DOCTORAL THESIS

Mothers' Experiences of Postpartum Psychosis and Negative Emotions during Breastfeeding

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Thesis Abstract

Objectives: Maternal health and well-being has been studied widely from the angle of postpartum depression and practical aspects of infant feeding. However, two kinds of difficulties, postpartum psychosis (PPP) and negative emotions experienced during breastfeeding, have received significantly less attention in the perinatal research field. Consequently, clinical guidelines and available support are limited for mothers with such experiences. Therefore the main objective of this thesis was to explore how experiences of PPP and negative emotions during breastfeeding influence the way mothers view themselves and their relationships, in order to identify recommendations for clinical practice.

Method: A systematic literature review of 10 studies on PPP and an empirical qualitative study of 11 mothers experiencing negative emotions during breastfeeding were undertaken.

Findings: Across both studies, themes captured how mothers' negative experiences influenced the way they viewed themselves, their relationships with others and how they navigated the mother-child bond and breastfeeding. Mothers also felt disappointed with professionals' lack of knowledge and understanding of their experiences. However, gaining insight into their own difficulties alleviated mothers' distress and enabled them to develop and employ various coping strategies, such as seeking peer support.

Discussion: Discussion of findings highlighted that the psychological nature of difficulties associated with PPP and breastfeeding problems is often given a secondary priority. In contrast, mothers experienced that relationships with others and increased understanding of their experiences was essential to their ability to cope and recover. In light of mothers' disappointment with the care they received, clinical recommendations highlighted the importance of training and raising awareness about less common difficulties that mothers may experience in the perinatal period, which may affect how they feel about themselves and consequently, how well they adapt to the mothering role.

Declaration

This thesis records research activity completed between June 2014 and July 2015 for the Doctorate in Clinical Psychology course at Lancaster University. The work presented in this thesis is my own except where reference to other authors or sources is made. The work has not been submitted for the award of a higher degree elsewhere.

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Marcelina Anna Watkinson

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Section One: Literature Review

Mothers' Experiences of Postpartum Psychosis: A Meta-synthesis

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Abstract

This meta-synthesis sought systematically to review and synthesise qualitative studies on mothers' experiences of postpartum psychosis (PPP). A systematic literature search was carried out across seven electronic databases, resulting in 10 studies being included in the synthesis. The quality of the selected studies was appraised using the Critical Appraisal Skills Programme ([CASP]; Public Health Resource Unit, 2006). Studies were synthesised using Thomas and Harden's (2008) method of *thematic synthesis*. This resulted in the identification of five themes; 'PPP permeating women's experience of self and relationships with others', 'Navigating motherhood in the context of mental health problems', 'Experience of care characterised by lack of knowledge and understanding', 'Overcoming PPP through support from others', and 'Acceptance of losses, increased understanding and recognition of positive changes'. These themes portray PPP as a multifaceted experience that has consequences for mothers' sense of self, their ability to mother, and their relationships, resulting in permanent life changes. Findings also highlighted mothers' disappointment with professionals' lack of knowledge and empathic understanding, which formed a basis for the clinical recommendations suggested, including educating professionals to recognise PPP and to involve families in the intervention.

Mothers' Experiences of Postpartum Psychosis: A Meta-synthesis

The postpartum period has been identified as a time when the risk of developing severe mental health problems is elevated (Valdimarsdottìr, Hultman, Harlow, Cnattingius, & Sparen, 2009). Such mental health problems include unusual sensory and psychological experiences which are often referred to as postpartum/puerperal psychosis (PPP)[1] in research (e.g., Engqvist & Nilsson, 2014; Robertson & Lyons, 2003) as well as in clinical practice guidelines (e.g., in Australia the National Health and Medical Research Council [NHMRC], 2011; and in the UK the National Institute for Health and Excellence [NICE], 2014). Common early signs of PPP have been reported to be feelings of elation and inability to sleep (Heron, McGuinness, Robertson-Blackmore, Craddock, & Jones, 2008), followed by increased activity, rapid speech and mood lability (Brockington et al., 1981). Other observed behaviours and reported experiences include delusions (e.g., religious or persecutory), hallucinations and behavioural/cognitive disorganisation (Heron et al., 2008).

PPP is reported to affect 1-2 % of mothers in the postpartum period (Harlow et al., 2007). The experiences associated with PPP may emerge suddenly, frequently a few days or weeks after delivery (Harlow et al., 2007; Heron et al., 2008). For example, a population based study of 745,596 first-time mothers found that there was a significant peak in the emergence of PPP in the first seven days following labour, even in mothers with no history of mental health problems (Valdimarsdottìr et al., 2009).

Experiences associated with PPP may have serious immediate consequences (Patrick & O'Keane, 2007) as PPP is associated with 5% suicide risk and 4% rate for infanticide (Bennett, 2009). Currently, clinical guidelines state that inpatient admission may be required for mothers experiencing PPP (NHMRC, 2011; NICE, 2014) and management by a

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[1] The terms puerperal/postpartum psychosis (PPP) do not reflect the researcher's view of diagnosis. However, because these are the terms that are largely used in the literature, they will be used in this meta-synthesis also.

psychiatrist may be necessary (NHMRC, 2011). In addition to immediate risks associated with the experience of PPP, there may also be long-term implications for the mother who experiences PPP and her family (Robertson & Lyons, 2003). This can include a sense of grief or loss of an unmet expectation of new motherhood, especially when experiences associated with PPP have lasted a long time (Twomey, 2009).

Studies on PPP have focused mainly on the aetiology and nosology of PPP (Sit, Rotschild, & Wisner, 2006) including clinical symptoms (Heron et al., 2008), course of PPP, causes and risk factors (Valdimarsdottìr et al., 2009). Such research, perhaps unsurprisingly, points to a biological basis for PPP (Doucet, Letourneau, & Robertson-Blackmore, 2012) stating potential causes to be severe hormonal shifts following delivery (Sit et al., 2006). Such literature also links some cases of PPP to a previous history of bipolar disorder (Brockington et al., 1981; Patrick & O'Keane, 2007; Sit et al., 2006) and an increased risk of recurrence in subsequent births (Bennett, 2009).

Quantitative reviews on PPP have outlined the available interventions, which currently include mainly pharmacological management of experiences associated psychosis, mania or depression (Jones & Smith, 2009). This could include offering antidepressant, antipsychotic or stabilising medication (NICE, 2014). However, a review by Sit et al. (2006) emphasised the need to consider the consequences that severe mental health problems may have on the mother-infant relationship and subsequent development of the child. Although clinical guidelines have more recently begun to provide broader advice regarding managing perinatal mental health difficulties, not limited to postnatal depression (PND), they highlight the absence of evidence of assessment and psychological interventions for mothers with PPP (NHMRC, 2011; NICE, 2014; Scottish Intercollegiate Guidelines Network [SIGN], 2012).

Quantitative research in the area of PPP has generated a number of findings that broaden the knowledgebase in this field and offers avenues for future research. However, existing quantitative studies have not been able to explore the idiosyncratic nature of mothers' experiences of PPP and the needs arising from such experiences. Thus, in the past decade a number of qualitative empirical studies have been conducted, investigating mothers' experiences of PPP. By using an idiographic mode of inquiry, highlighting each individual perspective as important and employing a flexible approach to data collection (e.g., Smith, Flowers, & Larkin, 2009), qualitative studies can offer useful insights about how individuals make sense of their experiences (Harper, 2012; Thompson & Harper, 2012). This, in turn, may offer new information that can inform policies and clinical guidelines (Sofaer, 1999), such as including mothers' preferences regarding management of PPP. Existing qualitative studies on PPP have highlighted mothers' disappointment with services (Engqvist, Ferszt, Åhlin, & Nilsson, 2011), researchers' limited knowledge (Posmontier & Fisher, 2014) and health-care professionals' limited understanding of PPP (Robertson & Lyons, 2003).

Despite the growing body of qualitative studies on mothers' experiences of PPP, research suggests that single qualitative studies may not have the ability to influence practice guidelines or generate policies in a given field, thus synthesising such studies enables clinical application of their content (Britten et al., 2002). Consequently, a meta-synthesis of qualitative studies on mothers' experiences of PPP may be relevant for two main reasons. Firstly, current understanding of mothers' experiences of PPP is limited and a number of studies have focused on one particular aspect of PPP, such as recovery. A meta-synthesis may provide a more coherent picture of an area of study by using a transparent, systematic approach (Malouf, 2012), highlighting commonalities across a range of studies and making findings better accessible to the target audience (Lucas, Baird, Arai, Law, & Roberts, 2007).

This may be particularly relevant to novel and complex fields where the knowledge base is limited (Fossey, Harvey, McDermott, & Davidson, 2002; Smith & Osborn, 2008).

Secondly, policy and practice guidelines related to the interventions offered to mothers with PPP are limited. By systematically synthesising data from qualitative studies, findings from those studies may become better available for clinical application by health care professionals (Thomas & Harden, 2008) and may contribute to the generation of policy and clinical practice guidelines (Barnett-Page & Thomas, 2009; Britten et al., 2002; Walsh & Downe, 2005). For example, the perinatal NHMRC (2014) guidelines have been developed based on a systematic literature review (SLR) which included qualitative studies in their methodology, particularly when identifying barriers that mothers perceived in relation to overcoming mental health problems.

Thus, the main aim of the present review was to synthesise qualitative studies exploring mothers' experiences of PPP. A secondary aim was to identify suggestions for clinical practice and research, in light of existing guidelines and research on perinatal mental health difficulties. More specifically, the research question for this meta-synthesis was: How do mothers experience and make sense of their experiences of PPP?

Methodology

Thomas and Harden's (2008) approach *thematic synthesis* was chosen because it aligned well with the aims of this meta-synthesis, which were to generate suggestions for future research and offer clinical recommendations (Lucas et al., 2007). This approach consists of a number of steps including a literature search, quality assessment, identifying data and performing a three stage synthesis (coding, developing descriptive themes, and developing analytic themes). In contrast to a narrative summary, thematic synthesis aims to produce novel findings which go beyond the combined findings of the original studies included in the synthesis (Barnett-Page & Thomas, 2009; Lucas et al., 2007). This is regarded as a central objective of conducting a meta-synthesis (Thorne et al., 2004).

Literature Search

A systematic search was carried out in November 2014 across seven databases (Academic Search Complete, Adolescent and Child Development Studies, CINAHL, MEDLINE, PsycINFO, PubMed, and Web of Science). Descriptions of each of these databases suggested that they held articles relevant to the current research question. All searches, except for PubMed, were run without restrictions of language, publication date or medium. PubMed searches were restricted to studies published in 2013-2014 because MEDLINE and PubMed draw on the same sources but the latter is more up to date.

A number of searches were performed in order to formulate, check and refine the search strategy. The thesaurus linked to PsycINFO was utilised to identify relevant synonyms for search terms (e.g., “experience”). Please see Appendix 1-B for a breakdown of the final searches. The following search terms were combined:

- Mother* OR women* OR maternal
- Experience OR perception OR perspective OR perceive OR view OR attitude OR belie*
- “Postnatal psychosis” OR “postpartum psychosis” OR “perinatal psychosis” OR “puerperal psychosis”

The final searches returned 293 studies which were reviewed in relation to the following inclusion/exclusion criteria. Firstly, studies had to report, fully or partially, on mothers’ experiences of PPP. Although PPP does not have a separate entry in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V; Bergink, Boyce &

Munk-Olsen, 2015), a mother may be diagnosed with PPP if she meets criteria for e.g., bipolar disorder, major depressive disorder, schizoaffective disorder with postpartum onset (Engqvist et al., 2011). The appropriateness of a distinct diagnosis of PPP has been debated elsewhere (e.g., Boyce & Barriball, 2010; Bergink et al., 2015). However, for the purpose of this study, studies were not excluded if the mothers had not had a formal diagnosis of PPP and were accepted based on mothers' self-reports of having had experiences associated with the description of PPP. Secondly, studies had to report on empirical peer-reviewed studies utilising qualitative methodology in the form of interviews, focus groups or written text. Finally, studies had to be published in English. Studies were excluded if they reported on other perinatal/non-puerperal mental health issues (e.g., non-puerperal psychosis or postnatal depression).

The length of time elapsed since mothers experienced PPP was not used to exclude studies to allow for a sufficient breadth of experiences to be represented. Studies were not excluded on the basis of differing epistemological positions provided that there was a family resemblance in their assumptions, that is, a focus on mothers' lived experiences of PPP.

In total, 10 studies were included in the review. See Figure 1 for a more detailed outline of the selection process.

Insert Figure 1

Key Features of Studies Included in the Meta-synthesis

This meta-synthesis was based on qualitative data from 67 mothers (1-10 in each study) who had originally participated in nine studies, reported across 10 articles (see Table 1). Although two studies (Engqvist & Nilsson, 2013; Engqvist & Nilsson, 2014) used the same participants for both studies, they were both included as they had focused on different aspects of PPP. The participating mothers had experienced PPP between two and 32 years previous to being interviewed and viewed themselves as recovered from PPP at the time when the studies were conducted. For the current meta-synthesis, some studies included mothers who had had a formal diagnosis as stated by a physician, matched psychotic descriptions in line with DSM criteria for psychosis, or self-reported having had the experience and associated intervention.

Insert Table 1

Out of the selected studies, four studies were conducted in the UK (Glover, Jomeen, Urquhart, & Martin, 2014; Heron et al., 2012; McGrath, Peters, Wieck, & Wittkowski, 2013; Robertson & Lyons, 2003), two in Sweden (Engqvist & Nilsson, 2013; Engqvist & Nilsson, 2014), one in the USA (Posmontier & Fisher, 2013), one in USA and Canada (Doucet et al., 2012) and one in Uganda (Nakigudde, Ehnvall, Mirembe, Musisi, & Airaksinen, 2013). One study was carried out using narratives drawn from the Internet and, thus, did not specify location (Engqvist et al., 2011). All studies provided broad research aims related to mothers' experiences of PPP, but focused on somewhat different aspects of this experience. Studies varied in the approaches used including grounded theory, thematic analysis, content analysis, and narratology. For further information about study characteristics, please see Table 2.

Insert Table 2

Quality Appraisal

Once the main studies had been identified for inclusion in the synthesis, each paper was quality appraised with regards to the criteria outlined in the Critical Appraisal Skills Programme ([CASP]; Public Health Resource Unit, 2006). The CASP is a tool for appraising the reporting quality of research and has been used in other recent systematic reviews (e.g., Murray & Forshaw, 2013). The CASP checklist focuses on the quality of a study's reported aims and design, appropriate sampling and methods of data collection and analysis. In addition, it considers researcher reflexivity, reporting of findings and overall value of these findings.

The first two items on the 10-item CASP scale are regarded as screening questions. These were sufficiently met by all studies. Each study was scored on a three-point-scale on the remaining eight items. A score of 1 indicated that the authors had merely mentioned, or failed to include, the criterion in question. A score of 2 was given on items where authors addressed the criterion, but gave limited discussion or justification for it. Finally, a 3 was awarded on items that had been explicitly discussed and justified. All studies scored between 18 and 22, out of a maximum of 24, and thus, were regarded to be of acceptable quality. Most studies failed to meet fully the criteria for researcher reflexivity and outlining ethical issues. For a summary of the quality assessment, see Table 3.

Insert Table 3

Studies in this meta-synthesis were not excluded on the basis of their quality for two main reasons. Firstly, it was recognised that there is significant variability in the nature of quality appraisal tools and methods as well as the criteria for what constitutes "good" quality research (Sandelowski, Docherty, & Emden, 1997). Secondly, it was noted that even among well-conducted studies certain aspects of methodology or findings may be omitted due to word limit constraints of the journal or “surface mistakes” (Sandelowski et al., 1997, p.368) inherent in the presentation of findings. For example, a study lacking in transparency of the methodological process might nonetheless provide detailed accounts relevant to the study aims (Hannes, 2011).

Studies were quality appraised in order to enable the researcher to weigh and monitor the contributions of studies with higher or lower ratings (Hannes, 2011), a concept that Thomas and Harden (2008) have referred to as “sensitivity analysis” (p.48). This might be of particular relevance in instances where studies of higher and lower quality differ in their findings or when assessing the validity of claims made by lower quality studies, which are unsupported by higher quality studies.

Data Analysis

In line with guidelines by Thomas and Harden (2008), the results sections and relevant sections of the discussion of each study were identified as data. In circumstances where studies included data from mothers experiencing PPP as well as other informants, such as next of kin (Doucet et al., 2012; Engqvist & Nilsson, 2013; Engqvist & Nilsson, 2014; Nakigudde et al., 2013), only data relevant to mothers’ experiences of PPP were coded.

Original studies were imported into NVivo 10, which is a computer software facilitating analysis of large sets of data and may assist in the process of conducting qualitative research in a systematic and rigorous way (Leech & Onwuegbuzie, 2011). The role of NVivo in the current review was to effectively organise data, facilitating the practical aspects of data analysis. However, it is important to highlight that the use of software cannot substitute the manual and interpretive processes inherent in coding of the data, and the generation of final themes (Fossey et al., 2002).

The analysis process involved several stages including coding of the data, grouping codes into *descriptive themes,* and the development of *analytic themes*. However, the nature of analysing data is an iterative process that requires moving between stages as appropriate (Braun & Clarke, 2006; Howitt, 2010). In line with Thomas and Harden's (2008) approach any text relating to participating mothers' lived experiences of PPP was regarded as data. This included the relevant sections of the results and discussion of each original article. Firstly, sections that were regarded as data were read to allow familiarisation with their content. Secondly, the relevant words or sentences were captured in a code, using descriptions that closely reflected the original content. Some sentences were repeatedly coded if their content fit well into several categories. This process generated 1,113 initial codes. Thirdly, codes were considered in terms of their similarities and differences and grouped into 11 descriptive themes.

Finally, descriptive themes were considered in relation to the research aims and analytic themes identified by the researcher. For example, initial codes and descriptive themes provided the researcher with a set of descriptions of mothers' experiences of PPP. The step of generating analytic themes, however, required going beyond the initial descriptive themes. In this final step, the content of the descriptive themes was used to infer challenges and facilitators of mothers' experiences of going through PPP. See Appendix 1-C for a worked example of the development of one of the main themes.

In a qualitative synthesis the final stage of data analysis is one where the researcher's own preconceptions are most likely to influence the inferences and judgements that are being made about the data (Thomas & Harden, 2008). Thus, in order to ensure rigour the researcher's own preconceptions and experiences of motherhood were acknowledged and bracketed off in order to ensure that the analysis was data driven. However, it is worth acknowledging that an element of interpretation is always present when conducting qualitative research (Smith, Flowers, & Larkin, 2009). Transparency was achieved by detailing the methodology and development of themes across studies in a worked example (see Appendix 1-D).

Findings

Data analysis generated five main themes capturing mothers' experiences of PPP, namely 'PPP permeating women's experience of self and relationships with others', 'Navigating motherhood in the context of mental health problems', 'Experience of care characterised by lack of knowledge and understanding', 'Overcoming PPP through support from others', and 'Acceptance of losses, increased understanding and recognition of positive changes'. These themes captured how the experience of PPP was strongly influenced by personal and professionals relationships. See Figure 2 for a visual representation of how themes were related. Although all studies were judged to be of adequate quality, results from studies that were appraised to be of somewhat lower reporting quality (Doucet et al., 2012; Engqvist & Nilsson, 2014; Glover et al., 2014; Heron et al., 2012) were, where possible, cited together with other studies to increase the rigour of their findings. One study (Nakigudde, et al., 2013) was carried out in Uganda in a cultural context differing significantly from the other studies. Thus, findings from this study were interpreted cautiously.

Insert Figure 2

Theme 1: PPP Permeating Women's Experience of Self and Relationships with Others

Mothers described how PPP pervaded every aspect of their experience of self, both in terms of understanding self and seeing self in relationships with others. The onset of PPP was sudden and unexpected (Engqvist et al., 2011; Heron et al., 2012), associated with the biological aspects of childbirth (Nakigudde, et al., 2013) and mothers referred to the experience as “trauma” (Heron et al., 2012, p. 162). Mothers reported episodes of distressing beliefs, hallucinations and delusions (Engqvist et al., 2011). One mother reported: “I just woke up and thought that someone had taken my brain out and I was trying to explain it to [husband] that someone had sawn off my head to get my brain and put someone else’s in and I didn’t know me anymore” (Glover et al., 2014, p. 260). Mothers reported confusing cognitions, memory loss and disorientation and experienced the world as distorted and unreal (Robertson & Lyons, 2003). They spoke of feeling “messy inside” (Engqvist & Nilsson, 2013, p. 84), as if their “mind was erasing things” (Posmontier & Fisher, 2013, p. 172) and were unable to comprehend or prevent their own thoughts (Engqvist & Nilsson, 2013; Glover et al., 2014; Posmontier & Fisher, 2013).

Two studies (Doucet et al., 2014; Engqvist et al., 2011) also reported mothers’ experiences of mania as part of their experiences of PPP, including feelings of elation, racing thoughts and positive delusions:

> I was filled with love and light. I felt that I had been invited to a party in my honour at Buckingham Palace. I rummaged through my wardrobe to find something suitable to wear, selected a straw hat with a pink ostrich feather, lace gloves and a size eight two-piece suit. (Engqvist et al., 2011, p. 381)

However, for a number of mothers, severe depression followed experiences of mania or psychosis, at which time their world was experienced as a dark existence (Engqvist & Nilsson, 2013). Mothers described acts of self-harm and suicidal attempts (Posmontier & Fisher, 2013) and for some it was the only solution they could imagine: “I didn’t want to kill myself because I didn’t want to live, but because I wanted to get away from feeling this way” (Engqvist & Nilsson, 2013, p. 87).

The experience of PPP had negative consequences for mothers’ personal and professional relationships. Mothers described uncontrollable paranoid beliefs and suspicions towards others (Engqvist & Nilsson, 2013), including beliefs that conversations were being taped, that staff and family colluded to kill them (Posmontier & Fisher, 2013), or that staff were keeping the baby away from them (Engqvist et al., 2011). Such beliefs not only created confusion about the intentions of others (Engqvist et al., 2011) but also put strain on spousal relationships in terms of stresses, anxieties and breach of trust associated with PPP (Heron et al., 2012).

> For in my paranoia I was certain that my husband (who really is one of the world's greatest men and husbands) was out to get me. I thought he wanted to divorce me and take our child. I thought he was probably sabotaging our efforts to get help. This man, who I trust more than anyone in the world, I felt I could not trust. (Engqvist et al., 2011, p. 383)

Mothers described experiencing a sense of guilt for burdening and worrying their families (Engqvist et al., 2011; Heron et al., 2012; Robertson & Lyons, 2003), while also talking about how others’ unawareness downplayed the level of support that mothers needed:

> I was told the classic line – you should be happy, you have a baby. Or I had the baby blues, I completely understand what you are going through. They mean well, but it makes you feel worse. (Doucet et al., 2012, p. 241)

In summary, mothers highlighted the all-encompassing nature of PPP which affected their internal and interpersonal worlds. This included altered perception and emotional life as well as strained relationships with close others.

Theme 2: Navigating Motherhood in the Context of Mental Health Problems

Mothers spoke of negotiating the tasks, demands and expectations of mothering at a time of being strongly influenced by an altered perception of themselves, others and the world. Although mothers' experiences of pregnancy and labour varied, many expressed a mismatch of expectations of the experiences of PPP that followed in the period shortly following giving birth: "It's such a shock and at the time that you were expecting to be such a wonderful time" (Heron et al., 2012, p. 157).

Upon embarking on the task of motherhood mothers found that many of their natural protective mothering responses were amplified by influence of PPP, such as being extremely protective of their infants (Engqvist et al., 2011). Some even struggled to trust themselves with the infant (Engqvist & Nilsson, 2013) and reported having thoughts or delusions around accidentally (Glover et al., 2014; Posmontier & Fisher, 2013) or deliberately harming their infants (Engqvist et al., 2011; Engqvist & Nilsson, 2013).

> I was carrying my baby past the top of the stairs when I got an incredible urge to throw her down the stairs. I was appalled that I could have such an awful thought. (Engqvist et al., 2011, p. 382)

Mothers reported lacking in strength, ability or desire to care for or interact with their babies, and described low confidence in taking on the mothering role (Engqvist et al., 2011). Some mothers reported questioning whether the baby was theirs (Engqvist & Nilsson, 2014), not wanting the baby and not wanting to mother:

> When I saw a couple together without children, I just broke down in despair because I wanted to recapture our time together, just the two of us. I wanted my life back. I could not see myself as a mother; the word mother was a dirty word to me. (Engqvist & Nilsson, 2013, p. 85)

In several studies mothers worried about long-term developmental consequences of PPP for their children (Heron et al., 2012; McGrath et al., 2013). They reported guilt and shame around not meeting expectations of motherhood, for example, in their inability to put their baby's needs first (Robertson & Lyons, 2003). Mothers spoke of evaluating their ability to mother in comparison to societal ideals, according to which "new motherhood… does not allow for a mental illness" (Glover et al., 2014, p. 261). Indeed, other people's lack of understanding exacerbated mothers' sense of shame and guilt, especially in response to comments that indicated that PPP was a choice that mothers had made:

> Pull yourself together; she's [mother in law] that sort of brigade. Pull yourself together don't you think I wasn't depressed but in 1960 we didn't allow that. Yes snap out of it. If I heard that once, I heard it a hundred times. (Glover et al., 2014, p. 261)

In summary, this theme captured women's attempts to develop an identity as mothers in the context of conflicting expectations and an altered perception of the world.

Theme 3: Experience of Care Characterised by Lack of Knowledge and Understanding

Across studies women highlighted disappointment with the quality of care that they received as it fell short of their needs and expectations. Mothers' experiences of hospitalisation were described as stressful (Engqvist et al., 2011), lonely and isolating (Doucet et al., 2012; Engqvist et al., 2011; Posmontier & Fisher, 2013). The lack of desired care amplified mothers' sense of isolation (Posmontier & Fisher, 2013; Robertson & Lyons, 2003) and a sense of not being seen or heard was recurrent in their accounts (Heron et al., 2012; Posmontier & Fisher, 2011).

