ways, the revelations appeared to have taken her by surprise, and to potentially reflect a deeper significance, which caused her to seek to qualify and minimise her disclosures as the interview meeting came to an ending. My clinical awareness as a therapist, of the potential impacts of disclosures indicating a sense of disloyalty or betrayal, remaining unaddressed and uncontained were approached in the debriefing following the interviews, but reassurances and normalisation of the issues did not seem to offer her great consolation – indeed it appeared that she perhaps regretted having allowed me to glimpse 'behind' her mask. Participants were, of course, reminded of their right to withdraw from the study, particularly in the event that they appeared concerned about their level of disclosure, with the result that one mother did withdraw following the interview, and appropriate and necessary liaison ensued. The mother was supported by her GP to seek help from the appropriate mental health services.

The mothers made reference to their mental health, some directly, as in the case of *Alice* who was fearful and anxious because of a family history of depression. She also expressed concerns that she would repeat the experience she had as a daughter, worrying that she might lack a maternal instinct in the way that she felt her mother had done. Her relief, at an instant feeling of bonding with her baby which she thought might elude her, was heartfelt and touching, however her struggles were ongoing, and highlighted as her husband made occasional reference to her latent vulnerability. *Kate* questioned her mental health at the time two decades earlier, and felt the extended experience of disturbed sleep with her first child had long term impacts, both on her sleep but also in terms of her relationships with her eldest son and her ex-partner. Meanwhile *Emma* and *Natalie*, both of whom enjoyed positive and supportive relationships with their parents, referred more to their reactions and feelings of anger and loss of control due to sleep loss. The need for recognition of the complexity of the issues facing parents adjusting to the demands of being a parent was emphasised by *Helen*, whose professional role brought her into contact regularly with the

struggles encountered by those who are either unwilling or unable to engage with support services.

All of the women interviewed scored within the 'normal' range on the self-report depression measure; although perhaps not surprisingly the two new mothers' scores were higher than those with older or adult children. Reactions to their scores were generally ambivalent, and although this was not explored in any detail, particularly for the new mothers it is hypothesised that whilst a normal result might have offered some reassurance, it may not for others who perhaps under disclose, or feel their emotions fluctuate daily, as indicated by *Emma* at the close of our interview

R: "Do you have any questions of me, or has anything occurred to you?"

P: "No, I mean...the only thing I would say is obviously day-to-day the way I feel is very different...I'll wake up one morning and... you know I won't have slept and things are a bit tough...so it's really just to say that had you met with me tomorrow it might be different what I'd say, or (how I'd) come across..." (Emma: 226)

From the current study, in the case of *Alice*, it could be seen that vulnerability to depression, specifically postnatally, attracted negative responses even from partners. Whilst *Natalie* highlighted links between accepting support from Early Intervention and becoming stigmatised and vulnerable to further unwanted involvement from Social Services, offering insights into masking of not coping by others that she knew.

The interventions outlined briefly via the mothers' accounts provide evidence for a range of positive outcomes from alternative therapies which encompassed more than the treatment alone. They valued the clinical expertise and support, and there was perceived value added in the advice and tips they received. The trust that they placed in the hands of the practitioner offering an intervention outside of the established medical norms may reflect a spectrum of attitudes from openness to desperation. They committed to paying for a treatment whose efficacy has not been validated by conventional medicine, and in so doing bought in to a process that offered hope but no certainty of sleep 'cure'. However, the interactions between clinician and infant offered a novel perspective from which to observe their baby as central to

a relational dynamic with another adult, which demonstrated their uniqueness and individuality.

Sleep training, by contrast, as experienced by the mothers, presented as an intervention which caused distress to infant and mother. Based on behavioural conditioning, management of sleep training programmes relies on consistency but these mothers found their children's distress too affecting to continue. An experience which heightened distress and was abandoned was seen to cause confusion and self-blame, reinforcing a sense of 'difference' and isolation. If sleep training was a last resort what hope could they see for the future? Meanwhile medication to address sleeplessness appeared a vexed issue, with both *Natalie* and *Kate* expressing discomfort founded in a lack of trust or full understanding of the total effects of pharmacological interventions on their child. So, even if efficacious, results were felt by *Natalie* too pronounced, whilst seemingly unreliable, and, decades later appeared a source of ongoing parental guilt for *Kate*.

Clearly in the current climate of health and welfare service constraints, the focus of strained resources becomes directed at those perceived to present the highest risk. However, that these women struggled through, and apparently overcame the challenges, appears to neglect the complexity of the dynamics which gripped their situations, and may indicate the potential vulnerability of many others (Hogg, 2012). Prevalence statistics suggest that 40% of children are insecurely attached, with slightly more than 50% achieving developmental expectations at age 5 (Public Health England, 2014), and that one in three women suffer some form of mental ill health during the perinatal period (Boots Family Alliance, 2013; Hogg, 2012). These figures in isolation suggest that variables other than recognised or diagnosable maternal mental health issues are implicated in these worrying outcomes for children. Infant crying and sleep difficulties have gained greater recognition for the potentially destructive impacts they have on parent-child dynamics (Hogg & Coster, 2014). Set against a backdrop of a reduction in universal ante-natal education, closures of Children's Centres, limited support for infant sleep issues under six months, and a paucity of early interventive psychotherapeutic services for parents who do not meet current clinical

thresholds, women, as represented in the current study, who may experience significant distress, walk a tightrope between coping privately, or seeking help and risking their distress becoming pathologised. Despite recent successful efforts to reduce the stigma associated with seeking help for psychological ill health more generally, issues surrounding motherhood, and perhaps parenting more generally, as reflected in these accounts, are often undisclosed, even to partners, due to fear and shame. The study findings also serve to highlight the need for accessible and relevant psychoeducation to inform all those with new babies, but particularly infants under 6 months old, for whom there are no recommended interventions with which to address infant sleeplessness, of the physiological sources of their distress, plus support to develop adaptive coping strategies.

In highlighting these issues, the current study is not claiming to be adding novel findings to the extant literature, however it does intend to emphasise the needs of new parents, similar to those of decades past, which continue to cause distress, and that do not find easy answers or interventions.

Obvious limitations of this study include the homogeneous nature of the participants, and the researcher – all White European, middle-class women, in relationships with the fathers of their babies at the time of the birth. At the proposal and planning stages separate and distinct efforts were made to recruit fathers, and teenage mothers, for whom attempts at establishing a support group were being made in the local area. For a range of reasons two fathers who had been identified were unable to proceed as participants, whilst the local support group failed to begin in the time frame of the data collection. It is unfortunate that this study, in common with many others, failed to access the voices of these underrepresented groups.

5. Conclusions, recommendations for practice, and future research directions

The simplicity of the symbolism utilised in the visual representation of the 'wearing mask of transition' model intends to capture and convey the timeless, enduring and elliptical nature of what is a common, but by no means universal experience. Extant literature, supported by the current research findings, suggests that for the UK demographic groups represented, well identified, arguably eternal experiences of distress in the transition to motherhood are routinely masked, for a range of motives.

The findings of this study suggest that these mothers were living through the early period of their child(ren)'s life in various states of emotional and psychological distress, and this has implications for the welfare and development of individuals, families and societies. However, despite several decades of compelling qualitative research findings, and acute awareness in those directly affected, this troubling yet largely unseen despair resists open dialogue in wider society.

Barclay and Lloyd's 1996 paper, entitled "the misery of motherhood", concluded that women's distressed responses at that time were appropriate, within "a culture that neither acknowledges nor sufficiently supports the process of becoming a mother" (p.138). Disappointingly the current situation within UK society reflects a perpetuation of issues that provoked such commentary two decades ago. Outside of the immediate population of new parents who may now form their own supportive communities via social media, this is reflected in a lack of broad recognition, and therefore routes to, if not solution, then support and intervention for mothers and babies - both recognised as highly vulnerable groups. It could also be argued that the pressure women feel to mask their distress has increased with the rise of social media, and the inherent expectations of personal life made available on a public platform. Negotiation of, and adaptation to these socio-technological realities is understandably beginning to attract research interest (e.g. Davis, 2015).

Isolating the issue of sleep disturbance and deprivation recognises these uniquely predictable and perhaps universally expected aspects of (new) parenthood. However,

arguably, sleep loss is one factor that has the power to create the most devastating effects, being implicated in the development and exacerbation of serious mental health conditions. Yet it is one area that attracts no clear-cut solutions. The largest global sleep and cognition study launched in 2017 (Cambridge Brain Science, 2017), and, although it invites on-line participation over just three days, its scope and reach are extensive. As such its findings may be very relevant to this population.