> When I was really bad soon after I had the diagnosis, it was just something that was…um…avoided, yeah. They wouldn't ask me how I was. It's like the whole stigma of mental illness mustn't be talked about. (McGrath et al., 2013, p. 349)

Mothers regarded PPP as “a separate form of illness” (Robertson & Lyons, 2003, p. 418), and those who were cared for on a general psychiatric ward reported feeling that they did not belong there (Doucet et al., 2012). Mothers who were admitted without their babies described that the separation from their baby impeded recovery and amplified their sense of not being adequate mothers (Heron et al., 2012), particularly when feeling ill prepared for taking the mother role upon discharge (Engqvist & Nilsson, 2013; Posmontier & Fisher, 2013):

> The transition from 24-hour-care for eight weeks to suddenly having nothing really, other than my husband’s bit of time off work, but being self dependent again was for me, the hardest part of those six months after coming out. (Heron et al., 2012, p. 160)

One frequently cited aspect of the hospital stay was professionals’ lack of knowledge (Engqvist et al., 2011) about PPP and lack of information provided to the mothers and their families (Engqvist et al., 2011; Nakigudde et al., 2013). “You have no idea what’s going on, what’s real and what’s not, but when the doctors don’t appear to know either that’s really scary particularly when they’re supposed to make you better” (Robertson & Lyons, 2003, p. 419). A sense of frustration regarding a lack of information on PPP was commonly conveyed: “Had somebody sat down and said: ‘You’ve got this. You’re going here. We’re going to do this, that and the other. You’ll be alright’, maybe it wouldn’t have been so bad” (Heron et al., 2012, p. 161).

Mothers described a conflicting dependency on professionals, including struggles to trust them (Engqvist et al., 2011), perceiving them as the enemy (McGrath et al., 2013) and feeling like they had no control over treatment (McGrath et al., 2013; Posmontier & Fisher, 2013). However, the reliance on professionals for information was emphasised (Heron et al., 2012) and professional involvement was viewed as essential to recovery (Engqvist & Nilsson, 2014; Nakigudde et al., 2013).

Although most mothers' accounts of their hospital stay were negative, a small number of mothers were able to report positive experiences of care (Engqvist et al., 2011) and positive empathetic moments of interactions with care staff: "It was incredibly comforting and nice to have someone sitting in my room when I had gone to bed. I had a feeling they really cared for me" (Engqvist et al., 2011, p. 384).

Following discharge, however, mothers described a lack of continuity between hospital services and community support (Doucet et al., 2012) and a continued lack of knowledge amongst health professionals (Heron et al., 2012). Community support was often limited, both in terms of availability, such as long waiting lists, but also due to lack of knowledge about available services (Doucet et al., 2012). For some mothers financial barriers made it difficult to access services or adhere to pharmacological treatment (Nakigudde et al., 2013).

However, positive aspects of community care were also noted amongst the mothers, including input from social services (Engqvist & Nilsson, 2014), community nurses (Heron et al., 2012) and mental health professionals:

> [The psychologist] just gave me time to cry and be upset and talk about all these worries. And with CBT, which is a sort of talking treatment, he helped me to find different ways into that negative cycle of worries. (Heron et al., 2012 p. 159)

In summary, with the exception of a few women's positive care experiences, there was an overall disappointment with in and outpatient services reported across studies. Mothers highlighted shortcomings in their care relating to professionals' knowledge, levels of empathy understanding and continuity of care beyond the hospital setting.

Theme 4: Overcoming PPP through Support from Others

Mothers related a diverse set of events and time points from which they began to experience positive improvements. Turning points included making decisions in line with values, such as good mothering (Engqvist & Nilsson, 2014), or not allowing self to dwell on worries associated with PPP: “I often say to my children that you really make your own decisions and you have to decide yourself how much of this is allowed to affect you. What do I do with this experience now - today?” (Engqvist & Nilsson, 2014, p. 10). Mothers reported discovering increased strength (Robertson & Lyons, 2003), hope (McGrath et al., 2013) and resilience (McGrath et al., 2013) that eventually led to the desire to return to their old self (Engqvist & Nilsson, 2014; Robertson & Lyons, 2003), to mother (Engqvist & Nilsson, 2014) and to socialise:

> …it was these mothers that I started to meet with too. We did not talk much about what we had been through, but we did things together. We had coffee, we went on excursions, and we barbecued hot dogs outside and so. It was very nice to get out and do things together. (Engqvist & Nilsson, 2014, p. 11)

Mothers’ ability to overcome PPP was dependent on a context of social relationships that made recovery possible. With time, they learned to delegate tasks (Engqvist & Nilsson, 2014) and accept help with daily chores (Heron et al., 2012; Doucet et al., 2012), self-care (Doucet et al., 2012) and child-care (Heron et al., 2012; Posmontier & Fisher, 2013; Robertson & Lyons, 2003).

Other people also played a significant role in mothers’ recovery (Glover et al., 2014), specifically other women who had been through a similar experience. Such exchanges provided a normalising function (Doucet et al., 2012; Heron et al., 2012), offered an opportunity to make sense of their own recovery trajectory (Robertson & Lyons, 2003) and sparked hope that recovery was possible (Doucet et al., 2012).

> So other people just, walking the journey with you and kind of saying ’I’ve done it too, I know how you feel’ and also you know, just to encourage you from the years ahead of you that they are, is really, really valuable. (Heron et al., 2012, p. 159)

Gaining a better understanding of the PPP experience allowed mothers to become better aware of their own needs (Heron et al., 2012), to recognise the need for compromise and revising expectations (McGrath et al., 2013).

> I used to be really career orientated. I wanted to do well, I wanted to be [top of profession]. Now I don’t have…you know, maybe I will when he’s older. I don’t have any inclination to do that now. (McGrath et al., 2013, p. 349)

By adjusting expectations and using various strategies to control symptoms or prevent relapse mothers became active participants in their own recovery (McGrath et al., 2013). This included getting rest and solitude (Engqvist & Nilsson, 2014), setting and monitoring goals (Heron et al., 2012) and actively making changes (Heron et al., 2012).

> I felt quite isolated at times… I was so desperate to come back up here… So we moved house, we got married and I tried to go back [laughs] to work… I knew as soon as I went back to work that I wasn’t well enough to be there.” (McGrath et al., 2013, p. 351)

However, it was acknowledged that the ability to make certain changes was linked to environmental context, such as the setting in which care was provided (Heron et al., 2012), religious beliefs (Posmontier & Fisher, 2013) and socioeconomic factors: “We are sometimes not able to come back for medication because we lack the money for transportation to Butabika” (Nakigudde, et al., 2013, p. 139).

In summary, the presence of supportive others was emphasised as an essential factor in getting better, allowing mothers to set realistic goals and expectations and taking ownership of their recovery.

Theme 5: Acceptance of Losses, Increased Understanding and Recognition of Positive Changes

Mothers highlighted how overcoming PPP was a complex task (Engqvist & Nilsson, 2014), requiring changes to various aspects of their lives, not merely reducing symptoms (Heron et al., 2012). For a number of mothers recovery was regarded as constantly ongoing (McGrath et al., 2013), which was at odds with some mothers' expectations of the process.

> Once I was out of hospital, and the really delusional bit had gone, I thought 'I'm out of the woods' you know…'yeah it's all going to be fine', and then actually the depression afterwards, the deep, deep depression afterwards, was just such a blow, such a double whammy. (Heron et al., 2012, p. 162)

Indeed, recovery was not smooth and linear (Heron et al., 2012; McGrath et al, 2013) but rather a process of progress and setbacks, which for some mothers included readmissions or subsequent hospitalisations for psychosis or depression (Engqvist & Nilsson, 2014).

For many mothers medication was seen as an essential means to recovery (Engqvist & Nilsson, 2014; Heron et al., 2012). However, some mothers expressed mixed feelings about medication use as it was seen as a "passive route to recovery" (Heron et al., 2012, p. 159). In addition, medication side effects often imposed limitations on mothers' daily functioning (Doucet et al., 2012; Engqvist & Nilsson, 2014):

> The psychiatrist was a young guy not understanding that we had needs as a family. My husband really needed me to be awake enough to get my baby dressed and you know, do that kind of stuff. (Heron et al., 2012, p. 159)

One aspect of recovery, inherent in the process of making sense of experiences, was acceptance of losses and permanent changes that had been brought about by PPP (McGrath et al., 2013). Several studies reported mothers' sense of loss following PPP, including loss of dignity and independence (Heron et al., 2012), loss of value in society (Heron et al., 2012), and loss of employment (Nakigudde et al., 2013). In addition, mothers described losses associated with parenting, such as missing out on early motherhood (Engqvist & Nilsson, 2014; Heron et al., 2012; Robertson & Lyons, 2003) and the choice of not having any more children (McGrath et al., 2013; Robertson & Lyons, 2003). Mothers also reported second-guessing their private experiences of emotions and even normal fluctuations in mood were viewed as relapse by others and by the mothers themselves:

> You can have an off day and think you're really ill again but you're not, you're just having an off day, it took about two years to realize they were normal highs and lows, other people have them but it's like you can't have normal ups and downs.
> (Robertson & Lyons, 2003, p. 420)

However, losses associated with PPP also coexisted alongside positive consequences and changes brought about by the experience. Mothers' accounts indicated that they had used positive outcomes and newly acquired personality traits following PPP and incorporated these into a new sense of self (McGrath et al., 2013), which made it easier to accept their experiences (Heron et al., 2012). "I truly believe now, everything we go through can be used for good" (McGrath et al., 2013, p. 347). Mothers spoke of increased strength (Posmontier & Fisher, 2013), increased self-awareness, and increased confidence to make desired life changes (Robertson & Lyons, 2003) as well as having acquired a better understanding of mental health problems (Engqvist & Nilsson, 2013).

> I suppose you can sympathize, well empathize with people more because you've

> been there yourself. I think that has made me a better person, I would never have done this work before I was ill but now I feel I have something to offer them, and I want to give something back. (Robertson & Lyons, 2003, p. 424)

In summary, the final theme captured how women went through the process of accepting PPP and the associated losses. Incorporating such experiences into an altered, or improved, sense of self aided the acceptance process.

Discussion

The aim of this meta-synthesis was to synthesise studies on mothers' experiences of PPP and identify clinical recommendations and avenues for future research. The process of data analysis generated five main themes which reflected the experiences of a total of 67 mothers across 10 papers. Findings highlighted the infusing nature of PPP influencing mothers' sense of self, their personal and professional relationships and their ability to meet expectations of motherhood. Findings also portrayed overcoming PPP as a multi-faceted continuous process, including other people as paramount in aiding mothers' understanding and acceptance of experiences.

Parenting in the context of all-permeating PPP experiences gave rise to maternal worries about the potential consequences that PPP may have on the developing infant. This is particularly important because infancy is a time during which foundations for the baby's social and emotional development take place (Chen & Lee, 2013; Fonagy, 2001; Gerhardt, 2004; Liotti & Gilbert, 2010). Severe maternal mental health difficulties at an early stage in the mother-infant relationship may interfere with a mother's ability to adequately care for her infant (NICE, 2014). If a mother's attention is focussed on her own internal states she may be unable to respond sensitively to the needs of her infant (Gerhardt, 2004; Stein et al., 1991). In addition, the inability to meet expectations of motherhood may give rise to a sense of inadequacy and shame (Blegen, Hummelvoll, & Severinsson, 2012), further lowering a mother’s confidence in managing parenting demands (Edwards & Timmons, 2005).

Mothers in this meta-synthesis shared numerous examples of times when PPP had a perceived, or actual, impact on how they were seen or treated by others and how this impeded recovery. Stigmatising responses may lead mothers to conceal their unusual experiences (Edwards & Timmons, 2005; Twomey, 2009), avoid talking openly about their problems (Dolman, Jones, & Howard, 2013) and disconnect from their actual feelings and needs (Blegen et al., 2012) in order to conform to social expectations of motherhood.

Mothers in this study expressed disappointment with services, both with regards to knowledge but also the setting in which they were cared for, echoing findings of Neil, Sanderson and Wieck (2006). Indeed, professionals’ lack of knowledge and understanding may result in reluctance to provide adequate care and support (Ussher, 2011). Research suggests that mothers with PPP should be cared for in an appropriate setting together with their infants, such as a mother and baby unit (NHMRC, 2011). Such facilities offer an opportunity for assessment and monitoring (Gillham & Wittkowski, 2015) while providing care with broad specialist perinatal focus of recovery, such as daily tasks inherent in parenting (Neil et al., 2006).

Mothers viewed empathetic personal and professional exchanges as a significant part of their recovery trajectory. Indeed, a collaborative (NHMRC, 2011; SIGN, 2012) and empathetic approach (Schmied, Beake, Sheehan, McCourt, & Dykes, 2011) to care allows for authentic positive working alliances to be formed between mothers, their support networks and professionals (Butler , Hare, Walker, Wieck & Wittkowski, 2014). This may, in turn, provide a foundation for both psychological therapy (Horvath, 2001; Norcross, 2005) and pharmacological interventions (Berk, Berk, & Castle, 2004) to take place.

Finally, findings highlighted that services failed to appropriately address mothers' needs as they changed over time, including care beyond the hospital setting. Access to support groups for example, may offer individuals opportunities to normalise their lived experiences (Dunn, Hanieh, Roberts, & Powrie, 2012) reduce isolation (Neff, 2003) and constructively deal with life's adversities (Brown, 2010; Cullberg-Weston, 2008). In addition, research suggests that psychological interventions, delivered when the most severe experiences of PPP have subsided (Heron et al., 2012) may provide mothers with an opportunity to share and make sense of their experiences and address maternal concerns around relationships (Wyatt, Murray, Davies, & Jomeen, 2015), while helping mother to incorporate their experiences into their sense of self (Heron et al., 2012; McGrath et al., 2013).

Clinical Recommendations

The following clinical recommendations are suggested based on the current findings.

Firstly, to acknowledge the multifaceted nature of recovery from PPP, services could provide collaborative care that takes into consideration women's needs and women and as mothers. Such care can be offered through mother and baby units where assessment, monitoring and interventions are tailored to consider the mother-infant relationship (Chen & Lee, 2013; Gillham & Wittkowski, 2015; NHMRC, 2011), benefitting both mother and baby.

Secondly, the varying needs associated with recovery from PPP at different time points needs to be reflected in women's care by offering a range of healthcare services at various ends of the healthcare spectrum (SIGN, 2012). This might involve early interventions, such as inpatient admission (NHMRC, 2011), enabling mothers to overcome initial symptoms associated with PPP and later offering psychological interventions (Wyatt et al., 2015) to enable women to regain a sense of self, navigating relationships and mothering (Blegen et al., 2012; Diaz-Caneja & Johnson, 2004).

Limitations

The definition of what constitutes PPP is controversial and debated. Despite the fact that PPP does not have its own entry in diagnostic manuals, it may be diagnosed in response to a number of wide ranging experiences including psychosis, bipolar disorder and delusional depression, provided that they present within 4-6 weeks of childbirth (Bergink, et al., 2015). This may have influenced the findings of this synthesis, such that studies exploring mothers' unusual experiences in the postpartum period not labelled as PPP may have been omitted.

Three of the studies included in the meta-synthesis were written by the same first author and two of those studies were, in fact, one larger study investigating different aspects of PPP. Thus, because a significant part of the data was based on the seven mothers whose interviews were used to write two different articles (Engqvist & Nilsson, 2013; Engqvist & Nilsson, 2014), there was a potential for findings to be weighted towards the understanding of PPP from the perspectives of these seven mothers and the authors of those studies. Where possible claims made by these studies were supported by citations from other studies to increase the rigour of the findings.

Another limitation included lack of an independent rater of a proportion of the studies using the CASP criteria and lack of a formal tool to help with the search. The opinion of another rater may have added to the rigour and triangulation of the outcome of the quality appraisal. The use of formal guidelines for selecting studies may have offered a clearer process of how studies were identified and screened for eligibility and inclusion.

Finally, studies were limited in stating participants' socio-demographic information, such as ethnicity, marital status, number of children and parental age, thus, potentially limiting what populations this research can be generalised to.

Suggestions for Future Research

Existing clinical guidelines on PPP are limited to relatively recent publications in the

UK and Australia (NHMRC, 2011; NICE 2014) and highlight the absence of available routine tools for screening, assessment and management of PPP (NHMRC, 2011; NICE, 2014; SIGN, 2012). The development of such tools may enable early detection of PPP for mothers who are at risk of developing PPP (SIGN, 2012) and enable referrals to the appropriate health care professionals (NHMRC, 2011). Moreover, mothers in this meta-synthesis reported a lack of interventions beyond pharmacological treatment. These findings that have also been emphasised by Wyatt et al. (2015) who provide support for the potential usefulness of psychological therapies for mothers affected by PPP. However, research is needed to evaluate the effectiveness of psychological therapies for mothers experiencing PPP and their families (NHMRC, 2011).

Conclusion

The findings of this meta-synthesis described mothers' experiences of PPP as traumatic and pervading all aspects of their lives. Mothers described a mismatch of expectations of new motherhood and struggled to be the mothers they had anticipated to be. However, perhaps the most important aspect of mothers' accounts was that the PPP experience was exacerbated by lack of knowledge of others, particularly health professionals. Mothers wished for professionals to understand that their experience of PPP was a product of the interplay of biomedical, psychosocial and contextual factors. Current findings emphasise the importance of collaborative, empathetic care that seeks to preserve the connection between mother and baby. In addition, services need to recognise the multifaceted nature of PPP, consider how needs change over time for mothers and their support networks and how best to address those needs in the context of a collaborative and empathetic environment.

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Table 1

Demographic Information of Participants

Study	Sample[3]	Definition of Postpartum Psychosis (PPP)	Time since PPP	Location
Doucet, Letourneau, & Robertson-Blackmore (2012)	9 mothers 8 fathers	Symptoms consistent with PPP according to DSM-IV or diagnosis of PP by physician	10 years or less	USA and Canada
Engqvist, Ferzt, Åhlin, & Nilsson (2011)	10 mothers	Symptoms consistent with PPP according to DSM-III/ DSM-IV-T	Not reported	Unknown due to data being collected anonymously from the Internet.
Engqvist & Nilsson (2013)	7 mothers 2 partners 4 next of kin	Self-report of having experienced and been treated for PPP	7-32 years	Sweden
Engqvist & Nilsson (2014)	7 mothers 2 partners 4 next of kin	Self-report of having experienced and been treated for PPP	7-32 years	Sweden
Glover, Jomeen, Urquhart, & Martin (2014)	7 mothers	At least one diagnosed episode of PPP	10 years or less	United Kingdom

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[3] Note: Only the mothers' experiences were included in the data, however, all participants included in the original studies are presented here for information purposes.

Heron, Gilbert, Dolman, Shah, Beare, Dearden, Muckelroy, Jones, & Ives (2012)	5 mothers	Self-report of having experienced and been treated for PPP	3 - 20 years	United Kingdom
McGrath, Peters, Wiecek, & Wittkowski (2013)	12 mothers	Diagnosis of PPP or manic and/or depressive episode, or any disorder in the schizophrenia category experienced following childbirth	4 months - 23 years	United Kingdom
Nakigudde, Ehnvall, Mirembe, Musisi, & Airaksinen (2013)	6 mothers 6 caregivers 5 psychiatric nurses 2 psychologists	Having been treated for psychotic illness postpartum	Not stated	Not stated
Posmontier & Fisher (2013)	1 mother	Self-report of having experienced and been treated for PPP	2 years	USA
Robertson & Lyons (2003)	10 mothers	Diagnosed and treated for PPP according to DSM-IV criteria	2-10 years	UK

Table 2

Key Features of Studies Selected for the Meta-synthesis

Study	Main Focus	Recruitment	Data collection	Data analysis
Doucet, Letourneau, & Robertson-Blackmore (2012)	The support needs associated with Postpartum Psychosis (PPP)	Via community and hospital agencies providing postnatal services	1:1 semi-structured interviews in person (n=8) or via telephone (n=9)	Thematic Analysis
Engqvist, Ferzt, Åhlin, & Nilsson (2011)	Exploring mothers' experience of PPP	Narratives accessed from the Internet	Narratives selected (n=10) from a larger pool of narratives (n=28)	Cross-case Analysis (between narratives) and Content Analysis (within narratives)
Engqvist & Nilsson (2013)	Experience of the first days of PPP	Snowball Sampling	1:1 semi-structured interviews in a mutually convenient location	Content Analysis
Engqvist & Nilsson (2014)	Exploring the process of recovery from PPP	Snowball Sampling	1:1 semi-structured interviews in a mutually convenient location	Inductive Content Analysis
Glover, Jomeen, Urquhart, & Martin (2014)	Exploring mothers' experiences of PPP	Via specialist psychiatry mother-infant services	Semi-structured interviews	Inductive Thematic Analysis
Heron, Gilbert, Dolman, Shah, Beare, Dearden, Muckelroy, Jones, & Ives (2012)	Experience of, recovery from, and support needs during PPP	Via Action on Postpartum Psychosis (APP) network	Using service user researchers (SURs) to interview each other in a 1:1 setting using a topic guide	Grounded Analytic Induction

McGrath, Peters, Wieck, & Wittkowski (2013)	Support needs during recovery from PPP	Via mother and baby unit; advertisements on Internet/newsletters	1:1 semi-structured open interviews; in person (n=11) or via telephone (n=1)	Grounded Theory
Nakigudde, Ehnvall, Mirembe, Musisi & Airaksinen (2013)	Family psychoeducation regarding PPP	Via mental health facility	Individual interviews	Not stated
Posmontier & Fisher (2013)	Experience of PPP in a religious context	Not stated	1:1 open, semi structured interview	Narratology
Robertson & Lyons (2003)	Experience of living with PPP	Recruited via a newsletter sent to women participating in a larger genetic study	1:1 semi-structured interviews in participants' homes	Grounded Theory

Table 3

Quality Appraisal using the Critical Appraisal Skills Programme (CASP)

Study	**1. Statement of aims**	**2. Appropriate methodology**	**3. Research design**	**4. Recruitment strategy**	**5. Data collection**	**6. Researcher reflexivity**	**7. Ethical issues**	**8. Data analysis**	**9. Results**	**10. Value of findings**	**Total Score**
Doucet et al. (2012)	Yes	Yes	2	3	3	1	2	2	3	2	18
Engqvist et al. (2011)	Yes	Yes	3	3	3	2	3	3	3	2	22
Engqvist & Nilsson (2013)	Yes	Yes	3	3	3	1	2	2	3	3	20
Engqvist & Nilsson (2014)	Yes	Yes	3	3	3	1	2	2	3	2	19
Glover et al. (2014)	Yes	Yes	2	3	3	1	2	2	3	3	19
Heron et al. (2012)	Yes	Yes	2	3	3	2	2	2	3	2	19
McGrath et al. (2013)	Yes	Yes	3	3	3	3	2	2	3	3	22
Nakigudde et al. (2013)	Yes	Yes	3	3	3	1	3	2	2	3	20
Posmontier & Fisher (2013)	Yes	Yes	3	1	3	3	2	3	3	2	20
Robertson & Lyons (2003)	Yes	Yes	3	3	3	1	2	2	3	3	20

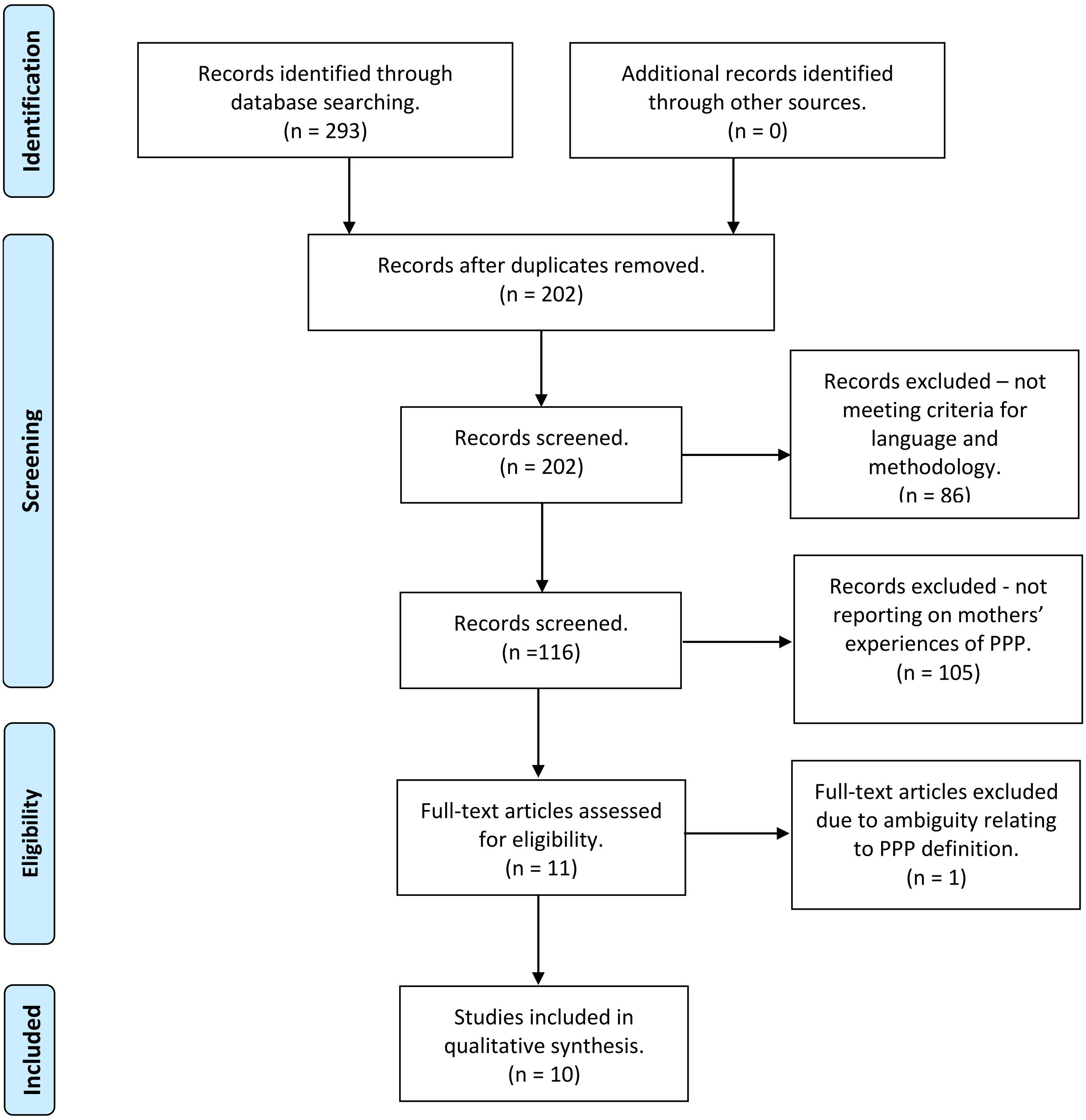

Figure 1. PRISMA flowchart outlining the process of selecting studies for inclusion in the meta-synthesis.

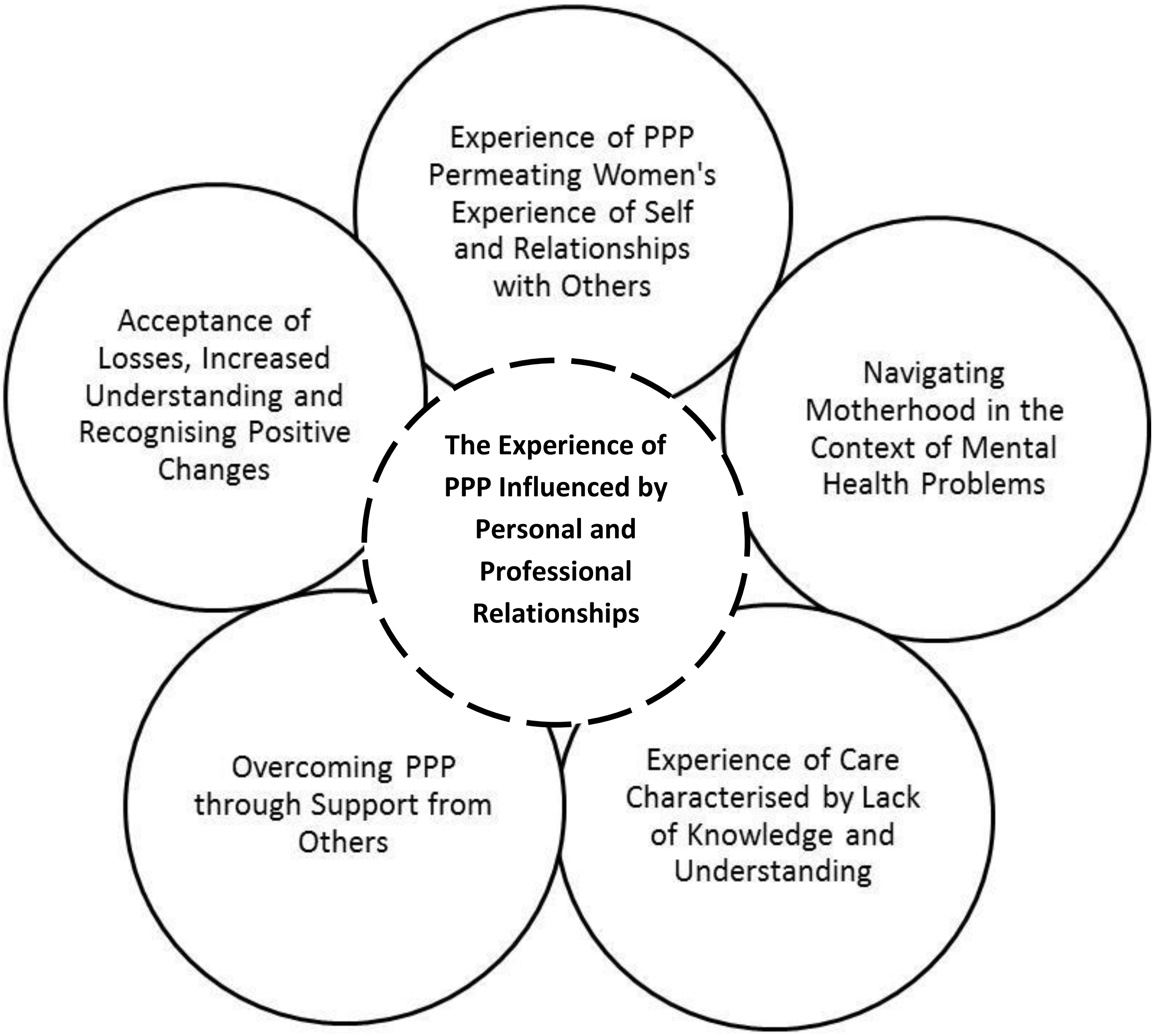

Figure 2. A visual representation of the main themes (solid circles) and how they related to the context of personal and professional relationships (dashed circles).

Appendices

Appendix 1-A: Author Guidelines for Submission to the Infant Mental Health Journal

Author Guidelines

The Infant Mental Health Journal (IMHJ) is the official publication of the World Association for Infant Mental Health (WAIMH) and is copyrighted by the Michigan Association for Infant Mental Health.

Information for Contributors

Reflecting the interdisciplinary nature of the field, its international focus and its commitment to clinical science, the IMHJ publishes research articles, literature reviews, program descriptions/evaluations, clinical studies, and book reviews on infant social–emotional development, caregiver–infant interactions, and contextual and cultural influences on infant and family development. In addition, there is particular interest in neurobiological organization, longitudinal evidence of early preventive-intervention effectiveness, assessment during infancy and early childhood, and those conditions that place infants and/or families at risk for less than optimal development. The Journal is organized into three sections: Research and Prevention/Intervention Studies, Clinical Case Studies and Perspectives, and Book Reviews. The first section on Research and Intervention Studies involves peer reviewed traditional research journal models. However, the Clinical Case Studies and Perspectives section allows for more diversity both in types of submissions and through the peer review process. This increased flexibility provides the opportunity to expand both the interdisciplinary and international scope of the Journal. The Book Review Editor screens books that are received by the Journal and requests a review from an appropriate person. The book reviews are then reviewed by the Book Review Editor and the Journal Editor. The Journal welcomes a broad perspective and scope of inquiry into infant mental health issues and has an interdisciplinary and international group of associate editors, consulting editors and reviewers who participate in the peer review process. In addition to regular submissions to the Journal, the intent is to publish two special issues or sections each year that may be guest edited and which provide an in-depth exploration through a series of papers of an issue that may be of particular interest to the readers of the Journal. The Journal also publishes special sections within an issue that focus on a highly defined topic. Please submit requests for special issues directly to the Editor. MANUSCRIPTS for submission to the *Infant Mental Health Journal* should be forwarded to the Editor as follows:

1. Go to your Internet browser (e.g., Netscape, Internet Explorer).
2. Go to the URL http://mc.manuscriptcentral.com/imhj
3. Register (if you have not done so already).
4. Go to the Author Center and follow the instructions to submit your paper.
5. Please upload the following as separate documents: the title page (with identifying information), the body of your manuscript (containing no identifying information), each table, and each figure.
6. Please note that this journal's workflow is double-blinded. Authors must prepare and submit files for the body of the manuscript that are anonymous for review (containing no name or institutional information that may reveal author identity).
7.All related files will be concatenated automatically into a single .PDF file by the system during upload. This is the file that will be used for review. Please scan your files for viruses before you send them, and keep a copy of what you send in a safe place in case any of the files need to be replaced.

Style must conform to that described by the American Psychological Association *Publication Manual* , Sixth Edition, 2009 (American Psychological Association, 750 First Street, N.E., Washington, D.C. 20002-4242). Authors are responsible for final preparation of manuscripts to conform to the APA style. In addition, authors must provide a statement of conflict of interest that will be published on the title page of the article, as well as an explanation of the contributions each author made to the work described in the submitted paper.

Manuscripts are assigned for peer review by the Editor or Associate Editor(s) and are reviewed by members of the Editorial Board and invited reviewers with special knowledge of the topic addressed in the manuscript. The *Infant Mental Health Journal* requires submissions to conform to the Sixth Edition of the American Psychological Association and its policies on conflict of interest, authorship, and ethical compliance. The Editor retains the right to reject articles that do not meet conventional clinical or scientific ethical standards. Normally, the review process is completed in 3 months. Nearly all manuscripts accepted for publication require some degree of revision. There is no charge for publication of papers in the *Infant Mental Health Journal*. The publisher may levy additional charges for changes in proofs other than correction of printer's errors. Proofs will be sent to the corresponding author and must be read carefully because final responsibility for accuracy rests with the author(s). Author(s) must return corrected proofs to the publisher in a timely manner. If the publisher does not receive corrected proofs from the author(s), publication will still proceed as scheduled.

Appendix 1-B: Breakdown of Search Terms for Each Database

Search terms (26.11.2014)	**Academic Search Complete**	**Child Development and Adolescent Studies**	**CINAHL**	**MEDLINE**	**PsycINFO**	**PubMed (2013/2014)**	**Web of Science**
Mother* OR Women* OR Maternal	1,012,976	37,259	199,803	1,048,143	327,454	125,873	1,074,443
Experience OR perception OR perspective OR perceive OR view OR attitude OR belie*	1,984,096	82,749	275,620	1,368,658	1,318,939	164,130	2,776,702
"Postnatal psychosis" OR "postpartum psychosis" OR "perinatal psychosis" OR "puerperal psychosis"	202	27	87	372	467	105	442
Combined	**42**	**2**	**16**	**42**	**95**	**13**	**83**
Total				**293**			
Duplicates removed				**202**			

Appendix 1-C: The Development of Descriptive and Analytic Themes for Theme 2

	Analytic Theme		
	Theme 2: Navigating motherhood in the context of mental health problems		
	Descriptive Themes		
	Baby alien, inconvenient and frightening	Experiences and expectations during pregnancy and birth	Self as mother in the context of extreme emotions and expectations
	Examples of Initial Codes		
Doucet, Letourneau & Robertson-Blackmore (2012)	Baby inconvenient	-	-
Engqvist, Ferzt, Åhlin & Nilsson (2011)	Baby as Jesus reborn Belief that baby had died Forgetting about baby	Delivery positively anticipated Guilt about failed labour Expectations of labour and delivery shattered	Not letting anyone touch baby Unable to meet baby's needs Tormented by thoughts of harming baby Hospitalisation = irresponsible Mother incapable and baby taken away Feeding baby without connection
Engqvist & Nilsson (2013)	Afraid of baby Child about to eat her Baby from another planet Thoughts of dead baby appearing as pictures	No joy post birth Unwanted pregnancy	No desire to touch or embrace baby Death better than caring for baby Mother dirty word Wall between mother and baby Uncertain if baby was theirs

Engqvist & Nilsson (2014)	-	-	Little interest in baby
Glover, Jomeen, Urquhart & Martin (2014)	In a room with greatest fear Baby seen as devil	Baby unexpected Depression during pregnancy Not involved in labour Labour traumatic	Fear related to well-being or loss of baby Motherhood not allowing for mental illness Expectations from others Fears that others might hear thoughts about baby
Heron, Gilbert, Dolman, Shah, Beare, Dearden, Muckelroy, Jones & Ives (2012)	-	Traumatic not joyful	Stigma impeding disclosure Too depressed to interact with baby Low confidence in taking on mother role Failed at motherhood Fear of doing the wrong things with baby Worries about lack of interaction affecting baby
McGrath, Peters, Wieck & Wittkowski (2013)	-	-	Mismatch of expectations Guilt and shame for failing at motherhood Concealing illness Fear of custody loss Reporting other thoughts than experienced

Nakigudde, Ehnvall, Mirembe Musisi & Airaksinen (2013)	-	-	Illness in breastmilk Baby to develop illness through breastfeeding Breastmilk sour
Posmontier & Fisher (2013)	Childcare seen as jail Baby looking sad	-	Nervous about baby at night Not into baby until 5 months Comparisons to other mothers Detached from infant Hard to feel connection with baby due to self-focus
Robertson & Lyons (2003)	-	-	Unable to put baby first Unable to fulfil maternal role Comparisons to other mothers Affecting baby for life Hospitalisation affecting baby

Appendix 1-D: The Development of Descriptive and Analytic Themes across Studies

Analytic Themes	PPP permeating women's experience of self and relationships with others		Navigating motherhood in the context of mental health problems			Experience of care characterised by lack of knowledge and understanding		Overcoming PPP through support from others		Acceptance of losses, increased understanding and recognition of positive changes	
Descriptive Themes	Experiencing self and reality through the lens of PPP	Relationships strained by uncertainty, breach of trust, and lack of understanding	Baby alien, inconvenient and frightening	Experiences and expectations during pregnancy and birth	Self as mother in the context of extreme emotions and expectations	Hospitalisation characterised by uncertainty, isolation and conflicting dependency	Community services valued despite intermittent availability	Desire to live, mother and return to self as signs of recovery	Overcoming PPP in the context of personal and professional relationships	Overcoming PPP through reflection, use of strategies, and increased understanding	Permanent losses coexisting with positive changes following PPP
Examples of Initial Codes											
Doucet, Letourneau & Robertson-Blackmore (2012)	Out of touch with reality	Paranoia Family members' lack of understanding Outsiders not trusted	Baby inconvenient	-	-	Wanting to remain with infant Isolated during hospital stay Family members not included in treatment	Wanting information from professionals Divide between community and hospital Care not collaborative	Recovery possible Turning point	Needing normalising experiences Family providing practical help Help with self-care	-	-
Engqvist, Ferzt, Åhlin & Nilsson (2011)	Not in control of feelings Deep dark desperate fear Trying to understand if events were real	Not trusting of anyone Staff taking or keeping baby away Burdening families	Baby as Jesus reborn	Guilt about failed labour Expectations of labour and delivery shattered	Unable to meet baby's needs Wishing baby unborn Tormented by thoughts of harming baby	Hospital stay stressful Poor postpartum knowledge at postnatal unit Satisfaction with care	Angry and frustrated with services	-	Help with baby Husband always there	-	-

Engqvist & Nilsson (2013)	Skewed reality Not the person I really am Darkness beyond possibility for improvement Too painful to live	Suspicious Constantly persecuted No control over paranoia	Child about to eat her Baby from another planet Baby as strange person	No joy post birth Unwanted pregnancy	No desire to touch or embrace baby Death better than caring for baby Mother dirty word Thoughts of harming baby	-	Anxiety about going home	-	-	Something happening in brain	Not there for the first months Something positive out of experience
Engqvist & Nilsson (2014)	-	-	-	-	-	-	Support from social services Psychological therapies helpful in recovery Practical professional support helping recovery	Ability to socialise sign of recovery Clear decision to return to life Discovering joy of caring for baby	Help with childcare Family members relieving the burden Home helpers checking in on children	Understanding background to inability to mother her baby Building identity as a mother through therapy Taking time for self during recovery	Greater understanding of mental health awareness
Glover, Jomeen, Urquhart & Martin (2014)	Content of thoughts unbearable Unspeakable thoughts Detachment or unreality following birth	Judgement exacerbating distress Dismissed by personal networks Support not realised in family	In a room with greatest fear Baby seen as devil	Worries during pregnancy Not involved in labour Labour traumatic	Fear related to well-being or loss of baby Motherhood not allowing for mental illness Expectations from others	PPP dismissed due to its rarity	-	-	Support important in journey through PPP	Biological cause protective Unavoidably caused by childbirth Illness feeding on itself	Labelled and judged by society

Heron, Gilbert, Dolman, Shah, Beare, Dearden, Muckelroy, Jones & Ives (2012)	Internal and external worlds changed Affront to identity Shocked by own behaviour	Breach of trust Socially vulnerable Fearing judgement from others	-	Traumatic not joyful	Stigma impeding disclosure Too depressed to interact with baby Low confidence in taking on mother role	Separated from infant Lack of understanding by professionals Feeling unsafe impeded recovery	Transition from hospital to home tough PPP care should involve the wider family Desire for 1 to 1 support after discharge	-	Sharing stories, powerful to recovery Psychological therapy allowing time to share story Family support pivotal to recovery	Context for recovery important Story as means of communication Soliciting information from others	Missing out on early motherhood Loss of dignity and independence Positive personal characteristics following illness
McGrath, Peters, Wieck & Wittkowski (2013)	Symptoms uncontrollable and unpredictable Self vs mentally ill person	Reluctant to share experiences	-	-	Mismatch of expectations Guilt and shame for failing at motherhood Concealing illness Fear of custody loss	Information seeking too costly PPP not talked about Diagnosis unhelpful label	Support from professionals essential Flexibility facilitating recovery Empathic responses and behaviour facilitating recovery	I can do this Turning points markers of recovery More resilient to negative reactions Regaining sense of self	Sharing to help others Quality of relationship important for recovery Recovery facilitated by feedback Others important for own understanding of PPP	Understanding parallel to recovery Increased awareness of needs Re-evaluating expectations Active in recovery process	Permanent changes in self Resigned to some stigma around PPP Positive consequences aided acceptance Using experience for something good
Nakigudde, Ehnvall, Mirembe Musisi & Airaksinen (2013)	Ill only following giving birth	Caregivers don't believe they are truly ill Family thinking that behaviour during illness is intentional	-	-	Illness in breastmilk Baby to develop illness through breastfeeding	-	Wanting family planning advice Breastfeeding to be targeted in psychoeducation	-	-	Ill only following giving birth	Unable to access services due to £££ PPP getting in the way of employment

Posmontier & Fisher (2013)	Disoriented Mind erasing some things Acting crazy	Uncertain of family's intentions Husband seen as police Losing trust with family	Childcare seen as jail	-	Nervous about baby at night Not into baby until 5 months	Unsettled in hospital Professionals not recognising PPP symptoms Warm and caring nurse	Ill prepared for arrival home	-	Husband taking childcare responsibilities Turning to others for support Family playing large role in recovery	Trying to make sense of PPP episode Not responsible for PPP Illness reframed as religious trial	Sad for breaking religious tradition Sadness of missing time with baby Pride of getting through PPP Sense of inner strength
Robertson & Lyons (2003)	Lost identity No control over behaviour Out of touch with reality	Detrimental effect on spousal relationship Friendships affected by PPP Guilt for PPP affecting family	-	-	Unable to put baby first Comparisons to other mothers Affecting baby for life	Treated like other patients with mental illnesses Anger at staying at general ward Treatment isolating	More information meaning less stress and quicker recovery	Regaining confidence during recovery Feeling like self - marker of recovery	Sharing with like-minded gave hope Others normalising experiences Processing by educating others Talking about the illness	Gaining strength from successful use of coping mechanisms Use of humour to process	Life-changing experience Loss of mother role Increased self-awareness Appreciation of relationships

Section Two: Research Paper

Mothers' Experiences of Negative Affect while Breastfeeding: An Interpretative Phenomenological Analysis

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Word Count (excluding tables, references and appendices): 7,999

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Prepared for submission to Qualitative Health Research (see Appendix 2-A for author guidelines).

Abstract

Breastfeeding is promoted worldwide as a method for infant feeding, providing psychological and physiological benefits to both mother and baby. However, the breastfeeding experience has the potential to raise negative emotions during feeding, which may impact on mothers' sense of self and how they relate to their infants. The purpose of this study was to explore mothers' experiences of negative emotions during breastfeeding and to understand the meaning and consequences that such experiences had on mothers' sense of self and the relationships they formed with their children. A qualitative design was applied to this novel field of enquiry. The sample consisted of 11 mothers who reported experiencing or having experienced negative emotions associated with breastfeeding in the past five years. Semi-structured interviews were conducted with the mothers and interviews were transcribed to enable the process of data analysis. Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009) was chosen as a method of data analysis, enabling in depth understanding and interpretation of the meaning of mothers' experiences. IPA was chosen due to its idiographic commitment and particular interest in sense-making, phenomenology and hermeneutics. Through the analysis process, three themes were generated reflecting the multifaceted nature of breastfeeding experiences (i) 'Breastfeeding: An unexpected trigger of intense negative experiences incongruent with view of self', (ii) 'Fulfilling maternal expectations and maintaining closeness with the child', (iii) 'Making sense of breastfeeding distress essential to acceptance and coping'. Discussion of findings highlighted the psychological nature of breastfeeding experiences and clinical recommendations were made, such as offering tailored breastfeeding support based on the meaning that breastfeeding has for each individual mother.

Mothers’ Experiences of Negative Affect while Breastfeeding: An Interpretative Phenomenological Analysis

Breastfeeding is associated with a number of health benefits for both the mother and baby (Murphy, 2000) and has been incorporated in both national (National Institute for Health and Clinical Excellence [NICE], 2008; Department of Health [DoH], 2007) and international (World Health Organization [WHO], 2009) policies on infant feeding. However, alongside providing nutrients and health benefits for the baby, breastfeeding has also been argued to fulfil a number of psychological functions for breastfeeding mothers (Marshall, Godfrey, & Renfrew, 2007). These range from soothing or distracting the infant (Wiessinger, West, & Pitman, 2010), to matters concerned with meeting expectations of motherhood (Hauck & Irurita, 2003) and maternal identity (Huang, Atlas, & Parvez, 2012; Larsen, Hall, & Aagaard, 2008). In addition, the meaning that a mother ascribes to infant rearing practices, such as feeding, will be reinforced by her own mental representation of being mothered and influenced by a range of factors in her previous and current circumstances (Raphael-Leff, 2001).

A commonly cited reason for mothers choosing to breastfeed is that it can serve as a source of bonding between mother and infant (Uvnäs-Moberg, 2009). A longitudinal study including data from 570 mother-infant dyads found that mothers who breastfed reported lower levels of negative emotions and their infants showed higher quality attachment security at 12 months, compared to mothers who bottle fed (Else-Quest, Hyde, & Clark, 2003). One explanation for such findings can be found in literature looking at the role that oxytocin plays in human relationships. The hormonal activity, particularly oxytocin release, occurs in the baby during suckling and in the mother from nipple stimulation and touch (Uvnäs-Moberg, 1998). Oxytocin released from stimulation of the skin has shown to have a soothing and calming effect on both mother and baby (Uvnäs-Moberg, 2009). Furthermore, Strathearn, Fonagy, Amico, and Montague (2009) reported that mothers who had an increased response to oxytocin showed activation of brain regions associated with pleasure and rewards when interacting with their infants. In another study Stuebe, Grewen, and Meltzer-Brody (2013) reported that mothers' elevated anxiety and depression scores during breastfeeding were linked to lower oxytocin levels, which, in turn, may impact on mothers' vulnerability to postnatal depression and breastfeeding difficulties.

Although the above evidence points to psychological benefits of breastfeeding for mothers and babies, a number of mothers do not experience breastfeeding as a calm and soothing experience. For example, early experiences of breastfeeding may include a range of physiological challenges, such as problems with supply, maternal or baby illness, or breast/nipple complications (Hegney, Fallon, & O'Brien, 2008). Such experiences may, understandably, contribute to negative mind-states such as feeling disappointed, overwhelmed and anxious (Kelleher, 2006).

Mothers may also experience negative emotions during feeding in the absence of, or unrelated to, physical problems associated with breastfeeding. For example, while feeding some mothers report strong feelings of irritation, aggression or disgust, not uncommonly displaced onto the nursing infant or child, an experience that is referred to as *breastfeeding/nursing aversion* or *agitation* in breastfeeding communities (Flower, 2003). Such experiences have been discussed on blogs and breastfeeding forums on parenting websites, but with the exception of Flower's (2003) brief outline of breastfeeding aversion, no other published resources, formal or informal, exist to further elaborate on this experience.

Another example of negative feelings during breastfeeding is the experience during which mothers report a marked drop in mood occurring a short period of time before milk release during breastfeeding, following which they experience wide ranging mind states including hopelessness, hollowness, anxiety, shame, dread and even suicidal ideation (Heise, 2011). This set of experiences has been informally referred to as Dysphoric Milk Ejection Reflex (D-MER) in a number of Internet-based breastfeeding communities (Heise, 2011). Heise and Wiessinger (2011) propose D-MER to be distinct from a general dislike of breastfeeding or the experience of postnatal depression (PND). Indeed, PND is associated with persistent experiences of low mood over a substantial period of time (NICE, 2014) and not specifically in relation to feeding. However, PND and negative feelings during feeding may coexist (Heise, 2011).

In contrast to breastfeeding aversion, D-MER has been documented in two case studies independent of each other (Cox, 2010; Heise & Wiessinger, 2011). However, as yet no formal research has been conducted to further explore either of these negative breastfeeding experiences. One reason for this may be that breastfeeding is frequently portrayed as a natural skill and not a competency to be learnt, and thus, omits the difficulties that establishing a breastfeeding relationship may involve (Larsen et al., 2008).

Investigating the experience of negative affect during breastfeeding may have implications for two main reasons. Firstly, a number of studies have shown that mothers' expectations of breastfeeding and expectations of motherhood are reciprocally related (Hauck & Irurita, 2003; Marshall, 2011), like "two sides of the same coin" (Larsen et al., 2008, p.655). When mothers take personal responsibility for breastfeeding to be successful, an inability to meet such expectations can have deleterious consequences for their sense of self (Larsen & Kronborg, 2012; Redshaw & Henderson, 2012).

Secondly, research suggests that mothers, whose expectations around the perinatal period have not been met, are more likely to struggle with postpartum adjustment (Lewis & Nicolson, 1998; Pancer, Pratt, Hunsberger, & Gallant, 2000). For example, a recent study of nearly 14,000 mothers found that breastfeeding significantly reduced the risk of PND for mothers who had planned to breastfeed and successfully managed to do so, whereas mothers who had planned to breastfeed, but had to wean prematurely, were at increased risk of PND (Borra, Iacovou & Sevilla, 2014). Self-focused anxiety and rumination associated with PND (Kleiman & Wenzel, 2011) may compromise a mother's ability to engage responsively and sensitively to her infant's cues (Gerhardt, 2004; Stein et al., 1991). Thus, supporting mothers, who want to breastfeed, to be successful is not only a public health matter (Hausman, Smith & Labbok, 2012), but also a way to support mothers post birth, at a time when many women feel vulnerable in their mothering role (Kleiman & Wenzel, 2009).

Given the above issues, the present study aimed to qualitatively explore the previously under-researched area of mothers' experiences of negative emotions during breastfeeding. For the purpose of this study, *negative emotions during breastfeeding* refer to the marked or sudden emergence of any negative emotions (e.g., sadness, anger or anxiety) associated with milk-release or the breastfeeding act, rather than a reaction to physical problems such as mastitis, painful nipples or issues with milk supply.

Due to the novelty of this research field (Smith & Osborn, 2008) and the purpose of this study being to gain a deeper understanding of individuals' experiences (Harper, 2012; Sofaer, 1999; Thompson & Harper, 2012), a qualitative methodology was deemed the most appropriate approach. More specifically, the research questions were: 'How do women experience negative emotions during breastfeeding?', 'How, if at all, do such experiences influence mothers' well-being and sense of self?' and 'What consequences, if any, do mothers perceive that their experiences have had for the bond between them and their children?'.