The women interviewed sought help to tackle their infants' pain and sleep difficulties, but not their own fatigue and distress for a range of individual reasons. These have been explored as relating to self-concept, anxiety and potential stigmatisation, which in some cases resulting in them avoiding contact even with other new parents. A sense of failure appears to surround issues of infant and child care, and arguably 'management', particularly in relation to sleep routines, with women internalising shame and seeking to present as 'functioning' rather than seek help and risk judgment.

It has been identified that the most effective interventions are provided by professionals who are well qualified (Barlow et al., 2010). In response to perpetual calls for the integration of findings from psychology into benefits to society, it is hoped that this small-scale study will encourage all those who support perinatal women, to engage with the wealth of cross disciplinary literature addressing the depth and complexity of issues faced by a possible majority of mothers in the time of transition with a new baby. In line with emerging provision of specialist perinatal mental health services, personnel may be sought and recruited from within generic psychology, and other mental health services, that may lack the specialist awareness and training of the traditional and accepted professions within the field. The clinical objective is often to 'cure' symptoms, or resolve issues which may be more complex than will be likely to yield to imposed or generic solutions imposed by brief interventions. A more positive alternative to the current situation would be to encourage a greater generally informed awareness, and more sensitive approaches, by any in a position to walk alongside women during this time of transition. Awareness raising within all services in contact with perinatal women, such as

GP surgeries, children's centres, and IAPT and secondary care mental health services, would address the fragmentary nature of knowledge bases, and better inform the contact and continuity of reception and care offered to women and their families.

There are several factors which are well recognised *within*, but not necessarily *across* specialisms, such as the psychological impact on women and their partners of: traumatic experiences during pregnancy, birth and labour, neonatal intensive care requirements that separate mothers from babies, difficulties with breastfeeding, and sleep deprivation. Meanwhile the importance of social and peer support for new mothers is the single most significant factor whilst increasingly new mothers are struggling in isolation.

The findings from this study echo those of many previous works concluding that prospective parents could be more fully prepared for the challenges inherent in caring for a new baby, via supportive interventions, such as ante- and post-natal groups facilitated by suitably qualified professionals. There are obvious safeguarding issues arising from the potential dialogue which this position is encouraging, as informed and sensitive clinical judgment is required in working with parents in ways which would allow them to express their conflicted emotions, with containment and safety for them, and their babies and families. Practitioner counselling psychologists are amongst those ideally positioned to provide the range of professional, therapeutic and relational tools necessary to develop approaches to tackle issues of this complexity.

Evaluative studies of supportive and clinical intervention are needed in line the the emergent specialist perinatal mental health service provision. A formal evaluation of the Finding Yourself Again groups, as an effective preventative early intervention in women's postnatal psychological wellbeing, offered within the IAPT service in Cornwall, is suggested as a future direction for research.

6. Consideration of researcher reflexivity within a field of enquiry with personal relevance

This section intends to critically consider the impact of myself as a researcher embedded within the social constructivist research process and theory development, and how the process has shaped and continues to inform my development, both professional and personal. The dossier represents the results of an academic and clinical training undertaking which has extended beyond the anticipated three years. The last six years represent for me a somewhat fragmented and disjointed period characterised by times of transition, and this has had consequences for the research process and progress. What follows will chart the research process in experiential terms, both in-, and on-action (Schön, 1983), drawing on personal reflections derived from the research diary and notebooks, and developed during the process of addressing post-viva amendments.

Effective researcher reflexivity has been outlined as pivotal within constructivist GT methods, which offer inherent opportunity to exercise and demonstrate capacity for self-examination of assumption and biases (Hoover & Morrow, 2015; Morrow, 2006). The terms 'reflective practice' and 'reflexivity' are often applied interchangeably, although the latter comprises a highly complex layering and enfolding of reflecting upon experiences, and ways of thinking about experiences, that results in "reflection at several levels or directed at several themes" (Alvesson & Skoldberg, 2009, p. 8). The term, 'researcher reflexivity' requires and implies that the researcher is operating on more than one level, in terms of paying attention to thinking about the thinking involved in interpretation (Maranhão, 1991).

The extent to which an individual is capable to fulfil this obligation is, of course, dependent on degrees of self-awareness and development of reflective capacity. However, complementary to individual capacity, the GT paradigm offers a series of inherently reflexive strategies that underpin the methods to ensure 'groundedness' in prioritising the data above other input and influences (Charmaz, 2006; Ramalho et al., 2015). The constant comparative method is employed as an analytic tool that promotes reflective practice, by which codes, categories and

memos are compared within and between themselves, and eventually against the literature. Another mainstay of the methods, and another analytic tool, the memo writing process, provides an audit trail of thoughts, that may be reflective or descriptive, analytical or questioning, all of which engage reflective thinking, and require further reflexive engagement as the analytical process deepens, and becomes abstracted towards the development of theoretical ideas (Charmaz, 2006; Ramalho et al., 2015). As a novice researcher engaging in this process it was reassuring to experience the process characterised as first “fragmenting the data”, before weaving “the fractured story back together” (Glaser, 1992, p. 72).