Methodology

Design

Due to the nature of the current research questions aiming to gain an in-depth understanding of mothers' experiences of negative emotions during breastfeeding, the study design included semi-structured interviews combined with Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009). IPA was chosen due to its idiographic focus (Shaw, 2010) and particular concern with how individuals experience and make sense of specific experiences (Pietkiewicz & Smith, 2012; Starks & Trinidad, 2014). For this purpose, IPA is often used with small homogenous samples where participants are purposefully chosen to have certain factors or experiences in common (Smith et al., 2009; Smith & Osborn, 2008). In addition, the intersubjective relationship between researcher and participant is a foundation of IPA (Smith, 2007; Smith et al., 2009), where it is explicitly acknowledged that the researcher's understanding and interpretation of the participants' accounts will be viewed through the lens of their own knowledge and experiences (Pezalla, Pettigrew & Miller-Day, 2012). In agreement with a critical realist standpoint, IPA holds that the language that participants use reflects their lived experiences (Smith et al., 2009).

Recruitment and Participants

The criteria for inclusion in the study were mothers who were currently breastfeeding or had done so in the past five years. A five year period was chosen because research suggests that maternal recall of perinatal experiences is accurate as late as 10 years after delivery (Liu, Tuvblad, Li, Raine & Baker, 2013). However, for the purpose of this study five years seemed an appropriate time frame that allowed for the sample to remain homogenous enough to be appropriate for IPA. Further inclusion criteria required that mothers had experienced negative emotions during breastfeeding; that they were able to undertake an interview in English, and that they were located within travelling distance of the researcher or had access to telephone or Skype. Mothers were not excluded if they had experienced mental health difficulties, such as PND. Previous case studies (Cox, 2010; Heise &Wiessinger, 2011) highlight that although negative emotions during breastfeeding may coexist with PND the former difficulties are experienced markedly differently by mothers due to their reported visceral and unexpected nature.

Mothers were recruited worldwide across five online parenting forums, two of which were for parents living in the north-west of England, while the three other communities included members of any nationality and country of residence. Mothers were invited to participate through an online advertisement raising awareness about the study which was posted online in the parenting communities. In total 25 mothers expressed initial interest in participating and were sent an information sheet and expression of interest form (see Ethics Section, Appendix 4-C and 4-D), however, 14 of them were unable to ultimately commit to participating due to time constraints and other life events. The final sample consisted of 11 mothers, a number which was sufficient to explore convergences and divergences across accounts while retaining the idiographic focus of the research (Smith et al., 2009).

Mothers ranged in age from 26 to 36 years (mean age 31). Seven of the mothers had two children, and four mothers had one child. The total length of breastfeeding ranged from 5 months to 48 months (mean length 27 months) at the time of interview and all but two were still breastfeeding. Mothers' nationalities included American, Australian, British, Dutch and Polish and they classed themselves as being of white, mixed or Hispanic origin. All mothers were currently in stable relationships, either married or living with long-term partners who were all the fathers of their children. Mothers reported varying employments, however, the majority of them held professional or higher professional occupations or qualifications. At the time of interview, five mothers were currently not working outside of the home and six mothers were employed one a part-time or full-time basis. Four mothers reported having experienced mental health difficulties such as depression or anger. Please see Table 1 for a summary of participant demographics.

Insert Table 1

Data Collection

Participating mothers were interviewed through various means; four face-to-face, one via phone, and six via Skype. Research has documented benefits of using Skype in contact with participants, allowing participants to remain in their preferred location, overcoming geographical distances and simulating a face-to-face contact (Hanna, 2012; Svensson, Samuelsson, Hellström, & Nolbris, 2014). Thus, such methods were deemed equivalent in terms of the purpose of the interviews which was gaining an understanding of the experiences and meanings that negative emotions during breastfeeding had for mothers. Written consent (see Ethics Section, Appendix 4-E) was obtained for all but one participant (see Ethics Section, Appendix 4-H). In relation to the latter, the relevant ethical committee judged that the verbal consent obtained for the final participant was sufficient. All interviews were conducted at a mutually convenient time and place, factoring in vast time zone differences for those living on other continents. For ten mothers the preferred setting for interview was in their homes, while one mother preferred to meet at a local café.

Data were collected through semi-structured interviews with six broad questions, prompts and probes to encourage conversation around the research aims (see Appendix 2-F). Participants were also asked some demographic questions (see Ethics Section, Appendix 4-F) and interviews, which lasted between 35 and 58 minutes (average 46 minutes), were audio recorded. The interview schedule was developed with the research questions in mind was modified prior to interviews through feedback from supervisors and through the ethical approval process.

Throughout data collection the inter-relational nature of interviewing was acknowledged and its influence on the interview process considered (Ellet, 2011). Although it is not possible, nor congruent with IPA, to fully detach from held theoretical and personal beliefs (Dahlberg, 2006; Probst, 2015; Snelgrove, 2014), such beliefs can be *bracketed* or *bridled* to avoid misleading the research process based solely on such beliefs (Dahlberg, 2006). For the current study, such bracketing/bridling included taking a reflexive stance throughout the process of data collection and write up. The keeping of a reflexive journal allowed for thoughts and feelings to be recorded and reflected on, considering how to best make use of them to benefit the research process (Creswell, 2012; see Appendix 2-F).

Data Analysis

The transcripts were initially analysed independently to retain the idiographic aspects of participants' accounts (Snelgrove, 2014). Each transcript was scanned for information relevant to the research questions. Notations were made, capturing the essence of participants' views, beliefs or experiences, both in terms of descriptions and meanings. Notations took one of three forms: descriptive, linguistic and conceptual. Descriptive comments related to participants' descriptions of experiences (e.g., 'Milk is about affection, love and cuddles'). Linguistic notations considered specifically how participants used language to describe their experiences (e.g., 'Filling *holes* in her son, with breast milk?'). Conceptual notations included more of a broader interpretation of participants' experiences (e.g., 'Breastfeeding to make up for imperfections in the mother-child relationship?'). Appendix 2-B offers another example of initial notations.

Next, notations were grouped into first iteration themes for each participant. For example, the sample notations above became part of the theme ‘Making up for losses in relationship and avoiding the repetition of childhood patterns’. This process was repeated for all transcripts and generated between four and seven first iteration themes for each participant. Please see Appendix 2-C for another example of how themes were derived from an original transcript.

When all transcripts had been individually coded, second iteration themes were developed by considering the similarities and differences between first iteration themes across transcripts. Thus, the above theme ‘Making up for losses in relationship and avoiding the repetition of childhood patterns’ became part of the second iteration theme across participants ‘Breastfeeding to maintain closeness and compensating for losses and parenting choices’. Finally, a similar process took place for the third iteration superordinate themes, where the theme ‘Breastfeeding to maintain closeness and compensating for losses and parenting choices’ became part of the superordinate theme ‘Fulfilling maternal expectations and maintaining closeness with the child’. Appendix 2-D offers an overview of how first, second and third order interpretations were developed, and also which participants contributed to each of the themes. In order to form a cohesive structure of the superordinate themes, they were refined and further interpretations were made throughout the write up stage. For the sake of transparency, an audit trail of the analysis process (Probst, 2015; Snelgrove, 2014) is offered in the appendices (Appendix 2-C and Appendix 2-D).

Ethics

The study was reviewed and approved by the researcher’s host institution ethics process. An ethical issue, concerning obtaining consent for an interview via Skype, was raised with the ethics committee resulting in no further action being deemed necessary.

Appendix 4-H in the Ethics Section offers detailed correspondence with the ethics committee and resolution of this ethical issue.

Findings

The process of data analysis generated three themes: (i) ‘Breastfeeding: An unexpected trigger of intense negative experiences incongruent with view of self’, (ii) ‘Fulfilling maternal expectations and maintaining closeness with the child’, (iii) ‘Making sense of breastfeeding distress essential to acceptance and coping’. Together, the themes contributed to an overarching understanding of how mothers navigated negative emotional experiences in the context of what breastfeeding meant to them. Themes will be outlined below and supported by original quotes[4] from participants[5].

Theme 1: Breastfeeding: An Unexpected Trigger of Intense Negative Experiences Incongruent with View of Self

Breastfeeding was an unexpected trigger of intense negative emotions, thoughts and behaviours that mothers regarded as contrasting with how they viewed themselves and their expectations of their own emotional reactions. For all mothers breastfeeding evoked a strong, negative physical response that they found difficult to comprehend and communicate: “If I try to think about it with my brain, it just doesn’t work, I can’t really put words to it” (Ciara); “I don’t know, it’s almost like it starts like a, it’s this feeling from your breast, I can’t even, ugh, I don’t even know how to describe it, it’s just this thing that you know” (Danielle).

Mothers’ choice of words such as “visceral” (Kate) and “physical reflex” (Donna) also portrayed the nature of the experiences as beyond verbal comprehension. Feelings were

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[4] For clarification, symbols used within participant quotes have the following meaning: Three ellipsis points (…) indicate that some text has been omitted; square brackets [ ] contain the researcher’s words aimed to clarify/contextualise the content; and round parentheses () contain non-verbal communication.

[5] In line with the British Psychological Society’s code of research ethics (BPS, 2010) all real names have been replaced by pseudonyms.

intense, instant and described as “skin crawling” (Leanne), “throat tightening” (Izabella) or “gut wrenching” (Donna). This occurred in association with milk release emerging at all or some feeds, or during the physical act of breastfeeding. Kate’s analogy depicted the all-permeating, bodily nature of the experience: “Every time I’d get let-down [milk release], I would start crying (…) so it was like I got let-down from both”.

The intensity and convincing nature of the feelings, which emerged in contexts that participants could not ascribe as responsible for these feelings, gave rise to mothers second-guessing their emotional experiences:

> It just felt like something terrible just had happened and I needed to cry about it but nothing terrible did happen, so that was kind of hard to place for me as well, because I had, I was just nursing my baby, not experiencing some, eh, tragedy or something, but it felt like that. (Ellen)

Negative emotional experiences characterised by anger or irritation were particularly conflicting for mothers who followed a parenting style that highlighted the importance of following parental instincts and prioritising closeness and attachment between mother and child. During feeding, however, they described not wanting to be near their nursing child: “It’s such a strong feeling of ‘get away from me’” (Cecile) and “it just kind of feels, I don’t know, like, like I never want to be touched again” (Leanne).

When mothers experienced emotions that felt alien to their beliefs and ideals, they separated themselves from them. Negative experiences during breastfeeding were described as “irrational” (Chloe) and “not really feelings of my heart” (Cecile) while at the same time their intensity and power were compelling: “It [the anger] made me do things I don’t want to do” (Ellen). Cecile preserved what she believed were her true feelings by describing her sense of self and her bodily and emotional experience in opposing dualistic terms: [I’m] shocked or surprised that my body could turn on me like that, and turn my emotions on me in ways that (pause) I don’t want them to. It’s kind of overpowering and overwhelming” (Cecile).

Thus, while some mothers coped with their experience by separating their negative emotional experiences from who they were, for others the discovery of such unexpected emotional reactions gave rise to negative evaluations of themselves. This included a sense of “failure” (Renee) and viewing their emotional reactions as flaws inherent in themselves: “I can’t help but sometimes feel like there’s something incredibly wrong with me that my body doesn’t work the way it’s supposed to, that I should be able to breastfeed, breastfeed my son and enjoy it” (Melissa).

Experiences such as those gave rise to mothers’ sense of being defective, which extended into a general sense of being “less immune” (Izabella) to everyday challenges, “doubting self as a mother” (Donna) and perceiving “judgement” (Renee) from others. A number of mothers reported that their experiences also exacerbated existing vulnerabilities. For Kate, breastfeeding intensified her postnatal depression and triggered self-harming urges:

> Everyone says when your milk comes in at a certain point you’re gonna feel baby blues. I was like yeah, you’re not gonna think about slitting your wrists when feeding your child (…) I’m pretty sure that that’s not standard. (Kate)

Mothers’ prior experiences provided an interpretive lens through which they made sense of their current experiences and evaluated how able they were to cope, based on what had happened in the past:

> When I was younger I suffered really big depression so it kind of felt the same and the thoughts that came in to my head were oh my god I’m going to have another

> depression, it’s going to last forever, I’m never going to get better. How can I be a mum when I’m so sick again? And well, it all seemed so dark um, with no light at the end of the tunnel. (Ellen)

When difficulties around breastfeeding compromised mothers’ sense of self they felt overcome by a loss of control. Ellen described her breastfeeding experience as having “gone on a ride and praying for it to stop”, while others responded to this loss of control with anger, further perpetuating a negative sense of self:

> It was just that moment and when the nursing session was done I was so angry at myself [that] I couldn’t control it (…) like I couldn’t believe that I’m a grown woman and I can’t control those feelings. (Danielle)

In summary, for the majority of mothers the unexpected negative breastfeeding experiences created conflicting emotional and cognitive processes in mothers, which led to them separating themselves from their emotions or negatively evaluating themselves as inherently flawed. Negative emotions during breastfeeding provided a lens through which mothers viewed their day-to-day struggles as overwhelming and for some, mimicked existing vulnerabilities like depression.

Theme 2: Fulfilling Maternal Expectations and Maintaining Closeness with the Child

Mothers chose to breastfeed partially due to the documented physical health benefits and immunity that breastmilk provided to their babies. In addition, all but one (Donna) explicitly considered breastfeeding as instrumental in meeting their children’s emotional needs and ultimately benefitting the mother-infant bond.

Breastfeeding was a conscious choice for all of the mothers and all but Donna spoke of the importance that breastfeeding played in their mothering identity. Mothers regarded breastfeeding as a “motherly duty” (Cecile), “mum’s job” (Chloe) and “the best thing I should be doing” (Renee). For Ellen, breastfeeding also provided her with evidence of her worth as a mother:

> [Breastfeeding] is the only proof, touchable proof, that I’m a good mother, so (…) if I stop nursing then I don’t have any proof for myself that I’m a good mother, but obviously it’s ridiculous, I know, but I think that feeling makes me wanting [sic] to not stop nursing. (Ellen)

Consequently, several mothers persevered to uphold their view of themselves as committed to their original choices and beliefs: “He [husband] was worried about me and he wanted me to give up (pause) and then I was being stubborn, saying no because this is the best thing for her [baby]” (Renee).

All of the mothers held breastfeeding in high esteem, for pragmatic and health reasons, but also because of how it made them feel, referring to it as “enjoyable” (Chloe), “snuggly” (Kate), and “wonderful” (Melissa). For Izabella becoming emotional during breastfeeding also made her receptive to the positive feelings associated with the act:

> Because right together with it [the negative feeling] comes another feeling, like very close attachment to the baby, like I care a lot about my baby (pause). I feel like, the (pause) love (giggles) or the butterflies as well. (Izabella)

For Danielle, prior to her negative experiences, breastfeeding was idealised as “the only perfect moment of the day“. Indeed, for numerous mothers the breastfeeding relationship was a reciprocal pleasure and experienced as a source of comfort for both mother and baby: “I’d go from feeling very down to then feeling very anxious, to then it sort of ebbing away, and then it was like, sort of comforting having her, you know, feeding her, and it was quite (pause) snuggly" (Kate).

The experience was viewed as "too valuable to take away" (Melissa) and mothers' wish to feed their children outweighed the distress associated with it: "I don't want to take that away from him and a few more minutes of discomfort for me, is kind of a small price to pay" (Leanne).

Some of the mothers continued to feed despite feeling negative emotions in order to compensate for difficult beginnings. Chloe, for example, whose daughter was born prematurely, was determined to persevere with breastfeeding because she was "trying to be as perfect as [she] could be with her [daughter]". Mothers also reported occasionally using breastfeeding to compensate for the relationship strains and ruptures which had initially emerged from the breastfeeding problems themselves:

> I feel like if anything after, after I, you know, treated him more roughly than I wanted to then of course, then I wanted to nurse him and tried to make it all better, and that was difficult too. (Cecile)

In addition, mothers persevered with feeding their children out of the belief that breastfeeding would compensate for stresses inherent in life transitions, such as the adjustment to the birth of younger siblings. For Ciara, the breastfeeding relationship was a means to express accumulated emotions: "I feel a lot of guilt in my relationship with him [son] in general, but I think it comes out when I'm feeding him". Through breastfeeding, mothers were hoping to make their children feel "included" (Cecile) and "connected" (Ciara): "I thought that nursing would be one way to show that he's still really important and gets to do some of the same things that the new baby does, you know, he still has a special place" (Leanne).

Some mothers persevered with breastfeeding in the hope that it would bring back the breastfeeding relationship that they once had: “I think that’s another reason why (…) I persevered is because I looked forward to having maybe what we did have, as a breastfeeding relationship again” (Melissa).

Mothers who experienced anger or irritation reported disappointment with the unexpected turn of events, where the act of breastfeeding, which was meant to offer closeness and increase the bond between mother and child, frequently had the opposite effect.

> He will come and sit on my lap, and he will need affection and love and cuddles, and he’ll ask for milk. Now, I really want to give affection, love and cuddles, but I may not want to give the milk, so I end up inadvertently rejecting him. (Ciara)

In addition, a number of mothers spoke of their concerns that their choice to continue the breastfeeding relationship despite anger and irritation was going to result in “emotional injuries” (Cecile). Mothers worried that repeated rejection around breastfeeding was going to have negative consequences for their children’s sense of self:

> He’s all, he’s on cloud nine, you know, happy and breastfeeding and all of a sudden the person who’s providing him that comfort, that safe place, is shoving him away. (…) I feel that has to (pause) at some level make, him feel may, maybe a little negative about himself. (Cecile)

Rectifying a strained breastfeeding relationship was particularly important to mothers who perceived that their feelings had negative consequences extending beyond the feeding relationship, such as getting in the way of desired parenting:

> I’m snapping more at my oldest child (…) it doesn’t improve my relationship, it doesn’t make me a nicer mum (…) because when I’m nursing and I’m feeling this

> anger and then later on snapping to my oldest one I feel really guilty because it’s not his fault, but I am snapping at him, for feeding his, for nursing his younger brother. (Ellen)

In summary, breastfeeding was highly important to mothers, not only because of its physiological and emotional benefits for mother and baby, but also because it was linked with their mothering identity and self-worth. Breastfeeding could be an ambivalent experience as both positive and negative psychological experiences for mothers were elicited at the same time or very close together. Mothers viewed some aspects of breastfeeding as enjoyable and bringing comfort to both mother and baby, while also serving as a means for compensating for imperfections in the relationship.

Theme 3: Making Sense of Breastfeeding Distress Essential to Acceptance and Coping

Seeking support and information about negative emotions during breastfeeding enabled mothers to better understand and manage their experiences. Mothers sought out information from a number of sources, including health professionals, support groups and breastfeeding literature. However, they all reported disappointment with the scarcity of information that was available to them.

Mothers who sought professional advice highlighted lack of knowledge from professionals and their experiences highlighted how professionals may use existing frameworks in an unhelpful way to understand new experiences. Ellen, Kate and Renee reported that breastfeeding distress was confused with postnatal depression:

> They [professionals] did offer me things like antidepressants and things, which I didn’t think I needed. I didn’t think that was what (pause) was causing it because I wasn’t like that all the time. It was just when I was feeding her (…) I didn’t think it was postnatal depression. (Renee)

Donna was told: “No, you don’t feel down, you should feel happy when you get the oxytocin release (…) without realising it, they made me feel a bit stupid and made me feel like I couldn’t talk about it”. In addition, the power imbalances and safeguarding procedures inherent in healthcare services, as well as lack of trust in professionals, impeded disclosure:

> I think it’s really hard to find a care provider that you can go to and say you, you know, ‘I’m angry and I had this urge to throw my kid across the room’ without them saying, ‘well, we need to call CPS [Child Protection Services]’ (…) I never actually would have or had the actual intension of hurting my child. (Melissa)

A number of mothers expressed their perception that breastfeeding promotion and antenatal care typically offer an idealistic picture of breastfeeding and that misleading information can have deleterious consequences for mothers’ sense of self and their breastfeeding experience:

> “All you ever hear how breastfeeding is brilliant, perfect, and you’re really happy when you breastfeed, and (…) some people are made to feel like they’re weird because you don’t have an oxytocin high.” (Donna)

Consequently, a number of mothers reported profound relief when they came across support groups or other mothers with similar experiences, as it alleviated their sense of defectiveness and failure at motherhood. Ellen said “It was like coming home (…) More souls who understand my feeling. I’m not crazy, I’m not a bad mother”. Meeting others with similar experiences, not only served a normalising function, but offered a “safe” (Leanne) space for talking about those experiences.

Mothers who did not access support groups or who did not meet other mothers with similar experiences sought information in breastfeeding literature or online. For Donna, identifying and understanding the experience as one which affected other mothers changed how she perceived it and reduced the power it had over her:

> When I kind of had researched it a bit, I knew the reason for it and I knew it wasn't me being abnormal or weird, you know, and I knew of other people that it happened to so it felt more (pause) I just kind of accepted it (…) it stopped bothering me that, I think when I could have a scientific, em, name and an explanation for it. (Donna)

Regardless of source of information, all mothers made sense of their experiences as resulting from hormonal activity associated with milk release or the physical act of breastfeeding. For example, Izabella noticed that the strength of her feelings correlated with the amount of milk she was producing: "When my son wasn't really feeling well I was breastfeeding him [more] and I think I produced more milk and then all the hormones were affecting me more". Having professionals to support such claims further added credibility to mothers' own explanations:

> It seemed to be such a strong hormonal response in me, because I had, um, pre-natal depression in my second trimester as well and they [health professionals] said it's sort of classic signs that the hormones are sending me a bit crazy. (Kate)

In addition, some mothers found relief in putting an evolutionary explanation to their experiences:

> It feels like my body is rejecting the, the, the milk theft, (both laugh quietly) from the other child so the milk is actually being directed away from my little baby who needs it, and that's being expressed by my body like a physical revulsion. (Ciara)

Understanding their experiences as mammalian instincts or hormonal activity served a non-blaming and de-shaming function for mothers, allowing them permission to externalise the cause of their experiences: “It was just a biological thing that I couldn’t really control” (Leanne). However, having a biological explanation also created frustration in some of the mothers making them feel powerless to change their evolutionary programming:

> Food is plentiful and we can supply enough, I can supply enough breast milk for both kids. (…) It’s kind of frustrating that those biological pieces are still stuck with us, even many thousands of years later when it’s not necessary for us to stop nursing (…) I can understand why it’s happening but I can’t really do anything about it. (Leanne)

In contrast, however, when mothers began to observe that the intensity of their experiences fluctuated depending on other factors such as being “stressed” (Izabella) or “tired” (Ciara) they were able to regain a sense of ownership of their well-being: “If I took my vitamins, I ate well and I was able to sleep at least a good amount, I felt less irritable and, like, I was able to control it a little more” (Danielle). Such discoveries motivated them to proactively seek out strategies, such as distraction or limiting feeds:

> I tell him that he needs to stop, or, you know, try to redirect him to something else but he doesn’t always want something else and then he’ll get really upset, so I feel like those times it’s, um, kind of pulls us apart. (Leanne)

Paradoxically, strategies that were intended to maintain closeness and connection through the breastfeeding relationship, pushed mothers further away from their children resulting in guild-laden relationships. Melissa’s retrospective understanding was: “Honestly, looking back now I probably would have weaned him entirely, because for a good while our relationship was extremely strained (…) because he would get extremely upset” (Melissa). In addition, a number of mothers contemplated “giving up breastfeeding” (Chloe) and for Renee, the intensity of her experiences led to completely weaning her daughter at five months: “It was most difficult then so that’s when the final decision was made”.

In summary, mothers sought formal and informal sources of support to alleviate their breastfeeding distress and to gain a better understanding of their experiences, enabling them to cope. They felt disappointed with professionals’ lack of knowledge and instead turned to support groups and literature. Coming across explanations of breastfeeding struggles as partially biological or hormonal served a normalising and de-shaming function for mothers, and although it could lead to a sense of powerlessness, it also enabled them to seek out strategies to manage their experiences.

Discussion

The aim of this study was to explore how mothers experience and make sense of negative emotions during breastfeeding. Analysis resulted in three main themes, which together reflected mothers’ experiences of distress during breastfeeding as complexly interlinked with their beliefs around mothering and breastfeeding.

Existing research on breastfeeding has highlighted how physical breastfeeding difficulties can give rise to guilt, a sense of inadequacy and failure (Hegney et al., 2008; Kelleher, 2006). Additionally, the current findings brought awareness to breastfeeding as a potential trigger for psychological responses in absence of physical breastfeeding problems. Such emotional experiences were viewed as incongruent with the thoughts, feelings and behaviours characteristic of mothers’ view of themselves. Consequently, mothers oscillated between two mind states, either feeling overpowered by their experiences, such as seeing self as inherently flawed, or separating themselves from their experiences, for example, by referring to the feelings as not part of themselves. Ussher (2003) has argued that when women label their experiences as biological “symptoms” separate from themselves, it may lead them to a sense of powerlessness. Viewing their experiences as solely based on biological processes contributed to mothers’ sense of frustration and helplessness in relation to their inability to control their feelings. However, current findings also highlighted how understanding negative breastfeeding experiences as a biological phenomenon served as a coping mechanism to avoid blame and ameliorate feelings of guilt.

Mothers spoke of breastfeeding fulfilling both physiological and nutritional needs of their infants/children while also highlighting the relational value that breastfeeding had for them. Research has demonstrated how the physical act of breastfeeding takes on a deep seated emotional meaning for many mothers, making inseparable the biological and psychological aspects of feeding (Palmér, Carlsson, Mollberg, & Nyström, 2010). Ryan, Todres and Alexander (2011) also interpreted mothers' views of breastfeeding as an "interembodied experience" (p. 737) leading to mutual fulfilment between mother and infant and a means to communication between them (Palmér et al., 2010). However, extending from this research, current findings also showed how, in addition to feelings of fulfilment, breastfeeding can lead to ambivalent emotional responses where positive and negative emotions can emerge in close succession of each other.

Mothers also spoke about breastfeeding as a fundamental aspect of their maternal identity and worth, where failing at breastfeeding was equivalent to failing at motherhood. This echoes existing research suggesting that mothers' expectations of breastfeeding and mothering are intimately linked (Hauck & Irurita, 2003; Marshall, 2011) and that a negative sense of self may follow if they do not manage to successfully breastfeed (Larsen & Kronborg, 2012; Redshaw & Henderson, 2012). However, this study uniquely revealed how, in addition to fulfilling maternal expectations, breastfeeding served the function of compensating for imperfections in the relationship between mother and child, such as premature birth, illness in the infant or difficulties in adjusting to the birth of subsequent siblings in the family. In addition, current findings highlighted how negative emotions experienced during breastfeeding had the potential to put strain on the mother-child relationship, which was in stark contrast to the initial reasons why mothers chose to breastfeed.

Coming across literature and breastfeeding support groups enabling mothers to make sense of and share their experiences with likeminded others. Research suggests how increased awareness and normalisation of a phenomenon can have an ameliorating effect on how it is experienced, because it opens up an individual to proactively engaging in coping strategies that reduce distress associated with that experience (Ussher & Perz, 2013). More specific to the experiences reported in this study, mothers recognised that their experiences during breastfeeding were, in part, dependent on contextual factors, such as lack of self-care and sleep-deprivation. Such observations motivated mothers to take ownership of their experiences by engaging in coping strategies, including getting rest and eating well, and to seek further information and support.

Clinical Recommendations

Mothers in the current study expressed disappointment with professionals' lack of knowledge about negative emotions during breastfeeding. Instead, professionals' existing theoretical and experiential frameworks led them to inaccurately label breastfeeding distress as postnatal depression, even in women without a history of mental health difficulties. This contributed to mothers' lack of trust in professionals and impeded disclosure for some of them, out of fear that their emotional breastfeeding experiences would be misconstrued as tendencies to be violent. Consequently, training for professionals who come into contact with mothers in the perinatal period could include awareness of the range of breastfeeding problems that mothers may experience, not limited to physical breastfeeding problems, and a better understanding of the kind of support that mothers require. Health professionals are often perceived as sources of knowledge and reliable information (Doucet, Letourneau, &

Robertson-Blackmore, 2012; Hauck & Irurita, 2003), therefore, they can play an important role in creating an environment in which successful breastfeeding can take place (Ryan et al., 2011; Schmied, Beake, Sheehan, McCourt, & Dykes, 2011).

For a number of mothers in this study, negative emotions during breastfeeding triggered existing vulnerabilities, such as previous experiences of depression. Thus, employing a person-centred approach to care whereby mothers' previous experiences, beliefs, expectations and goals are explored allows for a tailored form of support (Hauck & Irurita, 2003; Palmér et al., 2010; Schmied, et al., 2011). This means that mothers may be supported to continue breastfeeding or supported to wean. Indeed, a few mothers in the current study expressed hindsight regret of not weaning their child earlier, because consequences that the experience had on the mother-child relationship were perceived as outweighing the benefits of extended breastfeeding.

Mothers expressed surprise, disappointment and frustration with not having been prepared for breastfeeding struggles and experienced that breastfeeding had been promoted solely in positive terms. Rather, for many of them, breastfeeding problems triggered a sense of defectiveness in the self. While existing knowledge recognises that breastfeeding occurs in a context of physiological, psychological and environmental processes (Hauck & Irurita, 2003), current clinical guidelines (e.g., WHO, 2009; WHO & United Nations International Children's Emergency Fund [UNICEF], 2003) and research scarcely acknowledge psychological and environmental aspects of breastfeeding (Ryan et al., 2011). Perinatal care could more specifically convey the multifaceted nature of breastfeeding and thus avoid setting unrealistic expectations for mothers (Hauck & Irurita, 2003; Leeming, Williamson, & Lyttle, 2013; Schmied et al., 2011). There appears to be a discrepancy between existing clinical guidelines (e.g., NICE, 2008) that acknowledge the need for a multifaceted approach to breastfeeding support and mothers' actual experiences of such support.

In addition to formal support, current findings also identify a number of functions that informal peer support groups may have for mothers, such as alleviating guilt and a sense of defectiveness, allowing them to normalise and make sense of their experiences in a safe, shared space. Current clinical guidelines (NICE, 2008; NHMRC, 2012; WHO, 2009) emphasise the usefulness of peer support groups for mothers who struggle with breastfeeding. Thus, raising professionals' awareness and use of the links with informal peer-support groups or forums specific to negative emotions experienced during breastfeeding may play a powerful role in helping mothers to understand and be supported in their breastfeeding endeavours. Unlike professionals in overstretched services, peer supporters have the time and commitment to develop trusting relationships with mothers (Schmied et al., 2011).

Limitations

The current sample consisted of mothers for whom breastfeeding was particularly important. Consequently, they were able to persevere with feeding for long periods despite their distressing experiences. Within the current sample there was limited representation of experiences of mothers who felt emotional distress and decided not to persevere with breastfeeding.

Five out of the 11 mothers were recruited from the same breastfeeding support group which may have influenced how they viewed, understood and talked about their breastfeeding experiences. However, their conclusions and the way they sought information was similar to mothers drawn from more generic parenting groups. In fact, the majority of mothers had come across similar information online and incorporated this into how they understood their experiences.

Finally, there were some differences among the mothers in the sample including the wide range of negative emotions that were reported (e.g., sadness, anxiety and anger) and different mental health history. However, the sample was homogenous on a number of socio-economic variables and, most importantly, the variables that were relevant to the research question.

Future Research

One of the highlighted issues expressed by mothers in this study was professionals' lack of knowledge. A potential avenue for future research could be to investigate healthcare professionals' understanding of breastfeeding problems and what they perceive that mothers experience as barriers to successful breastfeeding.

In addition, future research could more specifically examine mothers' perceived support needs around negative emotions during breastfeeding, in order to inform staff knowledge and services for mothers in the perinatal period.

Finally, current findings bring into awareness that current clinical guidelines do not explicitly acknowledge the psychological nature of breastfeeding. Thus, future research could incorporate the importance of psychological and environmental aspects of support into existing clinical guidelines.

Conclusion

This study explored how mothers experience and make sense of negative emotional experiences emerging during breastfeeding. Mothers experienced such feelings as an unknown part of self that exacerbated existing vulnerabilities and expressed great disappointment when their emotional experiences interfered with their desired or expected breastfeeding relationship. This was partially because breastfeeding was intimately linked in with their maternal identity. Taking a psychological approach to difficulties with potential biological origins can be an empowering way for mothers to accept, own and manage their experiences. However, it was noted that despite breastfeeding involving a number of relational dynamics that are important for mothers who breastfeed, such aspects are rarely the focus of clinical guidelines and practice. In light of this, clinical suggestions were made, encouraging healthcare professionals to approach breastfeeding as a holistic experience, involving physiological processes, indeed, but also psychological and environmental factors.

Potential future research avenues suggested, among other things, a qualitative exploration of healthcare professionals’ understanding of such difficulties. Continued clinical and research activity in this area may help mothers to manage their difficulties during the breastfeeding period, while feeling empowered and supported to make choices that are right for them and their children.

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Table 1

Participant Demographics[6]

	Izabella	**Donna**	**Ellen**	**Kate**	**Chloe**	**Renee**	**Melissa**	**Cecile**	**Ciara**	**Leanne**	**Danielle**
Age	32	28	31	35	27	33	26	36	31	32	28
No of children	2	2	2	1	1	1	2	2	2	1	2
Breastfeeding duration	20 + months	20 + months	36 + months	13 months	14 + months	5 months	36 + months	39 + months	48 + months	22 + months	39 + months
Occupation	Graduate	Health care	Education	Research	Health care	Education	Full time mum	Education	Health care	Mental healthcare	Managerial
Working outside the home?	No	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	No
Nationality	Polish	British	Dutch	British	British	British	American	American	Australian	American	American
Ethnic origin	White Polish	White British	White Dutch/ Spanish	White British	White British	White British	White American	Mixed (Indian/ British)	White Australian	White American	Hispanic
Marital status	Married	Married	Married	Living with partner	Married	Married	Married	Married	Living with partner	Married	Married
Previous mental health problems	None	None	Depression	Postnatal Depression	None	None	None	Anger	None	None	Low mood/ Depression
Data collection method	Face-to-face	Phone	Skype	Face-to-face	Face-to-face	Face-to-face	Skype	Skype	Skype	Skype	Skype

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[6] To honour the British Psychological Society’s code of research ethics commitment to confidentiality all real names have been replaced by pseudonyms (BPS, 2010).

Appendices

Appendix 2-A: Author Guidelines for Qualitative Health Research

4. Preparing your manuscript

4.1 Word processing formats

Preferred formats for the text and tables of your manuscript are Word DOC, RTF, XLS. LaTeX files are also accepted. The text should be double-spaced throughout and with a minimum of 3cm for left and right hand margins and 5cm at head and foot. Text should be standard 10 or 12 point. Word and LaTex templates are available on the Manuscript Submission Guidelines page of our Author Gateway.

4.2 Artwork, figures and other graphics

For guidance on the preparation of illustrations, pictures and graphs in electronic format, please visit SAGE's Manuscript Submission Guidelines. Please refer to clause 4.5 for information on SAGE Language Services.

Figures supplied in color will appear in color online regardless of whether or not these illustrations are reproduced in colour in the printed version. For specifically requested color reproduction in print, you will receive information regarding the costs from SAGE after receipt of your accepted article.

4.3 Supplementary material

This journal is able to host additional materials online (e.g. datasets, podcasts, videos, images etc) alongside the full-text of the article. These will be subjected to peer-review alongside the article. For more information please refer to our guidelines on submitting supplementary files, which can be found within our Manuscript Submission Guidelines page.

4.4 Journal layout

In general, QHR adheres to the guidelines contained in the Publication Manual of the American Psychological Association ["APA"], 6th edition (ISBN 10:1-4338-0561-8, softcover; ISBN 10:1-4338-0559-6, hardcover; 10:1-4338-0562, spiral bound), with regard to manuscript preparation and formatting. These guidelines are referred to as the APA Publication Manual, or just APA. Additional help may be found online at http://www.apa.org/, or search the Internet for "APA format."

4.5 Reference style

QHR adheres to the APA reference style. Click here to review the guidelines on APA to ensure your manuscript conforms to this reference style.

4.6 English language editing services

Authors seeking assistance with English language editing, translation, or figure and manuscript formatting to fit the journal's specifications should consider using SAGE Language Services. Visit SAGE Language Services on our Journal Author Gateway for further information.

Appendix 2-B: Transcript with Initial Notations for Ciara

Key:

Descriptive notations in normal text.

Linguistic notations in italics.

Conceptual notations in bold.

C: I probably kept thinking I wish I knew how to wean [M: uh-uh] I'd probably think of strategies to wean, [M: uh-uh], when I'm, when I'm actually feeding I properly try and brain storm at that time [M: m-h] strategies for reducing his feeds [M: mmm], none of which I've ever even been implemented (laughs).	Thinking I wish I knew how to wean *Repeatedly talking of seeking strategies to avoid or reduce feeding*
M: Uh-uh, uh-uh, so what have you, I suppose, what have you thought in terms of strategies to, to wean?	Strategies to stop/reduce never implemented
C: Umm… I thought of talking to him about it, [M: m-h] um, I've heard of other women using a weaning party…	**Barriers to implementing strategies?**
M: Oh, cool, that's cute.	**Split between part that wants to feed and that wants to wean**
C: Yeah (laughs) so when you've been off the boob for a week we'll have a cake and we'll invite everyone and [M: aawwww]. I think that's a little bit disrespectful, emotionally [M: m-h, m-h] to the child, to try to make them enjoy something that they know in themselves is wrong [M: yeah, yeah, mmm] I don't think that's good validation (laughs) [M: mm, mm] so I haven't really done that [M: no] I've, I've, heard that when the milk teeth fall out, about six, that they wean naturally [M: uh-uh, uh-uh] um… I don't know if I can wait another 2 or 3 years (laughs quietly)…	Strategies to wean Weaning party disrespectful to child *Premature weaning inherently wrong* **Premature weaning enforcing the wrong message of not trusting own instincts?** Not sure if she can wait for natural weaning
M: Yeah, yeah, yeah, um, mmm, mmm…	
C: Um, but it's not everyday so some days are good and some days, I'm not good. It definitely, um, yeah, definitely goes with my mood [M: m-h] so if I'm not having a good day anyway, then it will definitely feel worse.	Feelings around feeding go with mood
M: Ok, uh-uh, uh-uh, and what would, what would a not so good day look like?	
C: So if he were woken up and cried and were demanding [M: m-h] in general, um, now that he's older, the demands are less, sort of, the product of, um,	Misinterpreting son's communication

you know, um, not enough vocab and more sort of the product of not being able to articulate fully and it gets misinterpreted as rudeness [M: uhuh, uhuh, uhuh] and if I'm in a bad head space, I'll get a lot of that (laughs) [M: uhuh, uhuh, uhuh] I think my headspace informs his, um, his style of speech, a lot, so he'll, he'll speaks to me rudely if I'm sort of tired and [M: m-h] not coping and stuff, (deep inhale) um, so yeah, if he, if he's demanding all day, if he asks for milk a lot, if we're at home that's not a good thing, we have to go out, a lot [M: m-h, m-h], going out helps a lot [M: m-h, m-h] cuz he doesn't ask for feeds, so if he asks for a lot of feeds in a day then I get really really worn down [M: yeah, yeah] tired, if I haven't had a good sleep at night [M: m-h, m-h]… these sorts of things. Um… and if my nutrition is not good.	My head space informs his *Being linked by shared 'head space'* **Informing each other's moods, evidence of closeness?** Going out reduces son asking for milk **How is avoiding feeds respectful but weaning is not?** Description of bad day
M: Yeah, yeah..yeah… do you always, em, do you always offer when he asks?	
C: (inhales) No, I do limit [M: uhuh] definitely limit, um, depending on where we are, so I won't feed if he asks and we're out [M: uhuh] um, frightened to offend other people that might be around, um, probably too conscious of what other people think of feeding a 4 year old…	Limits feeds Won't feed in public for fear of offending others **Societal beliefs hindering expression of mum's own held beliefs?**
M: M-h, m-h, what do you think about it, what are your thoughts about…?	
C: I think it's, I think it's very unfortunate that it's so social unacceptable [M: uhuh] in the west, because I'm aware that in other countries, most of the world, it's actually the norm [M: yeah, yeah] um, and I think it's the norm because it's natural and necessary for a child that age to still be feeding [M: m-h, m-h] but I'm also aware that if you've got another baby the child would be going to his aunties and other women around for the feeds [M: uhuh, uhuh, yeah, yeah] and somebody said to me recently, you must not feel guilty for feeling this aversion because, um, because you shouldn't be having to do this, it's just there aren't any other women around to do the feeds.	**Explains her situation as mismatch between culture and what is necessary for her child** *I 'shouldn't' have to be doing this, but no choice* **Western society to blame for mum having to have these experiences?**
M: Yeah, yeah, yeah… yeah, yeah, so, in terms of your little one, do you ever feel these feelings towards him?	
C: Th, the, the little girl?	

M: Oh, sorry! I'm sorry I just assumed you had two boys. Yeah, the little girl!	
C: My little Veronica, no I definitely don't, it's totally different feeling [M: ok, ok] yeah	Totally different to feed younger child
M: So only towards your little boy… So, you said something earlier that I wanted to pick up on, em, yes, so, so I suppose, I mean it sound like really tough time to be doing and it impacting, it sounds like it's impacting a lot on your day, so what, what have you kind of… what's made you persevere to feed this long, uh… em?	**Reinforcing narrative around it being hard feeding her son?**
C: There's been the, em, the desire to, um, bridge the trauma [M: m-h] the, the second baby was, I didn't realise, but apparently 3 is the worst time to gain a sibling [M: uhuh] especially for a boy [M: uhuh] um, and I was horrified to find him coping so badly with it and I didn't realise it was gonna happen and I thought, no I can't wean now, I have to put him back on [M: ok] I also thought two and a quarter years wasn't enough breast milk, I think you probably should be getting as much of the good stuff inside of them as possible [M: mm, mm] um, it's im, immunisation purposes , um, it's yeah, uh, um, it keeps him well, [M: m-h] I love how healthy he is, they're both incredibly robust kids [M: mmm, mmm] eh, as long as he's feeding I don't have to worry too much about his health [M: m-h] um, but mostly the emotional side of it I really want to make sure he still feels connected to me [M: yeah] um, but I sort, sort of also think that at this point, I think the ability to be able to cuddle him without him asking for milk and having to reject him would probably help at this point [M: yeah, yeah, awww].	Feeding to bridge trauma of new sibling being born Breastfeeding making the kids healthy and robust *Breast milk as a key reason for being 'robust' and 'healthy'* **I love how healthy he is - mum's milk is the cause of this?** Feeding to keep emotional connection **Feeding to make up for something in the mother-child relationship?** Cuddling without rejection would help emotional connection **Search for connection, via milk, leading to rejection and breach of connection?**
C: But then I'm gonna have to put him through more trauma, that, that's the question in my mind I'm trying to weight up [M: uhuh] do I need to be supported to stop or do I have to be supported to keep going? [M: yeah] that's the question for me.	Putting child through more trauma to wean **Dilemma - will the weaning be worth it? What are the trade-offs?**
M: Yeah, yeah, that sounds like a dilemma, really really hard.	**Are imagined consequences of the decision to wean potentially unbearable?**
C: It's a big dilemma! (laughs) It's like, it's one that only I can call [M: yes] and I have to live with the decision… so I keep going.	

M: Yeah, yeah. In terms of, I suppose, support around you, what do, what does your partner say and does he have a say and, and things like that, um? C: Right well, um, let’s see, it’s um, it’ a matter of he understands why I do it [M: m-h] he sees all of it [M: m-h] and he understands and he’s very supportive, but no, he doesn’t get a say (both laugh) it’s not his decision at all [M: yeah, yeah] um, but he would support me no matter what I did [M: ok, uhuh] he would help me, he would talk to Aaron for me, he would, he would do anything I asked him to do [M: m-h] um, but no it’s not his decision at all.	Only mum's decision to wean – partner supportive, but has no say *Repeated emphasis on decision being solely mum's*

Appendix 2-C: The Development of Individual Themes from Kate’s Transcript

Key:
Descriptive notations in normal text.
Linguistic notations in italics.
Conceptual notations in bold.

Examples of notations	Theme summary
Theme 1: Breastfeeding dominated by intense negative emotions, detachment and robbing Kate of her sense of self	
Feelings during feeding instant Visceral reaction Mood plummeting Feelings during feeding not low-level sadness, but severe sadness *Clenched inside - bodily reaction to an emotional experience*? *Let-down from both eyes and breasts - crying with all of her body? Negative feeling as permeating all of her body?* Detached from the world *Like going into a shell of myself - essence of mum disappearing - breastfeeding experience robbing mum of herself?* *Like blinds coming down - visual separation from others around* **Feelings during breastfeeding amplifying existing thoughts and feelings** Questioning parenting choices Leaving baby and husband behind	Kate described her negative experiences during feeding as an instant, visceral and physical reaction of her mood plummeting. She described severe sadness and high emotion accompanied by tension, increased heart rate and crying. Milk letdown was a bodily expression of the emotional upset that was associated with breastfeeding. Kate’s breastfeeding experience was portrayed as robbing her of her real self. The sudden and instant effect that the breastfeeding experience had on her mood was reflected in her description that it was as if blinds had come down. Indeed, Kate’s drop in mood was so severe that it was visible on the outside for others to see and at times other people noticed a change in Kate before she did. Breastfeeding was experienced as amplifying Kate’s existing feelings or worries, including her questioning her parenting choices. However, she also recalled urges to self-harm and leaving her husband and baby behind, thinking that they would be better off without her.
Theme 2: Breastfeeding as a source of strain and distress, but also a source of comfort	
Physically feeding was easy **Feeding daughter source of calm and snuggliness**	Despite having such negative experiences during feeding, Kate continued to feed her daughter. She offered pragmatic reasons, such as it being physically easy to breastfeed and emotional

Bond with daughter persuasive to keep feeding **Perfectionistic ideal of motherhood - driving mum to feed despite negative feelings?** **Daughter's need to feed source of distress and a source of comfort** **Breastfeeding requiring mum to give up everything - surpassing her own limits** *Body not being mum's own - breastfeeding giving away more than mum had anticipated.* *Breastfeeding as something being demanded of mum* Not regretting feeding daughter **Breastfeeding not worth the sacrifices** **Breasts being *mine* - putting limits and boundaries to what she feels like her breasts can offer** Breasts as a *sexual thing* - **indicating other purposes for breasts opening up possibilities for other experiences** *Breasts being 'mine' indicating a new opportunity to use breasts on her demand* *Breasts now described as just another part of body - not associated with being needed, with negative feelings*	reasons, such as enjoying the bond that breastfeeding allowed the two of them to form, including moments of calm and snuggliness. In addition, breastfeeding was associated with the perfectionistic ideal of motherhood that Kate had formed in her mind. Although mum described breastfeeds as a source of comfort once the negative feelings had abated, the experience was also a source of great strain and distress. Breastfeeding was costly for Kate, and she described her experience that it required her to surpass her own limits and sacrifice perhaps more than she had anticipated. Kate had periods when she felt like breastfeeding took everything away from her, both physically restricting her ability to choose what to wear and taking away ownership of her own breasts, and also giving rise to the negative emotional experiences that she was having. Although Kate was happy to have breastfeed her daughter, there were indications of her sense that breastfeeding had not been worth the sacrifices. Weaning allowed Kate to regain control and boundaries of her own body. She described how she welcomed the feeling of her breasts being 'hers' opening up an opportunity to use them as a sexual thing, and use them on her demand, not a baby's demand. Thus her breasts became, once more, just another part of her body and not associated with being needed or the negative feelings that it had given rise to.
Theme 3: Avoiding vulnerability by use of CBT strategies and occupying the mind	
Active distractions helpful during feeding Coping by using hypnobirthing strategies Using CBT techniques to cope with negative feelings during feeding Strategy to postpone decisions and thoughts until after feeding *Best coping when occupying brain space - more vulnerable to effects of feelings if mind not busy*	Kate managed her feelings by using active distractions like reading or talking to other people while feeding. She also employed hypnobirthing and CBT strategies to cope and described feeling more vulnerable when her brain space was not occupied. Kate believed that hormones had a significant part to play in her experience of negative feelings during breastfeeding, as well as her PND. When

Breastfeeding feelings understood as triggered by hormones Hormones believed to have a play in PND and also feelings during feeding Health visitor not understanding the severity of feelings Response from professionals to feed less Professionals' explanation that breastfeeding can be an emotional experience - linked to hormones Pressure to get life back on track **Being allowed to say it won't be normal for a while would help mum to embrace what was not normal**	sharing her experiences with health professionals, her experience was that they did not have an understanding of the severity of her feelings. [use quote about slitting wrists]. The typical response from professionals was to feed less, and she experienced a sense that there was a pressure to get back on track. In contrast, Kate’s experience indicated that being allowed to say that things will not be normal for a while would have helped her embrace her experiences.
Theme 4: Sadness during breastfeeding viewed as linked in with PND symptoms and hormonal activity	
Feelings during feeding different from PND Not incremental Unusually predictable Strong memory of tensely awaiting the next feed **Amplified sensitivity to baby's cry associated with the experiences during feeding** Specific cry triggering strong emotional response Feelings of self harm when baby cried **Strength of experience only noticed when stopped feeding - Indicating the interlinked experience of PND and negative feelings during feeding** **Feeding and PND exacerbating one another**	Kate was able to distinguish feelings associated with PND and negative feelings to some degree. For example, feelings associated with feeding were abrupt and unusually predictable because they would occur during feeding. However, Kate observed that the feelings during feeding also affected her in between feeds. She recalled a strong memory of feeling tense and anxious awaiting the next feed and baby’s specific hungry cry would trigger strong emotional responses in Kate, sometimes even self-harming urges. Thus, Kate found it difficult, at times, to distinguish between the feelings during feeding from her experiences of PND. Interestingly, she noticed that the strength of the breastfeeding experience became particularly noticeable when she stopped feeding, suggesting that she viewed the experience of PND and negative feelings during feeding of interlinked and exacerbating one another.

Appendix 2-D: Comparison of Themes across Participants

<table>
<tr><th colspan="4">Third Iteration: Superordinate Themes</th></tr>
<tr><td></td><td><i>Breastfeeding: An unexpected trigger of intense negative experiences incongruent with view of self</i></td><td><i>Fulfilling maternal expectations and maintaining closeness with the child</i></td><td><i>Making sense of breastfeeding distress essential to acceptance and coping</i></td></tr>
<tr><th colspan="4">Second Iteration: Themes across participants</th></tr>
<tr><td></td><td><i>Intense sadness, anxiety and anger beyond verbal comprehension</i>

<i>Triggering existing vulnerabilities and undesired parts of self</i></td><td><i>Breastfeeding to maintain closeness and compensating for losses and parenting choices</i>

<i>Unmet expectations of mother-child relationship as a result of emotional breastfeeding struggles</i></td><td><i>Balancing the needs of self and child by employing coping strategies and seeking support</i>

<i>Dynamic understanding of breastfeeding struggles integral to coping</i></td></tr>
<tr><th colspan="4">First iteration: Original themes for each participant</th></tr>
<tr><td>Izabella</td><td><i>Breastfeeding triggering a mixture of positive and negative feelings:</i>

Mixed feelings during breastfeeding which would be short and intense; feelings emerging in response to milk production. Struggling to put words to her experience, but describing a throat tightening sensation, eyes watering and intense sadness in absence of an actual event.</td><td></td><td><i>Coping by rationalising, normalising and communicating feelings</i>

Coping by talking about it with her family members and sharing experiences with other mums, normalising the experience for her. Experiences viewed as temporary rationalised in between feeds.