As stated earlier, a constructivist approach to the exploration of meanings which emerge from phenomenological experience accords with some personal philosophical affiliations, which have gained depth and resonance throughout training as a counselling psychologist. The selection of a constructivist GT approach complemented awareness of, and interest in, the power and validity of the sense made of experiences as they are incorporated, or not, into life narratives.

An autobiographic element within applied fields of research is often acknowledged, accounting for curiosity arising from observation and lived experience, in addition to a range of other explicit or tacit influences and affiliations (Marshall & Rossman, 1999). A lifespan perspective considers the investigator’s position relative to their own developmental journal and associated tasks, and for this to form part of their acknowledged reflexivity and potential impact on the process (Sugarman, 2010). Accordingly, my own experience includes becoming a mother, almost two decades prior to planning this study, and having a first baby whose sleep patterns reflected those of a breastfed infant. Some post-modern, critical and feminist perspectives have conceptualised the research process as a ‘cycle of enquiry’ located within this subjective, phenomenological context, embedded within the broader societal factors – “larger social forces that shape it” (Crabtree & Miller, 1992, p.11). In framing the research process, the challenge lies in translation from a position which identifies, recognises and acknowledges “casual perturbations” (p.30) hunches, tacit theories, and desire for change or

improvement within a socially observed situation, to one of systematic enquiry which takes account of, but attempts to limit the bias of the researcher (Marshall & Rossman, 1999).

When this research was undertaken my clinical training had not offered any opportunity to work with post-natal mothers as a distinct group, but it is relevant to acknowledge the impact of my own perinatal experiences on my perspective as researcher, and co-constructor of the accounts with participants. My stance is acknowledged as one of broadly recognising and empathising with the experiences of the women, and identifying with some of their specific, and many of their general struggles in the transition to becoming a mother. As a counselling psychologist, I was also interested in developing a clinically holistic view that witnessed their experiences, rather than prioritising any identification of symptoms of mental ill health, sleep problems in their babies, or problematising their reactions to their challenges.

Accounting for my own experiences, as a mother to two children, I felt sleep deprived for several months with my first child, now 20, and this affected my initial transition to motherhood in many ways. Between the births of my two children I also experienced one miscarriage and a pregnancy during which a late diagnosis of foetal abnormality resulted in an induced stillbirth at 33 weeks. These experiences inevitably affect my outlook to some degree when approaching others who are facing challenges and distress, in what is often anticipated as a time of joy and fulfilment. It may be relevant to point out that my own experiences, during the time of transition to motherhood, did not include conscious 'masking' of my difficulties, and so this did not form a major part of my preconceptions when approaching the subject. Indeed, I sought support in my immediate distress, following the late diagnosis, directly from professionals – midwives, GP and health visitor, but to my humiliation, and compounding a sense of isolation, encountered a lack of response - it seemed as if nobody knew what to say. The meaning made was one of my failure to conform within what had been anticipated as a 'low risk' pregnancy – I had dropped out of step with the process, and additionally was completely lacking in awareness, and remained uninformed of the events that were yet to unfold before the unhappy situation was resolved. As an adult, particularly following pregnancy and childbirth, I had increasingly relied upon 'alternative' therapy, in the form of

chiropractic. At this time, I found what seemed surprisingly effective support and treatment via acupuncture which addressed my psychological and emotional wellbeing. I have continued to access acupuncture as a form of maintenance therapy since that time, as a sole source of physical, psychological and emotional 'intervention'. It is relevant to also note that I have some prior interest in and knowledge of McTimoney chiropractic – the treatment offered by the paediatric clinic - having completed part of a professional training route several years earlier. I have had positive experiences of treatment personally and have taken my children for treatment as infants and as they have grown older. An affiliation to 'alternative' forms of therapy are therefore evident and acknowledged.