<i>Hormonal explanation aiding understanding and</i></td></tr>
</table>

	Increased vulnerability - a double edged sword Breastfeeding experiences opening up a vulnerability to both positive and negative emotions, which resulted in experience of self-doubt and overwhelm, as well as an increased closeness to her baby.		*acceptance* Experiences linked to milk release, and understood as resulting from hormonal activity. Experiences also viewed as interplay of factors such as lack of sleep and other mothering demands.
Donna	*Breastfeeding accompanied by intense negative feelings* Observing a gut wrenching, sinking feeling in her chest and stomach at every feed. Difficult to put words to her experience but compared it to the feeling when receiving the unexpected news that somebody has died. *Feelings and thoughts of self-doubt and guilt amplified* Sinking feeling triggering mothering doubts, feeling guilty or negative. Sinking feeling triggering feelings similar to when her mum passed away and thoughts about her not being around to enjoy the children.		*Practical approach to coping with negative breastfeeding experiences* Coping with breastfeeding experiences in practical ways through distraction, keeping busy, and by knowing that the feeling was time limited. Taking a pragmatic approach to problems and getting on with things. *Lack of openness, knowledge and honesty among professionals* Breastfeeding portrayed only in positive terms, as happy, brilliant and perfect. Negative experiences are not highlighted by professionals, partly because they do not always know everything. Being made to feel silly for having such experiences.
Ellen	*Breastfeeding infused with intense sadness and anger* Experiencing intense sadness associated with milk flow, feeling as if something terrible had happened in absence of an actual event. Ellen experienced these feelings at every feed, often throughout each feed, and she rated their	*Breastfeeding a child's right and tangible proof of 'good mothering'* Describing breastfeeding as a child's right, a mothering obligation and the only tangible proof that she was being a good mother. *Mum unable to be the mum she wants to be*	*Acceptance and seeing the bigger picture provided comfort and strength* Coping by considering her choice to breastfeed in a greater picture in line with her values and goals. Children doing well on her milk and enjoying the feeding and the closeness. Trying mindfulness or meditation.

	intensity as off the scales. Ellen also began to experience nursing aversion when her second son was born. In contrast to the sadness, feelings of aversion emerged as a strong repulsive reaction to nursing her older son, and a physical desire to shove him off of her body. The aversion made her feel like she could hardly stand nursing, her body tensed up and sometimes even the thoughts of nursing her son would breed irritation.	Describing a lose-lose situation where stopping feeding would remove her proof of being a good mother, while simultaneously admitting that the feelings of aversion made her snappy and too exhausted to play with her children.	*Body communicating needs through negative breastfeeding experiences* Ellen came to perceive her feelings of aversion as her body's way of saying stop, and that breastfeeding was asking too much of her. She came to an understanding that she was giving away too much of herself and that she was paying the price for exceeding her own limits. *Seeking support from formal and informal sources* Support groups helpful in normalising experiences and easing guilt. Health professionals not knowledgeable about such breastfeeding experiences, relating them to stress and lack of sleep.
Kate	*Breastfeeding dominated by intense negative emotions, detachment and robbing Kate of her sense of self* Instant, visceral reaction of mood plummeting. Severe sadness and high emotion accompanied by tension, increased heart rate and crying. Milk letdown viewed as a bodily expression of the emotional upset that was associated with breastfeeding. Kate's breastfeeding experience was seen as robbing her of her real self. Drop in mood was so severe that it was visible on the outside.	*Breastfeeding as a source of strain and distress, but also a source of comfort* Distress associated with feeding making breastfeeding costly for Kate, requiring her to surpass her own limits and sacrificing more than she had anticipated. However, breastfeeds were also seen as a source of comfort once the negative feelings had abated.	*Avoiding vulnerability by use of CBT strategies and occupying the mind* Managing feelings through active distractions like reading or talking to other people while feeding. She also employed hypnobirthing and CBT strategies to cope and described feeling more vulnerable when her brain space was not occupied. *Sadness during breastfeeding viewed as linked in with PND symptoms and hormonal activity* Hormones viewed as playing a significant part to play in negative feelings during breastfeeding, as well as her PND. She viewed the experience of PND and negative feelings during feeding of interlinked and exacerbating one another.

Chloe	*Breastfeeding challenges upsetting and unexpected* Breastfeeding viewed as natural and therefore expected to be easy. Unmet expectations leading to overwhelm and distress.	*Breastfeeding - a mothering responsibility* Breastfeeding important to Chloe, describing it as her job and her responsibility stressing that the responsibility to feed her daughter was hers alone. By breastfeeding, Chloe believed that she was doing things perfectly for her daughter.	*Normalising experience and considering the wider picture* Persevering with breastfeeding due to belief that it was good for baby and for her. Coping by meeting other mums and learning that breastfeeding was emotionally draining for a number of mums around her. *Experience understood as an interplay between emotional and hormonal factors* Chloe drew tentative links to potential causes of this experience. This included fatigue, physical pain and hormonal activity in her body, and she speculated about emotional and physical pain being interlinked. *Professional support helpful* Explanations by professionals and helplines helpful providing reassurance and information.
Renee	*Breastfeeding accompanied by intense anxiety, tearfulness and a bodily tremble* Noticing high levels of anxiety during feeds, accompanied by tearfulness and a body tremble, including vivid imagery of daughter being ill and thin. Not wanting anyone close when breastfeeding. *Breastfeeding triggering severe mothering self-doubts* Noticing change in character from happy to anxious and paranoid. Triggering recurrent	*Giving the best to baby and avoiding feelings of failure and guilt* Breastfeeding seen as providing daughter with everything and giving her the best. Feelings of failure if unable to provide this, potentially linking mum's self-worth to her ability to breastfeed.	*Other mums normalising experiences and providing encouragement* Coping through support from friends, and persevering through breastfeeding problems together with other mums. *Making sense of feeding anxiety as hormonal changes normalising* Linking problems to hormonal factors, and potentially interlinking with experiences of PND. Finding out that she was not alone served

	doubts and questioning actions, which would further perpetuate the anxiety.		a normalising function for Renee. *Lack of professional support and knowledge* Offered antidepressants and referred for PND, despite own belief that it did not fit with her understanding of PND. Long waiting list and although helpful, counselling support came too late. Generally feeling unsupported by healthcare regarding breastfeeding issues.
Melissa	*Breastfeeding aversion extremely intense and unpleasant* Experience described as nails on a chalkboard. In her use of strong adjectives she descriptively portrayed the all-consuming experience as extremely unpleasant and incredibly intense. *Breastfeeding challenges unexpected and indicators of mum being defective* Experience of aversion affected her view of self and she would frequently question if there was something wrong with her hormonal response or a part of her brain for feeling this way.	*Aversion putting strain on feeding relationship* Experience put a strain on her relationship with her son. Dreading son asking to nurse and both Melissa and her son would frequently get very upset by the experience. *Persevering to maintain closeness and return to a positive experience* Experience seen as too precious to take away from her son. Persevering despite strong feelings of aversion with hopes to regain the breastfeeding relationship that she once had with her son.	*Limiting feeds to maintain own boundaries* Believing that mothers should not make disproportionately big sacrifices just because their child wants something. Developing a compromise where she allowed her son to nurse as frequently as he wanted, but only for 10 seconds on each breast. *Making sense of experience as a mammalian instinct normalising and de-shaming* Nursing aversion as a mammalian instinct. Aversion seen as having biological origins may have served a de-shaming and normalising function for Melissa. *Disclosure impeded by limited professional knowledge* Breastfeeding promotion avoiding negative aspects of breastfeeding. Trust and empathetic connection necessary to disclose such experiences to health professionals. Disclosure impeded by power-imbalances, fear of baby being taken away.

Cecile	*Breastfeeding infused with tension, anger and overwhelm* Aversion involving shocking and overwhelming feelings of wanting son to stop feeding. Feeling described as worse than labour. *Aversion complicated by anger and sadness* Aversion exacerbated by everyday stresses, and experiences of anger. Cecile queried whether they were somehow connected. Sadness turning into anger, turning into sadness.	*A unique way to provide safeness, comfort and making up for losses associated with the birth of a sibling* Breastfeeding making son feel safe, comforted and included. Also allowing Cecile to provide this through a unique means that nobody else can provide. Hoping to get back to old breastfeeding relationship. *Tension, unintended rejection and fear of causing emotional injuries* Tension surrounding feeds, and fears of the consequences for son's self-worth following repeated rejection.	*Practical distractions and limits allow the mind to be elsewhere* Coping by distracting the mind through reading, replying to emails, or using breathing or visualisation techniques. *Making sense of aversion in biological terms* Making sense of experience in biological terms as a mammalian instinct to preserve milk for the baby. Feels like she's going against evolutionary hardwiring. Seeing this pattern in other women and other mammals alleviated the sense of failure.
Ciara	*Aversion difficult to describe - feeling 'yuck'* Breastfeeding aversion described as a bodily experience that was difficult to comprehend verbally or logically. Best effort at describing it with words was 'yuck'. At its worst, Ciara experienced feelings of what she imagined would be like being molested or sexually abused. *Aversion upsetting, unexpected and making breastfeeding emotionally unmanageable* Experience upsetting, unexpected, and in stark contrast to her ideal scenario of breastfeeding, which was characterised by grace and willingness to feed. Feelings of aversion lasting entire feed and making breastfeeding emotionally unmanageable.	*Breastfeeding problems resulting in stress and rejection* Ciara spoke of her breastfeeding experiences affecting her relationship with Aaron, where a mismatch of what he wanted and what she felt that she was able to give, gave rise to her having to reject him. *Breastfeeding a means of validating child's instincts and staying true to parenting beliefs* She believed that by weaning her son before he was ready she would be invalidating of his natural instincts, and she felt that she would be enforcing the wrong message of not listening to his own bodily signals. *Making up for losses in relationship and*	*Coping by limiting or avoiding feeds* Ciara had developed strategies of compromise, such as limiting feeds and avoiding situations when her son would usually ask for a feed. *Feelings rationalised and justified by using evolutionary explanations* Making sense of experience in theoretical terms as her body rejecting the older nursling, to preserve milk for baby. Evolutionary explanation justifying negative feelings towards her son while he was nursing. *Lack of belief in medical healthcare* Medical healthcare at odds with Ciara's standpoint as a naturopath. Belief that thinking and talking about problems only perpetuate their

		avoiding the repetition of childhood patterns Feeding him may also have been a way to make up for the initial difficulties in their early breastfeeding relationship, but also to make up for her sense of lack of validation from her own childhood.	existence. Rather seeking validation from preferred healer to be supported to continue feeding or supported to stop.
Leanne	*Experience of aversion difficult to describe* Struggling to describe her experience in words, thus, used a number of analogies to paint a picture of her experience, including nails on a blackboard, tickling, her skin crawling. *Aversion making mum want to avoid feeding and touch* She experienced being highly sensitive to physical sensations, including her son's desire to touch her breasts and her skin. Experiencing as if she could not stand her son feeding, and she often felt like she wanted him to stop the instant he latched on.	*Breastfeeding providing son with a special place and avoiding feelings of failure and guilt* Breastfeeding was regarded as a special place for her son, which she did not want him to have to give up. Breastfeeding serving a function to reduce guilt for getting pregnant and the sense of failure if she were to stop prior to her set goals.	*Limiting feeds, distraction and therapy strategies provide compromise between mum's and son's needs* Using a number of strategies for coping, including counting or distraction. Making use of acceptance and mindfulness exercises which she applied in her own client work. *Understanding experience and sharing with like-minded preventing feelings of shame* Group support online a safe space to share breastfeeding experiences, preventing her from feeling negative about herself. The normalising aspect of the group experience confirmed to her that there was not anything wrong with her or her experiences.
Danielle	*Aversion a bodily experience difficult to describe with words* Danielle struggled to put words to her experience and explained that it had to be experienced to be fully understood. Danielle spoke about out control feelings of irritation, impatience and a sense of being violated associated with breastfeeding.	*Breastfeeding comforting for mum and son* Breastfeeding to comfort son and self, but aversion making mum less resilient, contributing to PND. *Aversion getting in the way of responsive and desired parenting* Anger getting in the way of responding to son's	*Seeking strategies and family support to alleviate distress* Coping by limit feeds, taking time out and increasing self-care. Seeking emotional and practical support from close family members. *Seeking to make sense of experience to be able to accept it*

	Breastfeeding experiences influencing view of self Aversion associated with feelings of failure and anger with self for getting angry with son. Blaming self for not having made the right breastfeeding choices. Feeling resentment for having put son and self in this situation, and being disappointed in unmet expectations. Thus, being self-critical of not having weaned him to avoid this emotional pain.	needs, being stricter, snappier and more impatient with her son. Experience triggering Danielle’s fears of lasting consequences for her son.	Looking for explanations within self to try to accept it. Viewing aversion as interlinked with other problems, such as low level depression, and influencing one another. Support group offering a normalising function and relieving distress by making mum realise that she is not alone with her experiences.

Appendix 2-E: Extract From Reflexive Diary

Field Notes and Reflections on my Interview with Ellen

- *I feel like the interview went well and that it would add interesting data to the study.*
- *Ellen had more severe experiences of both aversion and low mood during feeding and it was an interview that resonated with my own experiences to some degree.*
- *Ellen's weighing up of the pros and cons of breastfeeding were interesting and I thought of the literature around this.*
- *It seems like Ellen was willing to sacrifice a lot in order to maintain the feeling, proof and belief that she was a 'good enough mother', despite having a lot of negative feelings and experiences around feeding and the impact it has on the relationship she formed with her older son.*
- *When she told me tough parts of her story, I wanted to jump in and rescue/validate but resisted and it left me feeling cold-hearted and greedy to want to dig deeper into her story without giving anything in return. I wanted to say how hard it must be and how many women feel the same and that she is probably doing great even by just having this incredible self-awareness.*
- *Worrying that I wasn't validating enough in her tough story, discussing with fellow trainees about striking the balance between clinician and researcher.*
- *I found Ellen's story so interesting that I wanted to transcribe it straight away. I wanted to know and understand her story.*

Appendix 2-F: Interview Schedule

Interview Schedule for Semi-Structured Interviews

Instructions for the participant:

I am very interested in your experience of having negative feelings during breastfeeding and as a part of the interview I am going to ask you a few open questions which might help you talk about it. There is no right or wrong answer and you can say as much or as little as you want; it is your perception and your experience that I am curious about.

The experience of negative affect during breastfeeding:

1. Please tell me about your experience of negative feelings during breastfeeding.
   Prompts: How frequent are these experiences? How strongly do you feel them? How long do they last? What happens to you when you experience them? What do you think and feel? How do you feel afterwards?

The impact of negative affect during breastfeeding:

2. How do you think that the experience of negative feelings during feeding has impacted on the way you see and feel about yourself?
   Prompts: What aspects, if any, of your views/thoughts/behaviours/feelings about yourself have been affected?
3. How do you think that the experience of negative feelings during feeding has impacted on the relationship you formed with your baby?
   Prompts: What aspects, if any, of your views/thoughts/behaviours/feelings about your relationship with your baby have been affected?
4. What other areas of your life has this experience impacted on, if any?
5. Has the experience had any positive consequences for you?
   Prompts: Have you learnt something about yourself? Have you discovered something new about your feelings?

Background:

6. Do you have current or past experience of mental health problems or emotional difficulties?
   Prompts: How were/are those experiences different from the experience of low mood during breastfeeding? How were/are they similar to the experiences of low mood during feeding? How do you think that those experiences are linked, if at all?

Probes to be used in between questions:

- Can you tell me more about that?
- What was that like?
- What did that look like?
- Can you give me any examples?
- Why do you think that?
- What else do you remember about it?

Section Three: Critical Appraisal

Title: A Critical Appraisal of the use of Reflexivity in the Study on Mothers' Negative Emotional Experiences during Breastfeeding

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Word Count (including references): 4,734

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A Critical Appraisal of the use of Reflexivity in the Study on Mothers' Negative Emotional Experiences during Breastfeeding

Qualitative studies are increasingly being conducted and applied in health settings (Biggerstaff & Thompson, 2008), an undertaking that comes with an ethical responsibility (Remler & van Ryzin, 2015). One essential aspect of phenomenological research, reflexivity, is concerned with the researcher's awareness of how their own responses shape the research process and end product (Chan, Fung, & Chien, 2013; Probst, 2015). Interpretative Phenomenological Analysis (IPA) is particularly concerned with the intersubjective relationship between the researcher and the participant as they make sense of their experiences. This is referred to as the *double hermeneutic* (Smith, 2011; Smith, Flowers, & Larkin, 2009), when "both researcher and the researched shape the encounter" (Probst, 2015, p.38). Because reflexivity is a central aspect of IPA research, the aim of this critical appraisal was to offer a research overview, discuss how reflexivity was applied throughout the study and offer recommendations for future research based on the reflections on the research process.

Research Summary

The objectives of the research study were to explore maternal negative emotional experiences during breastfeeding. For this purpose, a qualitative design was employed in which data collection took place through individual interviews that were later transcribed and analysed using IPA (Smith et al., 2009). Through the process of data analysis three main themes were generated. These themes conveyed mothers' experiences of emotional difficulties during breastfeeding, how they affected mothers' sense of self and how they coped with their experiences. Findings supported previous research suggesting that breastfeeding and maternal identity are intimately linked for many mothers (Huang, Atlas, &

Parvez, 2012; Larsen, Hall, & Aagaard, 2008), highlighting the relational aspect of breastfeeding as a means to bonding and communication between mother and child (Palmér, Carlsson, Mollberg, & Nyström, 2010). In addition, this study uniquely offered an insight into mothers' experiences of negative feelings during breastfeeding, how they were experienced as incongruent with mothers' view of self and how they affected mother-child relationships. The clinical recommendations arising from this research included the need for health professionals to understand psychological aspects of breastfeeding and for breastfeeding support to be tailored to each mother's individual needs. On reflection, my unique "insider position" of sharing some of the experiences with the participating mothers can be seen as a strength and limitation. This is particularly relevant to the discussion on reflexivity within IPA research as such a position can both inform and also pose challenges to the research process.

Bracketing/Bridling - A Means to Reflexivity

The researcher's own preconceptions and beliefs unavoidably influence the research process from the very beginning (Chan et al., 2013; Dahlberg, 2006; Probst, 2015). Indeed, any encounter with another person's story inevitably involves interpretation (Smith, 2011). However, when the researcher is "too quick" or "too careless" (Dahlberg, 2006, p. 16) in their understanding and interpretation, previously held knowledge and beliefs have the potential to skew the research and an in-depth understanding of participants' experiences may not be achieved (Ellet, 2011). Taking a reflexive stance enables the researcher to become aware of held preconceptions and to put them aside, a concept known as *bracketing* or *bridling* (Dahlberg, 2006; Ellet, 2011). This involves loosening of currently held ideas, to allow for the participants' voices to be heard (Ellet, 2011). In this study, for the purpose of raising awareness of conscious or unconscious preconceptions (Smith, 2007), a reflexive diary was kept throughout the research process, which offered an opportunity to re-examine my own held beliefs and preconceptions as they emerged (Chan et al., 2013).

Choice of Research Topic

Berger (2015) has suggested that whether or not a research area has personal resonance with the researcher's own experiences will influence how they use reflexivity. Thus, being aware of my own preconceptions was particularly important in this study because, like my participants, I too had experiences of negative emotions during breastfeeding. My experiences also sparked curiosity and in my search for information I came across a support website for women with similar breastfeeding experiences. I learned that a number of mothers were deeply affected by such experiences.

Although I was initially certain of the importance of research on mothers' negative emotions during breastfeeding, as I further considered this topic for my research study, I began questioning the significance of this experience and its relevance to clinical psychology. This prompted me to seek out further literature around breastfeeding problems and how mothers make sense of such issues, but, more importantly, to consider my own motivation for carrying out the research (Probst, 2015), as reflected in this extract from my reflexive diary:

> I find myself intrigued by the mothers on [name of website] who seem to experience really severe negative emotions during feeding and I feel for them when they consider weaning their babies, because I know how hard that would be for me (…) I feel really privileged to have this opportunity to put their experiences on the 'research map'.

With this in mind, refinements to the research proposal were made in collaboration with supervisors. This included discussions around broadening my research question to include any negative emotional experiences during breastfeeding, not limited to the website which I had originally come across. Such discussions brought awareness to the fact that the environment and how phenomena are talked about, for example in support groups, may shape how individuals think about them (Raskin, 2004). Thus, by broadening the research question I was more likely to recruit participants whose beliefs were not coloured by beliefs and discourses of one community only.

Choosing the Appropriate Qualitative Approach

To explore mothers' experiences of negative emotions during breastfeeding a number of qualitative approaches could have been chosen and the choice would have fundamentally affected a number of key aspects of the research process, such as the research agenda, assumptions and the desired end product (Starks & Trinidad, 2012).

A narrative approach, for example, may seek to investigate how an individual's narrative creates a context in which their experiences are understood, such as a chronological timeline (Creswell, 2012; Smith et al., 2009). For this purpose, the narrative researcher encourages the individual to tell their story with minimal prompting rather than loosely following an interview schedule which is aimed to encourage the participant to speak about particular experiences, as would be the case in IPA (Smith et al., 2009).

Another common approach, Grounded Theory (GT), aims to generate a theory about the processes involved in a specific experience, grounding this theory in the data by using an inductive process (Charmaz, 2006; Creswell, 2012; Starks & Trinidad, 2012). In contrast to IPA's aim to explore in details individuals' experiences, a GT approach is more interested in a broader theoretical explanation of processes thought to be inherent in the studied phenomenon (Smith et al., 2009), such as the transition to motherhood in the context of postnatal depression (Homewood, Tweed, Cree, & Crossley, 2009).

The GT approach is also more flexible in terms of the heterogeneity of the sample. In contrast to IPA's criterion for homogeneity, a GT study may include unusual cases in the sample which helps the researchers account for the range of processes involved in a certain experience (Pietkiewicz & Smith, 2009). GT was not chosen because the aim of the current research was not the generation of a theory, but rather a detailed exploration of women's lived experiences.

The critical realist epistemological position underpinning IPA suggests that individuals' utterances reflect their lived experiences (Smith, 2011; Smith & Osborn, 2008) as opposed to approaches such as discourse analysis which view language as providing constructions for a social purpose (Howitt & Cramer, 2010) and may or may not accord with one's beliefs or personally held attitudes. This was in keeping with the research question that aimed to convey to the reader what it is like to experience negative feelings during breastfeeding. IPA also offered flexibility in relation to the sample size with a wide range of acceptable numbers. A low number, for example, would have allowed for in depth exploration of a few cases, while a higher number would provide sufficient data to draw conclusions about similarities and difference across individual experiences (Smith et al., 2009).

Data Collection

Data collection took one of three forms, face-to-face, via telephone or via Skype. My initial preconceptions were that face-to-face interviews would be superior to the two other forms of data collection enabling participants to more comfortably share intimate details about their experiences. This preconception has been echoed in the literature, raising issues around the absence of visual cues and loss, or distortion, of data inherent in interviews carried out at a distance (Mealer & Jones, 2014; Novick, 2008). However, Novick (2008) has stated that little evidence exists to suggest that such issues frequently occur and when they do, that they substantially and negatively influence the quality of the data.

Practical Issues Concerning Remote Data Collection

The use of Skype appears to have both positive and negative aspects attached to it. On the one hand, Skype is praised for its flexibility both with regards to overcoming logistical barriers to participation, such as geographical distance (Oates, 2015) and honouring the participant's preferred time and setting (Hanna, 2012). Simultaneously, however, research cites that chosen locations, such as work and home can be distracting for participants and highlights the risk that an internet connection may be lost or distorted, which may affect the recording quality of the data (Deakin & Wakefield, 2014).

In this this study, both positives and negatives of home-based Skype interviews were observed. Firstly, time boundaries became somewhat blurred when women were interviewed via Skype. A number of them were late logging on or could not remember their Skype account. My interview with Melissa started 40 minutes later than agreed which raised apprehension in me because of my own later commitments. Of course, one could argue that a person can be late for a face to face interview; however, it appeared that women had not considered potential technical glitches inherent in Skype use and had not left themselves sufficient time margins. In the future it may be helpful to remind participants of this potential issue to reduce mutual worry and frustration. However, offering women the opportunity to be in their homes, both for meeting face-to-face but also for telephone and Skype interviews, reduced barriers such as childcare or travel.

Secondly, occasional technological problems occurred during interviews, for example, when the internet connection was suddenly disrupted. Surprisingly, however, these issues did not necessarily reduce the flow of participants' stories. Ciara, for example, was so immersed in talking about her experiences that having to break mid-sentence due to connection breaking up, did not stop her from continuing where she had left off:

> Ciara: Emmm, the feeling, it (connection breaking up) feels like…
>
> Marcelina: You know, Ciara, I'm breaking up with you. I'm gonna turn off the camera, because it might, it might be a bit better then [switching off]. Sorry, I interrupted you there, em, eeem.
>
> Ciara: Ok, yeah, it can tend to feel like, um, like being sexually abused, or something like that, eehh, that's at its worst.

Problems were quickly fixed, for example, by turning off the video setting to enhance the quality of the audio. Indeed, Svensson, Samuelsson, Hellström and Nolbris (2014) also found that when connection problems occurred they were short-lived and resolved through discussion with participants.

Quality of Interviews Multiply Determined

Throughout the period of data collection I observed that the quality of the interviews was dependent on a number of factors other than the medium used for data collection alone. In some instances, face-to-face interviews felt less personal than Skype interviews. For example, I interviewed Renee (face-to-face) at a local café, which was a location chosen by her. It was a busy time of the day and she was speaking quite quickly and quietly, leading me to make this entry into my reflexive journal: "I found it hard sometimes to tune in to her story and found myself using many more validating words like 'uh-uh' or 'yeah' or nodding to compensate for not having fully heard her words".

My interview with Chloe, despite being face-to-face, felt uneventful. Although meeting her in her home with no other visible distractions, I found it difficult to get her story to flow. Chloe struggled to elaborate on aspects of her experience, even when prompted, and it left me somewhat confused about her experiences, as reflected in an excerpt of my journal.

> I felt like I had to drag answers out of her, she wasn't very engaged with wanting to tell her story and I wondered if she felt that there was much of a story at all (…) She felt a bit detached from the story, as if it wasn't a big deal, but at the same time she described really strong negative feelings.

This may have reflected the fact that although Chloe's breastfeeding experiences were distressing, they did not affect her much outside of the early stages of her breastfeeding experiences. On the other hand, Ellen, Cecile, Ciara and Danielle were all deeply affected and distressed by the severity of their breastfeeding problems. Interviews with these mothers generated much more detailed and intimate accounts of their experiences. All of these interviews were conducted via Skype, and some even without the camera on. Cecile's interview, for example, activated a deep sense of empathy in me, as seen in this excerpt from my reflexive diary: "I really felt for her son in her descriptions of her experience of aversion, it was really grabbing at my heart".

Thus, none of the methods was necessarily regarded as better in terms of generating high quality data. Rather, quality of the data was dependent on other factors, including the degree to which mothers were affected by their breastfeeding problems. Although Skype, telephone and face-to-face interviews yielded comparable data in terms of quality, it is worth noting that data collection when a participant only sees the researcher's face (as in Skype) or cannot see the researcher at all, may require paying specific attention to visual cues (Habibi, et al., 2012) and increasing the use of non-verbal communication to create and maintain the rapport built with participants (Mealer & Jones, 2014).

Interview style, which improves over time (Smith et al., 2009) will also affect what data is generated (Chan et al., 2013). In my experience, early interviews were more rigidly focusing on the interview schedule and questions asked in a somewhat convoluted way. I also realised that I could have left longer silences following mothers' answers as it may have promoted reflection on what had been said (Pietkiewicz & Smith, 2012). In addition, I noticed that some of the initial interviews focused on the descriptive characteristics of mothers' experiences and I kept closely to the interview schedule. Over time, however, I learned to more flexibly follow mothers' accounts of their experiences.

Another challenge that I discovered was striking the balance between being a clinician and a researcher, reflected in this diary excerpt:

> When she [Ellen] told me tough parts of her story, I wanted to jump in and rescue/validate and when I resisted it left me feeling cold-hearted and greedy for wanting to dig deeper into her story without giving anything in return.

This may initially have hampered by ability to ask detailed questions about mothers' experiences, a finding echoed by McNair, Taft, and Hegarty (2008) who found that researchers with a clinical background may at times fail to probe deeper for participant's deep seated meanings of experiences. Upon discussion with fellow trainees I was able to find compromises between acknowledging mothers' struggles while maintaining data quality.

However, despite limitations around the data collection process, I was able to form a good rapport with the women I was interviewing, as evidenced by their ability to tell me intimate details of their experiences, especially aspects that they felt were incongruent with the parent they wanted to be:

> I was on the line in terms of, I mean definitely way past my personal line but, you know in terms of um, physically correcting him, not spanking or anything like that, um, but like if he was, if he was acting up, um (pause) you know, picking him up and, you know, plopping him somewhere else. (Cecile)

Ethical Issues Concerning Remote Data Collection

In terms of data collection, research suggests that Skype and telephone interviews offer a number of ethical benefits for both the researcher and participants. For example, participants may regard interviews at a distance as a safe way of disclosing sensitive information which they may not have been comfortable sharing in a face-to-face setting (Novick, 2008). In addition, the use of Skype interviews allows for anonymity requirements to be met and participants can easily withdraw their participation by simply disconnecting without having exchanged personal details (Deakin & Wakefield, 2014).

The undertaking of collecting data at a distance raised a significant ethical issue. In line with the research protocol and information sheet, participating mothers were asked to send back their initialled and signed consent forms via post. Unfortunately, one participant did not return her signed consent form, what alerted me to an ethical oversight that I had made during the process of designing my study. More specifically, it was not sufficiently clear in my protocol that participants were going to return signed consent forms prior to interview, thus I had collected data which I had no formal consent for. Upon discovering this omission, I raised it with the ethical committee who, following discussion, concluded that no further action was required and that verbal consent from the participant in question was sufficient in this case. This experience provided me with several important learning points. As it was my first time collecting data at a distance I realised that the procedure was not clear in my mind or in my protocol. Thus, I did not consider the specific order in which consent was going to be obtained. Moreover, the competing demands of trying to overcome vast time zone differences and technical issues while making arrangements for long-distance interviews, the importance of having consent prior to carrying our interviews was unintentionally given lower priority.

Data Analysis

Throughout the process of data analysis reflexivity was considered in the following ways. The process of analysing data was discussed and initially supervised. This exchange and continuous input from supervisors throughout the process of draft reading enabled me to strike a balance between being interpretative throughout the analysis, which is one of the main components of IPA (Smith et al., 2009; Yardley, 2000), while still considering mothers' original accounts to support those interpretations. In addition, initial notations were deliberately coded to remain as close as possible to mothers' initial words, making sure that analysis was based in participant's actual accounts (Probst, 2015). All aspects of the analysis process, including an example of a reflexive diary, were documented to ensure a transparent presentation of findings (Snelgrove, 2011; Yardley, 2000).

Taking a Unique Position of Being an "Insider"

Throughout the study, I learned how my unique position of having experienced the researched phenomenon came with advantages and disadvantages. On the one hand, familiarity with the experience may have contributed to a better understanding of what to ask, facilitating the development of relationship with the participants and better understanding subtle difference between participants' responses (Berger, 2015). For example, when mothers in this study struggled to put words to their experiences I understood why. Their best attempts at describing their experiences included embodied and somatic characterisations, such as "sinking feeling" (Donna), "stomach clenching" (Kate) and Izabella's "throat tightening"

(Izabella) and because it resonated with my own experiences, I was aware that the bodily nature of such experiences might be an important area to explore.

Simultaneously it is important to keep in mind that although existing knowledge and values may inform the research process, they also have the potential to lead and distort findings (Dahlberg, 2006; Remler & van Ryzin, 2015). This excerpt from my reflective diary captures how I met with my own unknown preconceptions during my interview with Chloe:

> Much of her story did not resonate at all with mine and I noticed that during the interview I experienced that I was feeling a bit defensive at times, that I felt as if she wasn't describing the experience 'the right way'.

In practice, it was helpful to become aware of my preconceptions and consciously deciding how to make use of them in the study (Creswell, 2012). In this case I found that bringing awareness to my feelings allowed me to set them aside to honour Chloe's account of her experiences and realise how differently women experience negative feeling during breastfeeding.

Recommendations for Future Research

Reflections on the research process raised a number of areas for future research. Firstly, in light of mothers' sense that professionals considered breastfeeding problems through the lens of their limited knowledge about such difficulties, future studies could explore health professionals' understandings of negative feelings experienced during breastfeeding. Secondly, future research could investigate, more specifically, what mothers perceive that they need and how they would want to be supported throughout their difficult breastfeeding experiences. Finally, given that existing clinical guidelines do not explicitly consider psychological aspects of breastfeeding and the experiences that mothers in this study raised, future research activity could focus on updating clinical guidelines. Research activity suggested above could offer insights into the discrepancies between mothers’ experiences and professionals’ knowledge, informing training and clinical guidelines as a result and thus, help bridge the gap between the recommendations of existing guidelines and how they are actually implemented in clinical practice.

Reflections on the Link between Section One and Section Two

The two pieces of work presented in this thesis, the systematic literature review and the empirical research project, were conducted in research areas that were not immediately linked. This allowed for the two pieces of research to stand alone and not to impinge on each other too closely. For example, a literature review very close to the empirical paper may have put in question the need or rationale for conducting the empirical study. However, both pieces of research offered new understandings in the perinatal field on topics that are significantly less researched than, for example, postnatal depression. In addition, both pieces of research offered theoretical and clinical insights into how the application of a psychological lens to phenomena that are regarded as considerably biological in origin (such as hormonal activity), may offer new perspectives and approaches to managing such difficulties.

Conclusion

This critical appraisal aimed to discuss the role of reflexivity and how it linked to IPA throughout the research process. By systematically considering various aspects of the study, from initially planning through to data analysis and write up, methodological and ethical issues were observed and discussed. One such issue involved the practical and ethical issues associated with using Skype as one means of collecting data and a general discussion of what determines good quality data. Another issue related to the importance of acknowledging and making positive use of my unique position as a researcher and as a breastfeeding mother having experiences negative emotions during feeding. Finally, suggestions for future research were offered, which aimed to bridge the gap between current clinical guidelines around infant feeding and how they are implemented in practice.

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Section Four: Ethics Section

Application Process for Obtaining Ethical Approval for the Study Entitled: “Mothers’ Experiences of Negative Affect while Breastfeeding: An Interpretative Phenomenological Analysis”

Marcelina Watkinson

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Word Count (excluding references and appendices): 5,465

Word Count (including references and appendices): 10,897

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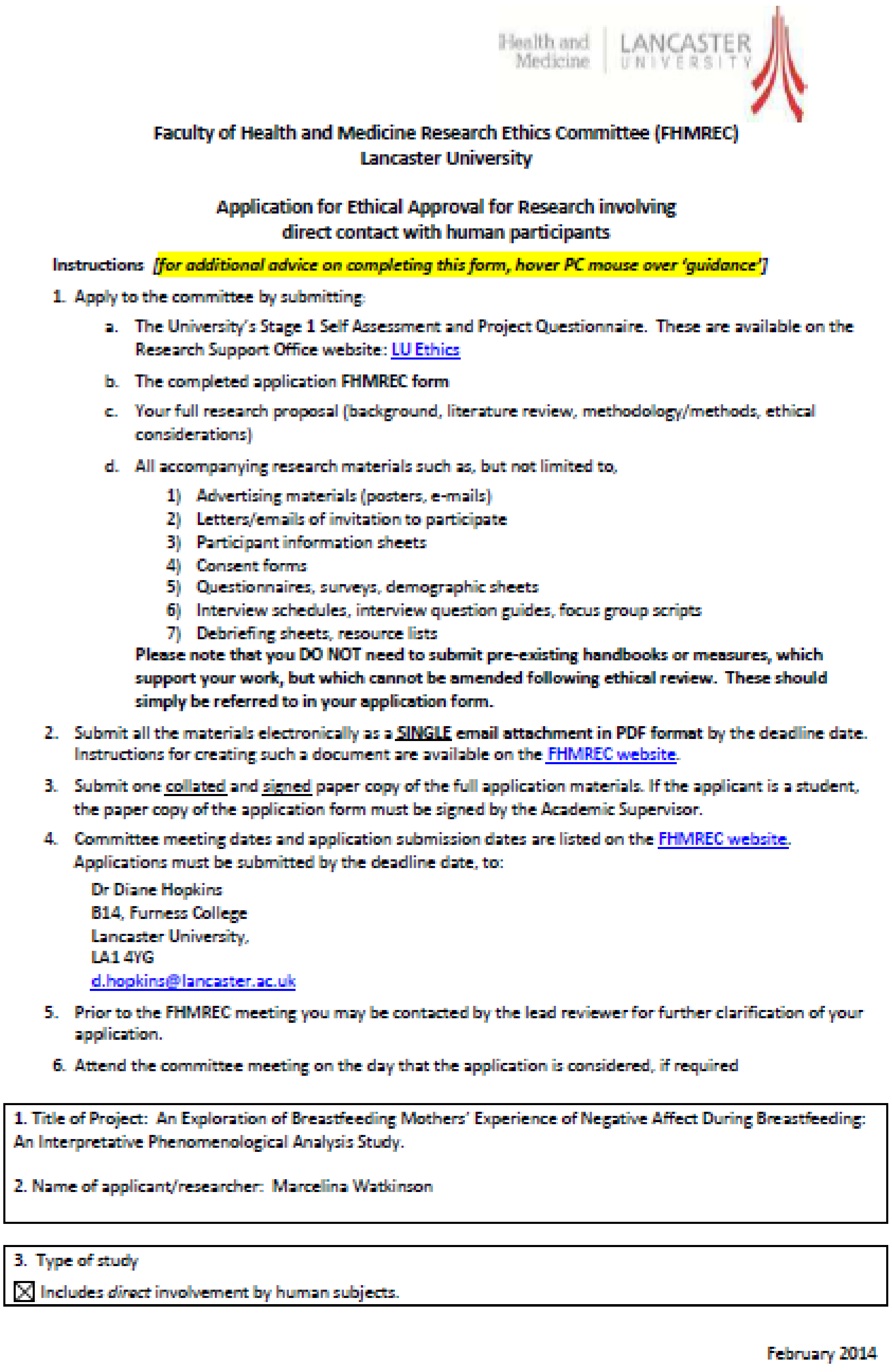
Faculty of Health and Medicine Research Ethics Committee Application Form



Faculty of Health and Medicine Research Ethics Committee (FHMREC)
Lancaster University

Application for Ethical Approval for Research involving
direct contact with human participants

Instructions *[for additional advice on completing this form, hover PC mouse over 'guidance']*

1. Apply to the committee by submitting:
    a. The University's Stage 1 Self Assessment and Project Questionnaire. These are available on the Research Support Office website: LU Ethics
    b. The completed application FHMREC form
    c. Your full research proposal (background, literature review, methodology/methods, ethical considerations)
    d. All accompanying research materials such as, but not limited to,
        1) Advertising materials (posters, e-mails)
        2) Letters/emails of invitation to participate
        3) Participant information sheets
        4) Consent forms
        5) Questionnaires, surveys, demographic sheets
        6) Interview schedules, interview question guides, focus group scripts
        7) Debriefing sheets, resource lists

    Please note that you DO NOT need to submit pre-existing handbooks or measures, which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.
2. Submit all the materials electronically as a **SINGLE email attachment in PDF format** by the deadline date. Instructions for creating such a document are available on the FHMREC website.
3. Submit one collated and signed paper copy of the full application materials. If the applicant is a student, the paper copy of the application form must be signed by the Academic Supervisor.
4. Committee meeting dates and application submission dates are listed on the FHMREC website. Applications must be submitted by the deadline date, to:

    Dr Diane Hopkins
    B14, Furness College
    Lancaster University,
    LA1 4YG
    d.hopkins@lancaster.ac.uk
5. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application.
6. Attend the committee meeting on the day that the application is considered, if required

1. Title of Project: An Exploration of Breastfeeding Mothers' Experience of Negative Affect During Breastfeeding: An Interpretative Phenomenological Analysis Study.

2. Name of applicant/researcher: Marcelina Watkinson

3. Type of study

☒ Includes *direct* involvement by human subjects.

February 2014

☐ Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. Please complete the University Stage 1 Self Assessment part B. This is available on the Research Support Office website: LU Ethics. Submit this, along with all project documentation, to Diane Hopkins.

4. If this is a student project, please indicate what type of project by marking the relevant box: (please note that UG and taught PG projects should complete FHMREC form UG-tPG, following the procedures set out on the FHMREC website

PG Diploma ☐ Masters dissertation ☐ DClinPsy SRP ☐ PhD Thesis ☐ PhD Pall. Care ☐

PhD Pub. Health ☐ PhD Org. Health & Well Being ☐ PhD Mental Health ☐ MD ☐

DClinPsy Thesis ☒

Applicant Information

5. Appointment/position held by applicant and Division within FHM Trainee Clinical Psychologist

6. Contact information for applicant:
E-mail: m.watkinson@lancaster.ac.uk Telephone: 07768642534 (please give a number on which you can be contacted at short notice)
Address: Division of Health Research, Furness Building, Bailrigg, Lancaster University, Lancaster, LA1 4YG

7. Project supervisor(s), if different from applicant: Jane Simpson, Craig Murray

8. Appointment held by supervisor(s) and institution(s) where based (if applicable): Research Director (JS) and Deputy Research Director (CM)

9. Names and appointments of all members of the research team (including degree where applicable)
Jane Simpson (Research Director)
Craig Murray (Deputy Research Director)
Marcelina Watkinson (Trainee Clinical Psychologist)

The Project
NOTE: In addition to completing this form you must submit a detailed research protocol and all supporting materials.

10. Summary of research protocol in lay terms (indicative maximum length 150 words):
Breastfeeding is associated with a number of physical and psychological health benefits and can be an enjoyable and soothing experience. However, a subset of breastfeeding women report a significant wave of negative emotions while breastfeeding, which may be so intense that they decide to wean their baby prematurely. This might have negative consequences for mothers for whom breastfeeding is essential to their identity as a mother. If they are unsuccessful, they may at increased risk of developing postnatal depression. Experiencing symptoms of depression in the postnatal period may have significant consequences for both mother and baby. Published research on symptoms of depression during breastfeeding is limited and therefore the aim of this investigative study is to explore breastfeeding mothers' experiences of this. Data will be collected using semi-structured interviews. Interviews will then be transcribed and analysed using Interpretative Phenomenological Analysis to draw out main themes reflecting participants' experience.

11. Anticipated project dates (month and year only)

Start date: Nov 2014 End date Sep 2015

Research Protocol

Doctorate in Clinical Psychology Thesis Research Protocol

Project Title: An Exploration of Breastfeeding Mothers’ Experiences of Negative Affect During Breastfeeding: An Interpretative Phenomenological Analysis Study.

Principal Investigator: Marcelina Watkinson

Project Summary

Breastfeeding is associated with a number of physical and psychological health benefits, for both mother and baby, and has been widely recognised and promoted (National Institute of Health and Clinical Excellence [NICE], 2008; World Health Organization [WHO], 2009). For many mother-infant dyads, breastfeeding is an experience of soothing and calm, partly due to associated oxytocin release (Uvnäs-Moberg, 2009). However, a number of women report a marked wave of negative emotions while breastfeeding (Heise & Wiessinger, 2011). Such repeated experiences may influence women to wean their baby prematurely (Heise, 2011), which might increase their risk of postnatal depression (Borra, Iacovou, & Sevilla, 2014). Experiencing symptoms of depression in the postnatal period may have significant consequences for both mother and baby (NICE, 2007).

Published research on symptoms of depression during breastfeeding is limited and therefore the aim of this investigative study is to explore breastfeeding mothers’ experiences of negative affect associated with breastfeeding.

Data will be collected using semi-structured interviews via the medium of Skype. The interviews will then be transcribed and analysed using Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009) to draw out main themes which reflect the researcher’s perspective of the participants’ experience.

Background

Breastfeeding provides a number of health benefits for both mother and baby (Murphy, 2000) and has been incorporated in both national (National Institute for Health and Clinical Excellence [NICE], 2008) and international (World Health Organization [WHO], 2009) policies on infant feeding. However, the concept of breastfeeding is far more complex than merely being a vehicle for meeting the nutritional needs of the infant (Marshall, Godfrey & Renfrew, 2007; Wiessinger, West & Pitman, 2010). The hormonal activity, particularly oxytocin release, associated with breastfeeding often has a soothing and calming effect on both mother and baby (Gerhardt, 2004; Uvnäs-Moberg, 2009; Solms & Turnbull, 2002). This attuned state of mind may increase a mother's ability to soothe and regulate her infant's emotions (Gerhardt, 2004) and oxytocin release might have significant psychological benefits such as facilitating the development of emotions and positive social behaviour (Carter, 2003; Macdonald & MacDonald, 2010) and enhanced attachment security (**Buchheim et al.,** 2009; Uvnäs-Moberg, 2009).

However, for a number of women the breastfeeding experience is not calm and soothing but instead filled with an array of strong negative emotions. During this period a number of women experience a marked drop in mood occurring a short period of time before milk release during breastfeeding (Cox, 2010; Heise & Wiessinger, 2011). Wide ranging thoughts and emotions have been reported by women experiencing this, including hopelessness, hollowness, anxiety, shame, upset, dread, irritability and even suicidal ideation.

Numerous women who experience negative affect during breastfeeding may not confide in their healthcare providers out of concern for being treated for postnatal depression (PND), which they do not experience that they have (Wiessinger et al., 2010). The time limited experience of dysphoria during breastfeeding in association with milk release is different from PND, where, in addition to other symptoms, the experience of dysphoria is present throughout most of the day, nearly every day (American Psychiatric Association, 1994). This experience is also different from a general aversion to breastfeeding or a psychological reaction to common breastfeeding problems (such as nipple pain, poor latching technique or mastitis).

Rationale

Investigating the experience of negative affect during breastfeeding may have implications for at least two main areas relevant to clinical psychology. Firstly, for many mothers, choosing to breastfeed is a “fundamental maternal commitment” (Murphy, 2000, p.301) and “a way of mothering” (Wiessinger et al., 2010, p. xxi). A recent study of nearly 14000 mothers found that breastfeeding significantly reduced the risk of postnatal depression for women who had planned to breastfeed and successfully managed to do so. Furthermore, women who had planned to breastfeed, but were unsuccessful in doing so were at increased risk of postnatal depression (Borra, Iacovou & Sevilla, 2014). Furthermore, Stuebe, Grewen and Meltzer-Brody (2013) reported that mothers’ elevated anxiety and depression scores during breastfeeding were associated with lower oxytocin levels, which, in turn may impact on mothers’ vulnerability to postnatal depression and breastfeeding difficulties. Both physical difficulties (Kelleher, 2006) and intense emotional experiences of negative affect during breastfeeding may lead mothers to the decision of weaning their child early (Heise, 2011). Premature weaning might trigger a range of difficulties for a mother for whom breastfeeding is tied to her identity as a mother, woman and partner (Marshall et al., 2007; Murphy, 2000). Thus, supporting women (who want to breastfeed) to be successful is not only a public health matter (Hausman, Smith & Labbok, 2012), but also a way to support women post birth, at a time when many women feel vulnerable in their mothering role (Kleiman & Wenzel, 2009).

The second reason for investigating maternal negative affect during breastfeeding relates to the consequences that such experiences may have on the bond between mother and baby. As outlined above, research has linked intended but unsuccessful breastfeeding to higher risks of postnatal depression (Borra et al., 2014; Stuebe et al., 2013). Symptoms of postnatal depression have, in turn, been associated with lower levels of maternal sensitivity and warmth (Musser, Ablow, & Measelle, 2012), disrupted emotional exchanges between mother and baby (Milgrom, Ericksen, McCarthy & Gemmill, 2006) and long-term difficulties for the infant (Department of Health [DoH], 2007), as well as the mother and other family members (NICE, 2007).

Literature on maternal negative affect associated with breastfeeding is limited. In addition to the above literature, a small number of case studies and lay publications exist, referring to the above experience as Dysphoric Milk Ejection Reflex (D-MER) (Wiessinger & Heise, 2011). However, no direct research has yet been carried out in this field.

Aims and Objectives

This IPA study aims to explore the hitherto under-researched area of negative affect during breastfeeding. The main focus will be on the impact that this experience has on breastfeeding mothers, both in terms of sense of self and well-being, but also the potential consequences it might have on the bonding experience they have with their infants. To aid this exploration the following research questions have been identified:

- How do breastfeeding women experience and make sense of negative affect during breastfeeding?
- What are the consequences for women who have been significantly affected by the experience of negative affect during breastfeeding in terms of their sense of self, identity and relationship with their baby?

Methodology

Design

As the nature of this study aims to explore a small number of individuals' experience of negative affect during breastfeeding, qualitative methodology has been identified as the most appropriate research design.

Participants

Sample

Following recommendations of Smith et al. (2009), the sample will consist of approximately 4-10 participants. Four participants are sufficient to allow the in depth exploration of a certain phenomenon, as well as comparing differences between accounts. Interviewing more than 10 participants might compromise the possibility to thoroughly engage with the data during the analysis stage (Smith et al., 2009).

The following inclusion criteria have been identified for this study:

- Mothers who are currently breastfeeding or have breastfed in the past 5 years.
- Current or previously experienced negative affect/dysphoria during breastfeeding.
- Sufficient fluency in the English language to be able to undertake an interview in English. The limited time frame and lack of funding for the study would make interpretation and translation difficult.
- Participants will have to be located within travelling distance, alternatively have access to telephone, or the Internet with the ability to communicate via Skype.

Recruitment process

Participants will be recruited via two routes. Firstly, the study will be advertised in play groups, breastfeeding groups, children's centres and via postnatal healthcare providers, such as health visitors (see Invitation to Participate – Face to Face). Should this not generate a sufficient number of participants, the recruitment process will be expanded to invite mothers to participate via parenting websites, such as [redacted] (see Invitation to Participate - Online). Women who show initial interest in participating will be sent an information sheet about the project (either via email or post), as well as an expression of interest form to return via email or post (see Expression of Interest Form, Information Sheet - Face to Face, and Information Sheet - Online). The expression of interest form will ask potential participants about information necessary to identify whether they meet the inclusion criteria.

Should the study attract more eligible participants than we can interview, participants will be accepted on a "first come first served" basis. Once the maximum number of eligible participants has been recruited, the advertising about participation will be removed from the locations where the study has been advertised. Should more participants be needed at a later point, for example due to participant attrition, the invitation to participate will be re-posted until sufficient number of participants has been recruited.

Consent

Participants' consent to participate in the study will be obtained by the principal investigator on a number of occasions. Firstly, formal consent will be sought at the point of contacting participants who, following reading the information sheet, have shown interest in participation. Participants will be asked to sign and initial a consent form (see Consent Form) upon meeting. Alternatively, the principal investigator via post, to be signed and initialled by the participants and returned to the principal investigator in a pre-paid addressed envelope.

Secondly, consent will be sought prior to beginning the interview as well as throughout the interview, particularly if the conversation leads into a sensitive area. Participants will be informed that they can discontinue their involvement in the study at any point prior or during the interview process, or withdraw their consent up to two weeks post data collection.

Materials

Materials to be used for this study include a digital audio recorder to record conversations, a computer to transcribe audio recordings and NVivo10 for analyzing qualitative data. NVivo 10 is a software application for qualitative research which facilitates organizing and categorizing large amount of data.

Should data be collected via telephone or Skype, a computer with Skype installed on it will be used. Skype is a software application making it possible to engage in voice and video communication via the Internet (Edirippulige, Levandovskaya, & Prishutova, 2013). The software application MP3 Skype Recorder will be used to record the sound of the interviews. Alternatively, a digital voice recorder will be used to capture the interviews by placing it close to the computer speakers/telephone.

Data Collection

Data collection will take place through face to face interviews at a mutually convenient location for principal investigator and participants. In the event that participants are recruited via the Internet, data will be collected via telephone or the medium of Skype. Several studies have documented benefits of using Skype in contact with participants, including simulating a face to face contact, allowing participants to remain in their preferred location, reducing stress of travel, and overcoming geographical distances (Hanna, 2012; Svensson, Samuelsson, Hellström, & Nolbris, 2014). In addition, it offers a time-saving, low cost and environmentally friendly means of collecting data (Hanna, 2012). Participants who do not wish to proceed via Skype will be offered the alternative of a telephone interview and can then withdraw if they do not want to proceed with either method.

Data will be collected by the principal investigator through semi-structured interviews with approximately 5-6 questions, prompts and probes to encourage conversation around the research aims (see Interview Schedule). In addition, the principal investigator will ask participants some demographic questions (see Demographic Information). Participants will be notified that the interview content remains confidential, with the exception of circumstances where their own safety or the safety of others are indicated to be at risk based on the information that they disclose. If confidentiality has to be breached, the study supervisors will be consulted and if supervisors are unavailable, the principal investigator will contact another appropriate university staff member. In the event of rapid action being needed, for example out of hours, safeguarding/emergency services (e.g. A&E or the local Crisis Team) will be contacted. All actions taken will be communicated to the research ethics committee.

In addition, participants who are interviewed via Skype will be told that by using Skype the principal investigator is not able to guarantee complete confidentiality, due to the fact that information transmitted via the Internet may not be completely secure. This will be openly shared with participants prior to the interview and they will have an opportunity to withdraw their participation, should this create a barrier for their ability to participate.

Data Analysis

Interviews will be audio recorded, transcribed verbatim by the principal investigator and anonymised in such a way that names, locations and other identifiers will be removed or replaced in the transcripts.