The responsibility for looking after my young son provided the necessary motivation to successfully negotiate this most difficult time, but it has offered much scope for reflection in the decades since, as these were pivotal events in my life. As a result of these experiences, I developed greater awareness of the potential complexities of emotions which took me to the edge of complete despair, incorporating aspects of grief – shock, disbelief, anger, depression, but also shame and humiliation, and some resistance in myself, but more particularly in others, to approach the issues. This lack of capacity and willingness to recognise the issues during my own times of challenge have been echoed, either explicitly in the experiences of friends, acquaintances and clients over the intervening years, or has formed at the edge of my awareness (Gendlin, 1996) in my interactions with women describing their experiences. I am aware that my experiences have had the effect that I take little for granted, and this salutary lesson has underpinned the development of a sense of my own resilience and capacities, that I hope is effective in informing a sense of therapeutic optimism in my clinical work.

During training, a course requirement was that students undergo a minimum of thirty hours of personal therapy in addition to participation in a weekly personal development group and completing associated reflective tasks. Prior to, and during the extent of my doctoral training programme I have undertaken therapy in a range of forms - humanistic, relationship counselling, and Lacanian psychoanalysis, and feel that that engagement with this level of introspection and personal development has facilitated my capacity for self-awareness, and

thereby improved my abilities to reflect effectively on and account for my role as embedded in the research process.

Spending three and a half years gaining clinical experience across a variety of settings including adult learning disabilities, outpatient clinical psychology - secondary care, and children and adolescent services, with several years' prior experience gained in an early intervention psychosis service and an alcohol misuse community counselling team, the work has touched many experiential issues. Working with clients in a secondary care setting offered insights into parenting difficulties which included partner violence arising from infant sleep issues, resulting in one case in supporting a client to self-refer to social services. The range of my clinical exposure, supplemented by life experiences which have included an introduction to parenthood impacted by infant sleeplessness, in addition to other unexpected events, has heightened an awareness of the significance and complexity of periods of transition across the lifespan.

Notwithstanding my own acknowledged lived experience of the issues, I remained naïve from a practitioner perspective during data collection, analysis, writing up and viva examination, having had no experience of working clinically with new mothers at that point. My lack of professional exposure to this group meant that I could become involved in their meaning making unburdened by preconstrued ideas developed through the lens of clinical practice. I approached the task of understanding and accounting for meanings made by others, of their challenging and often distressing experiences with genuine openness and curiosity, which was complementary to, and facilitated by the method that allowed accountability for my part in the meanings made. The degree to which the women shared their sense of being alone, unsupported, and often ashamed of their feelings and reactions was surprising and affecting, made more poignant as the setting was non-therapeutic. Whilst critiquing the development and evolutionary diversification of the methodology, Fassinger (2005) suggested that it offered counselling psychologists unique access to explore issues of "diversity and social justice" (p.157), resonant with the current research project as it highlights an area of often unspoken

and socially challenging distress, despite having been widely explored and represented within specific fields of research enquiry for many decades.

During the time of first submission and resubmission I have been fortunate to be able to work therapeutically with mothers at various stages in the transition, from the first weeks, to three years postpartum, which has offered much opportunity to reflect on both my clinical and academic contributions. My recent clinical work with new mothers ($n = 60+$) attending psychoeducation and therapeutic groups, in addition to individual work, designed to address the needs of those experiencing common psychological and emotional problems of low mood and anxiety, reinforces the assertions (Boots, 2013; Kahn, 2015) that many women continue to suffer in silence whilst 'masking' the extent of their difficulties, in various and often complex journeys to motherhood. It has also made manifest the effects of sleep deprivation, as women sometimes struggle to maintain attention throughout the sessions.

This experience has confirmed much of the understanding gained from the research interviews, and reinforced my sense of the relevance of the development of specialist skills for practitioners working with perinatal women and families. My clinical learning in this field has been largely autodidactic, and without the benefit of knowledgeable colleagues, I have relied on feedback from the women attending groups and one-to-one therapy sessions, in a process that has felt highly collaborative. Requests for sharing of resources and literature has formed part of the process for a high number of women. Women come from a wide demographic range, and have experienced a wide range of events perinatally, but many express very similar concerns. I am struck by their interest, and hunger for both information, but also a framework from which to make sense of their often unanticipated and troubling experiences. I am encouraged by their responses to the theoretical model produced by this study. This feels like important and relevant work, that I feel fortunate to be able to undertake, which may be largely due to a lack of more qualified alternative mental health practitioners. I am grateful for the last year which, whilst challenging, signals the start of a clinical episode within which I feel a renewed enthusiasm for developing specialist skills, but also developing research studies within the primary care provision of perinatal mental health services.

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