The aim of the present study is to explore the subjective interpretations of participants' experiences of a specific phenomenon, thus, IPA has been identified as an appropriate method for data analysis (Smith & Osborn, 2008). The aim of using IPA is to understand how an individual makes sense of, and derives meaning from, a specific experience, event or phenomenon (Pietkiewicz & Smith, 2012; Starks & Trinidad, 2014). IPA is often used with homogenous samples, where participants are purposefully chosen to have certain factors in common, such as experiencing a certain phenomenon (Smith et al., 2009; Smith & Osborn, 2008). The use of IPA can be particularly relevant to complex and novel areas (Smith & Osborn, 2008) and it has been applied to both health and clinical psychology research (Pietkiewicz & Smith, 2012), making it an appropriate approach for research on negative affect during breastfeeding.

Practical Considerations

Technical challenges

In the event that Skype is used for data collection, technical challenges might be present. Skype has been identified as a useful medium for both research and clinical/educational practice (Svensson et al., 2014; Edirippulige et al., 2013); however, potential difficulties inherent in the use of this technology must be considered for the present study. Such difficulties include occasional interruptions where audio and/or video are of poor quality or disrupted (Svensson et al., 2014) or contact with participants who are less knowledgeable or trusting of technology (Habibi et al., 2012). Building rapport in such situations may be somewhat more difficult, because subtle interactional cues may be lost when communicating virtually (Habibi et al., 2012). However, Svensson et al. (2014) found that allowing participants to stay in their preferred location contributed to a relaxed and comfortable conversation.

Suggestions of overcoming technical problems, as those above, involve openly discussing problems with technology and trying to reconnect if a connection is broken (Svensson et al., 2014). Another possibility, in moments of poor connection, might be to turn off the video setting and continue the interview through audio communication, alternatively continue the conversation via telephone.

Interview scheduling

Another practical consideration relevant to the present study concerns scheduling interviews around participants' work/home commitments and childcare availability while finding a mutually convenient location to conduct the interview. If participants are recruited online, they may be located in a wide range of countries and continents, some of which have different time zones from the UK. Scheduling will require flexibility on behalf of the principal investigator, in order to provide participants with a suitable time for interview.

Data storage

Data will be stored, transported and eventually deleted/destroyed securely in the following ways. Firstly, files on the computer with identifiable information (e.g., the expression of interest forms) will be encrypted and stored temporarily on a password protected computer. These files will be securely transferred to Lancaster University to be stored for ten years. Secondly, participants' original paper consent forms will be locked away in a filing cabinet at Lancaster University and kept for ten years, following which they will be destroyed. Third, anonymised transcriptions of the interviews will be stored on a password protected computer and transferred to Lancaster University, where they will be kept for 10 years following the end of the study. Finally, digital audio recordings will be encrypted, stored on a password protected computer and deleted once the project has been examined. The person in the position of the DClin Psy Research Coordinator (currently Sarah

Heard) will be responsible for storage and deletion of data once the principal investigator has completed the course. Any identifiable data, including participants' voices, will be deleted from the recorder as quickly as possible following having been transferred to a password protected PC. In the meantime the recorder will be stored securely.

Ethical Considerations

Support for participants

Due to the nature of the research topic, it is possible that the interview process might cause emotional discomfort or distress for some of the participants. In the event of data collection occurring via Skype or telephone, the physical distance between the principal investigator and participants, may present challenges in offering support to the same degree as one would in a face-to-face setting. A number of key measures will be put in place to support participants for whom the interview process brings up upsetting memories or thoughts. Firstly, prior to the interview participants will be briefed about the interview process, both in writing and verbally. Participants will be told that should they feel anxious about the potential content of the interview, they will have an opportunity to contact the principal investigator to talk about it prior to the interview. Secondly, in the event of carrying out Skype/telephone interviews the distance may provide a barrier for providing comfort and support. Thus, participants who are interviewed at a distance will be advised, prior to the interview, that it may be advisable to have someone close at hand who can provide further comfort and support, should this be necessary. Finally, participants will be advised that should the interview process trigger any prolonged difficult thoughts and feelings, they can turn to Family Lives (www.familylives.org.uk) alternatively Family Helpline (www.familyline.org.uk). These organisations offer parenting support via phone, email or post.

Fieldwork considerations

Minor health and safety issues have been identified for the principal investigator, including uncomfortable working hours to potentially interviewing participants in different time zones and significant amount of time spent in front of a computer. Awareness and mindful scheduling of work hours may reduce the impact of these risks.

In the event of interviewing participants at a distance, personal safety risks are reduced, for example risks inherent in home visits in unfamiliar locations. However, a number of safety precautions have been considered regarding the conduct of the research, as well as contact with participants. These risks will be reduced by adhering to Lancaster University's Guidance on Safety in Fieldwork. Firstly, the principal investigator will not use any personal means of communication with participants. The email and postal address provided for communication with participants are linked to Lancaster University. In addition, if required, a Skype account will be created for collecting data only and will not be used for any other purposes. Secondly, all aspects of the data collection process will be carried out in line with protocol and agreement with supervisors. Thirdly, the time and location of interview, intended length of stay as well as estimated time of return will be communicated to the supervisors. Contingency plans will be arranged with supervisors in the event that the principal investigator does not make contact following interview. Finally, participants will also be contacted previously to identify any preferences or expectations of the visit/interview. In addition, the 'expression of interest' sheet explicitly asks participants if there is any information that would be useful for us to know prior to the interview. The principal investigator is aware of the emotive nature of the topic under study, thus, it will be particularly important to adopt a non-judgemental, empathic style of interviewing.

Finally, it is acknowledged that the area of research may give rise to emotive interviews with participants. The DClin Psy programme has in place a number of professionals who can provide support, should the content of the interviews cause the principal investigator emotional distress.

Researcher bias

A final ethical consideration concerns the biases that are inherent in qualitative work, for example how the researcher's own experiences influence how they engage with the data and the interpretations that they make (King, 1996; Smith et al., 2009). This is particularly relevant for this study, as the topic under study has personal resonance for the principal investigator. My own experiences of mild waves of negative affect during breastfeeding may have contributed to my belief that research in this field is important and necessary. Simultaneously, my identity as a breastfeeding mother might contribute to the ability to truly understand and empathise with the participants in their navigation of the complex area of mothering and related identities. Acknowledging, understanding and being mindful of one's own pre-conceptions as a researcher is an essential aspect of conducting qualitative research as this enables participants to share their narratives as they have been experienced (Adame, 2012; Smith et al., 2009). Shenton (2003) suggests that open dialogue with supervisors or other members of the research team may serve the function of bringing personal biases into awareness and testing out interpretations.

Timetable

Ethics: Aug – Nov 2014

Literature review (metasynthesis): Sep 2014 – Dec 2014

Recruitment and data collection: Nov 2014 – Feb 2015

Introduction (study): Jan – Feb 2015

Analysis: Dec 2014 – Apr 2015

Write up (results & discussion for study): Apr – Jun 2015

Critical appraisal: July – Aug 2015

Submission: Sep 2015

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Appendix 4-A: Letter Confirming Ethical Approval

Appendix 4-B: Invitation to Participate

Advertising Wording

The following text will be used to advertise the study on various parenting websites before participants are sent an information sheet and expression of interest form.

Hello!

My name is Marcelina Watkinson and I am a trainee clinical psychologist at Lancaster University. Together with my supervisors I am currently working on a study which is exploring how breastfeeding mothers experience and make sense of low mood and/or other negative emotions during breastfeeding. If you identify with the following statements (see below) I would like to invite you to take part in my study.

- You are a breastfeeding mother (or have breastfed in the past 5 years).
- While breastfeeding, you experience/experienced waves of low mood/thoughts, or other negative emotions/thoughts/experiences associated with feeding or milk let-down. (This is different from postnatal depression or a general dislike of breastfeeding.)
- You are able to undertake an hour long interview about this in English.
- You have access to a computer with Skype or a telephone.

If the above sounds like you and you would be interested, please contact me via email (m.watkinson@lancaster.ac.uk) and I will be more than happy to tell you more about the study and send you an information pack.

Looking forward to hearing from you!

Warm Wishes

Marcelina Watkinson

Appendix 4-C: Participant Information Sheet

Study on Negative Emotions During Breastfeeding: Information for Participants

Hello!

My name is Marcelina Watkinson and I am a trainee clinical psychologist at Lancaster University in the United Kingdom. I want to invite you to participate in my study which is exploring breastfeeding mothers' experience of low mood or negative emotions during breastfeeding. Here is some information to help you to decide if you want to be involved.

What information do I want to know and why?

I am interested in your story and your experiences of low mood or other negative emotions during breastfeeding and how it has impacted on you and your relationship with your baby. There might not be any direct benefit from participating, but some people may find it rewarding to contribute towards a better understanding of this phenomenon. The more psychologists and other healthcare professionals know about negative emotions experienced during breastfeeding, the better they can identify how to best support women who experience it.

What does it mean to participate?

If you decide to take part we will agree a suitable date and time, at some point between November 2014 and March 2015, to meet for a one-to-one interview. The interview will be face to face, alternatively via phone or Skype in case we are a far distance apart. It will last approximately one hour during which I will ask you a number of open questions about your experience of low mood, sadness or other negative emotions during breastfeeding. I will audio record our interview, with your consent, in order to help me make sense of our conversation.

What will I do with the recordings of our interview?

Following our interview, I will type up our conversation and save it on a password protected computer. I will later analyse the interviews to try and identify similarities and differences of participants' stories. I might use some direct quotes from our interview in order to help the reader understand my findings better when I write up my final project.

Your real name, location or any other identifying information will not be disclosed, thus, nobody will know that you participated or what you said.

I will do my best to keep your information confidential and safe. However, if our interview is via Skype 100% confidentiality cannot be guaranteed, due to the fact that our communication will be transferred via the Internet. Confidentiality might also have to be broken if something you tell me during our interview indicates that there is risk of harm to you or someone else. If this turns out to be the case I will have to disclose this information to my supervisors or, if urgent action is required, contact appropriate safeguarding or emergency services. If possible, I will try to talk to you beforehand.

ow will data be stored and for how long?

The data collected for this study will be stored securely and only the researchers conducting this study will have access to it:

- Audio recordings will be deleted once the project has been examined.
- The files on the computer will be encrypted (that is only the researcher will be able to access them) and the computer itself password protected.
- At the end of the study, hard copies of consent and expression of interest forms will be kept securely in a locked cabinet for ten years. At the end of this period, they will be destroyed.
- The typed version of your interview will be made anonymous by removing any identifying information including your name.
- Lancaster University will keep written transcriptions of the interview for ten years after the study has finished.
- The study may be published.

What if I change my mind?

If you change your mind you are free to withdraw your participation at any point up to two weeks after the interview. If this would be the case, any information obtained during our interview will be completely withdrawn from the project and destroyed.

What to do if you would like more information.

The study has been reviewed by the Lancaster University Faculty of Health and Medicine Research Ethics Committee (FHMREC) and approved by Lancaster University Ethics Committee to ensure that it follows appropriate ethical guidelines. If you would like more information or if you have any concerns, please do not hesitate to contact me at m.watkinson@lancaster.ac.uk, and I will do my best to explain things further.

What to do if you are not happy with the researcher.

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Head of the Division of Health Research: Professor Bruce Hollingsworth

Email: b.hollingsworth@lancaster.ac.uk Tel: +44 1524 594154.

Address: Furness Building, Lancaster University, Bailrigg, Lancaster, LA1 4YG.

If you wish to speak to someone outside of the Division of Health Research, you may also contact:

Associate Dean for Research: Professor Roger Pickup Email: r.pickup@lancaster.ac.uk

Tel: +44 (0)1524 593746

Address: Faculty of Health and Medicine, Lancaster University, Lancaster, LA1 4YG.

Who to contact if you experience upset or distress after the interview process?

If you experience any distress after our meeting and you find it difficult to deal with it alone, please contact Family Lives (www.familylives.org.uk) or Family Helpline (www.familyline.org.uk). These are organisations that provide support that can be accessed via telephone and email.

Next steps

If you want to take part, please fill in and sign the ‘Expression of Interest’ form attached to this letter/email and return it to me.

Looking forward to hearing from you

Kind Regards

Marcelina Watkinson

Appendix 4-D: Expression of Interest Form

Expression of Interest Form

Hi!

You have shown interest in finding out more about the study advertised on the parenting website, about breastfeeding mothers' experience of low mood or negative emotions during breastfeeding.

Please find attached an information sheet in this email that provides more details about involvement in the study.

If you are still interested, we will ask you to fill out the following details and return via email to the following address: m.watkinson@lancaster.ac.uk

Expression of Interest	
First Name	Last Name
Email address	Phone number
Postal address	
Are you a currently or previously breastfeeding mother?	
Do you currently or have you in the past experienced negative waves of low mood, sadness or other negative emotions during breastfeeding or milk release?	
Are you able to undertake an interview in the English language?	
If not a North West UK resident, do you have access to the Internet and Skype?	
Other information that would be useful for me to know.	
Where did you find out about the study?	

Appendix 4-E: Consent Form

Appendix 4-F: Demographic Details Form

Participant Demographic Information

Participant number

Age______________

Nationality ____________

Ethnic Origin____________

Number of children________________

Ages of children_______________

Length of breastfeeding (previous or ongoing) ________(months)________(weeks)

Occupation_____________________________

Marital status____________________

Appendix 4-G: Interview Schedule

Interview Schedule for Semi-Structured Interviews

Instructions for the participant:

I am very interested in your experience of having negative feelings during breastfeeding and as a part of the interview I am going to ask you a few open questions which might help you talk about it. There is no right or wrong answer and you can say as much or as little as you want; it is your perception and your experience that I am curious about.

The experience of negative affect during breastfeeding:

7. Please tell me about your experience of negative feelings during breastfeeding.
   Prompts: How frequent are these experiences? How strongly do you feel them? How long do they last? What happens to you when you experience them? What do you think and feel? How do you feel afterwards?

The impact of negative affect during breastfeeding:

8. How do you think that the experience of negative feelings during feeding has impacted on the way you see and feel about yourself?
   Prompts: What aspects, if any, of your views/thoughts/behaviours/feelings about yourself have been affected?
9. How do you think that the experience of negative feelings during feeding has impacted on the relationship you formed with your baby?
   Prompts: What aspects, if any, of your views/thoughts/behaviours/feelings about your relationship with your baby have been affected?
10. What other areas of your life has this experience impacted on, if any?
11. Has the experience had any positive consequences for you?
    Prompts: Have you learnt something about yourself? Have you discovered something new about your feelings?

Background:

12. Do you have current or past experience of mental health problems or emotional difficulties?
    Prompts: How were/are those experiences different from the experience of low mood during breastfeeding? How were/are they similar to the experiences of low mood during feeding? How do you think that those experiences are linked, if at all?

Probes to be used in between questions:

- Can you tell me more about that?
- What was that like?
- What did that look like?
- Can you give me any examples?
- Why do you think that?
- What else do you remember about it?

Appendix 4-H: Correspondence with FHMREC Regarding an Ethical Concern

Dear Professor Pickup

Thesis title: An Exploration of Breastfeeding Mothers' Experiences of Negative Affect During Breastfeeding: An Interpretative Phenomenological Analysis Study.

I am writing to you as a trainee on the Lancaster DClinPsy programme. I have collected data as part of my thesis project and I am writing to you now as I need to raise and seek advice regarding an ethical issue which arose during the data collection phase of my project.

Consistent with my study protocol I conducted some interviews through Skype. Although all participants consented verbally to take part in the interviews, as some were overseas, I did not receive written consent before some of the interviews took place. Although all participants indicated that this consent was given and was being sent to me, I have been unable to obtain written consent for one participant. This is despite having had the promise from the participant in question that this was her intention. She has not recently responded to my emails to indicate that either 1) the written consent is on its way; or 2) that she wishes to withdraw her data.

I have identified a number of reasons why this omission might have happened. This was my first time collecting data at a distance, as opposed to face to face interviews. In hindsight, I realise that I did not have an adequately clear picture in my mind of the specific order in which consent was going to be obtained. My protocol did not state the exact procedure in sufficient detail. *"Participants will be asked to sign and initial a consent form (see Consent Form) upon meeting. Alternatively, the principal investigator will via post, to be signed and initialled by the participants and returned to the principal investigator in a pre-paid addressed envelope".* In addition, in the context of competing demands of trying to overcome vast time zone differences and technical issues while making arrangements for long-distance interviews, the importance of having consent prior to carrying our interviews was unintentionally given lower priority.

I would like to reassure you that I would not intentionally not follow the approved ethical process for my research. It was my decision to raise this with my supervisors and to inform you of this issue in the hope of learning from this process and conducting my research in the most ethical way possible. I would be grateful if I could receive guidance regarding how to proceed with this issue further.

Since the completion of my thesis is planned for mid-July and the progression of my work is heavily reliant on the decision of the ethical committee, I would welcome a quick response. However, I also understand that this might not be possible given the competing demands of the committee.

Yours Sincerely

Marcelina Watkinson

Trainee Clinical Psychologist

Dear Debbie,

We wish to inform you of a breach of ethics by an applicant within FHM REC. The matter has been investigated by Roger Pickup and myself, as Chair and Deputy Chair of the RECs, and Di Hopkins has been involved throughout the process.

We have spoken to Marcelina about the letter she sent (pls see attached) and the collection of consent from a participant interviewed via skype.

We commended her for flagging this up early with the REC and thanked her for informing us.

Marcelina clarified the following aspects of the situation with us:

- All participants received information ahead of the interview taking place so they had time to read and digest the information.
- All participants were asked if they had any questions about the project or participating in the project at the start of the interview.
- At some point throughout the interview, all participants were made aware that the interview was being recorded.
- All participants were sent a copy of the consent form <u>after</u> the interview took place.
- All participants sent back a copy of the consent form, except one participant.
- There was no clear rationale for sending the consent form <u>after</u> the interview took place ie research in an emergency setting.
- The interview where the participant did not return the consent form did not raise any whistleblowing or safeguarding issues and a copy of the transcript is available.

When making our decision, we have taken the following into consideration:

- verbal consent for phone interviews can be considered sufficient and typical
- an information sheet was sent in advance of the interview
- participants were asked if they had any questions before beginning the interview
- participants are not deemed to lack capacity or considered a vulnerable group

Therefore for FHM REC no further action is required and we are informing UREC of our decision. Please can you let us know if any further action is necessary for the applicant or ourselves?

Kind regards,

Laura

Dr Laura Machin

Lecturer in Medical Ethics

Lancaster Medical School

Deputy Chair FHM Research Ethics Committee

http://www.lancs.ac.uk/shm/people/laura-machin/med/

01524 594 973

Dear Laura

Thank you for the information in your email below which the Chair of UREC, Steve Decent, has considered. Steve has advised no further action is required.

Kind regards,

Debbie Knight | Research Ethics Officer | Email: ethics@lancaster.ac.uk | Phone (01524) 592605 | Research Support Office, B58 Bowland Main, Lancaster University, LA1 4YT

Web: Ethical Research at Lancaster: http://www.lancaster.ac.uk/depts/research/ethics.html

Appendix 4-I: Thesis Contract and Action Plan

Thesis

Contract & Action Plan

Lancaster University Doctoral Programme
in Clinical Psychology

This initial action plan and contract is to be completed at a meeting between the trainee, field supervisor(s) and research/course supervisor. This meeting should take place as near to the start of the project as possible and be submitted before the research supervisor reviews the ethics application. All parties are to retain a copy of this document. However, the contents can be re-negotiated at any point, with the agreement of all parties.

When the contract has been agreed the trainee should email a copy to the field supervisor for approval. Once the field supervisor has reviewed the content they should forward a copy on to the research supervisor. If the research supervisor is happy with the content they should send a copy to the research coordinator by email, copying in the trainee and field supervisor, stating that the attached contract has been agreed by all parties.

This document provides a clear action plan for all parties that covers the issues of roles and responsibilities, expectations concerning submission of the Thesis research for publication, and expectations concerning authorship.

Name	**Contact Details**
Trainee name: Marcelina Watkinson Date: 16.09.2014	Address: Clinical Psychology, Div. Of Health Research, Lancaster University, Lancaster, LA1 4YG Phone: 01524 592754 Email: m.watkinson@lancaster.ac.uk
Research/programme supervisor name: Jane Simpson	Address: Clinical Psychology, Div. Of Health Research, Lancaster University, Lancaster, LA1 4YG Phone: 01524 592858 Email: j.simpson2@lancaster.ac.uk

Research/programme supervisor name: Craig Murray	Address: Clinical Psychology, Div. Of Health Research, Lancaster University, Lancaster, LA1 4YG Phone: 01524 592730 Email: c.murray@lancaster.ac.uk

Roles, Responsibilities & Planned Activities

Please write the roles and responsibilities of each party concerning each step of the research process, and include target dates/deadlines for planned activities where appropriate.

Research Step	**Roles and Responsibilities**
Generating a research idea	Trainee: Contacting potential supervisors in area of interest; discussing area of interest with course staff and field supervisor. Research/course supervisors: Discussing ideas with trainee (JS & CM).
Developing a research plan/design (inc. power analysis if appropriate)	Trainee: Generating a research proposal; starting to identify and gather relevant literature; considering recruitment, going through the process of peer review for the proposal; making amendments to proposal based on feedback. Research/course supervisors: Discussing feasibility of the project with the trainee, reading and commenting on proposal draft generated by the trainee (JS & CM).

Research Step	**Roles and Responsibilities**
Gaining ethics committee approval	Trainee: Developing the research protocol; designing information, expression of interest and consent forms for participants; developing an interview schedule to be used for data collection; contacting LUPIN members for their input in the above mentioned documents; completing the Lancaster University ethics form; designing information, expression of interest and consent forms. Research/course supervisor: Commenting on above documents; discussing next steps with trainee (JS & CM).
Gaining access to participants	Trainee: Preparing information packs to be sent out to potential participants. Contact participant via email to confirm a convenient time for interviews. Research/course supervisor: N/A
Collecting data	Trainee: Arranging practicalities of face to face or Skype/telephone interviews; carrying out interviews with participants; storing data securely; anonymising transcripts (e.g., generating pseudonyms for participants). Research/course supervisor: Reading a part of the transcript in order to suggest modifications for the interview schedule for subsequent interviews (CM).
Analysing and interpreting data *N.B. Please consider for whom it is appropriate to have access to the raw data, up to the point of writing up the project. In most cases this will be trainee and DClinPsy programme supervisor,*	Trainee: Transcribing all audio recordings collected during the data collection phase; analysing data using NVivo10 computer software; interpreting data in light of existing literature.

in others it may be an external/field supervisor.	Research/course supervisor: Reviewing analysis and advising on the process as appropriate (CM).
Writing the literature review (including giving feedback) *N.B. The research supervisor will normally expect to read 2 drafts if they are submitted according to agreed deadlines*	Trainee: Identifying appropriate topic for meta-synthesis; gathering literature; synthesising data from literature; writing literature review; acting on feedback received. Research/course supervisor: Reading drafts and comment particularly on the methods section of the meta-synthesis (CM). Reading drafts (JS). Draft deadlines: Jan 2015 (1st draft); Feb 2015 (2nd draft)
Writing the research paper (including giving feedback) *N.B. The research supervisor will normally expect to read 2 drafts if they are submitted according to agreed deadlines*	Trainee: Gathering literature for introduction; writing up method, results and discussion; acting on feedback received. Research/course supervisor: Reading drafts and comment on the content (JS). Draft deadlines: April/May 2015 (1st draft); June 2015 (2nd draft)
Writing the critical review, thesis abstract, appendices and other aspects of the thesis (including giving feedback) *N.B. The research supervisor will normally expect to read 2 drafts if they are submitted according to agreed deadlines*	Trainee: Writing critical review, abstract; gathering relevant material for appendices; acting on feedback received. Research/course supervisor: Reading drafts and comment on the content (JS). Draft deadlines: May 2015 (1st draft); June 2015 (2nd draft)

Regularity of Supervisory Contact

Action Plan Summary

ACTIVITY	DATE	WHO
Submit ethics proposal	24th Sep 2014	Trainee
Data collection	Nov 2014 – Feb 2015	Trainee
Data analysis	Dec 2014 – Apr 2015	Trainee
Comment on first draft of literature review	Feb 2014	Jane/Craig
Comment on second draft of literature review	Early June 2014	Jane/Craig
Comment on first draft of research paper	Late May 2015	Jane/Craig
Comment on second draft of research paper	Mid June 2015	Jane/Craig
Comment on first draft of critical review	Late May 2015	Jane/Craig
Comment on second draft of critical review	Mid June 2015	Jane/Craig
Submit thesis	End of June 2015	Trainee
Submit papers for publication	Dec 2015	Trainee

Submission for Publication and Authorship

It is expected that, in most circumstances, the trainee will be the first author and will take a lead in ensuring that any publishable research is worked up into an appropriate form and submitted as agreed. The following points are intended to guide this process and outline exceptional circumstances:

- Material is not to be submitted for publication without all authors sighting the final manuscript and agreeing to its submission.
- The anonymised dataset is understood to belong to all authors and may be accessed by all authors for the purpose of contributing to publication.
- In the event that potentially publishable material is not worked up to a manuscript within 12 months of the Thesis submission date, supervisors may take a lead in developing the manuscript and submitting it. In this instance, the author order will be changed to reflect the leading role taken by the supervisor(s) in developing the publication. In practice, unless otherwise agreed, this will take the following form:
    1. Supervisor will work with supervisee to submit the thesis project/s for publication, with the supervisee as lead.
    2. If, within 6 months, the supervisee has not submitted the manuscript for publication, the supervisor may submit on behalf of the project team, with the supervisee remaining as first author.
    3. If any significant amendments have not been led and / or made by the supervisee after 6 months, the supervisor may continue with the process and act as lead author.

This part of the contract concerns the initial expectations of all parties regarding submission of aspects of the THESIS for publication, including contingencies if expectations laid down in this contract are not met. This part of the contract also concerns expectations regarding authorship. There are guidelines[7] concerning the authorship of publications published in *The Psychologist*. Parties to the contract should agree expected authorship in consultation with these guidelines.

In the event that publishable findings emerge from this study, the following expectations are shared by the named parties:

LITERATURE REVIEW:

Likely journal(s) for submission: Infant Mental Health Journal

Authorship (including author order):

Author 1: Marcelina Watkinson

Author 2: Craig Murray

Author 3: Jane Simpson

Any further authors: N/A

Target date by which submission will occur: March 2016

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[7] Game, A.,& West, M. A. (2002). Principles of publishing. *The Psychologist, 15,* 126-129.

RESEARCH PAPER:

Likely journal(s) for submission: Qualitative Health Research

Authorship (including author order) for research paper:

Author 1: Marcelina Watkinson

Author 2: Jane Simpson

Author 3: Craig Murray

Any further authors: N/A

Target date by which submission will occur: March 2016