

**AN INTERPRETATIVE
PHENOMENOLOGICAL STUDY
EXPLORING THE ATTITUDES OF
FIRST-TIME MOTHERS TOWARDS
SLEEP DEPRIVATION IN THE
POSTPARTUM PERIOD**

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An interpretative phenomenological study exploring the attitudes of first time mothers towards sleep deprivation in the postpartum period

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ABSTRACT

Background

This study set out to explore first-time mother's attitudes to sleep deprivation. During the transition to motherhood sleep deprivation is considered a 'normal' adjustment to motherhood. However, there is no evidence to suggest that new mothers are able to cope better with sleep deprivation or the detrimental impact on physical or psychological health compared to the population as a whole. Women often feel they should be able to manage the effects and are often unprepared for the reality when experiencing the effects.

Methodology

Guided by the philosophical assumptions of interpretative phenomenological analysis (IPA), this study explores the experience of maternal sleep deprivation through the voices of six first-time mothers. Testimonies were collected through face-to-face, semi-structured interviews during the postnatal period. Each testimony was analysed using Smith et al.'s (2009) IPA model.

Findings

Four main themes emerged: power of the professional, relationship with child, transition of self and idealism vs reality. Women's attitudes were influenced by their sense of identity defined through their relationships with professionals, their child and previous role. Attitudes are influenced by relational care: the ability of professionals and mothers to connect, be compassionate and explore sleep deprivation in collaboration. Training professionals and mothers in mindfulness, particularly 'being present', may have a positive impact on women's attitudes to sleep deprivation including their ability to develop appropriate coping strategies.

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Finally, and most importantly, I would like to acknowledge the unequivocal support from my husband Gary and children Adam and Sarah.

DEDICATION

'In memoriam'

Evie

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DECLARATION

I declare that this thesis is entirely my own work. No material contained in this thesis has been used partially or fully in any other submission for another academic award.

CHAPTER 1 – DEVELOPING THE RESEARCH QUESTION

Introduction

I have spent many years working as a nurse and a health visitor (HV). Reflecting upon the career choices I have made, women and children's health has been a recurring theme. My inherent motivation is an increasing curiosity regarding the physical and emotional transition into motherhood. I am fascinated by the collective 'normalisation' of motherhood by society, professionals and families, and yet creating another life could easily be defined as extraordinary. It is not an unusual phenomenon, but it has the ability to generate significant physical and emotional changes in mothers from the moment of conception.

Normalising motherhood has allowed society to develop connotations of ease or self-limiting feelings or behaviours. Consequently, I have witnessed first-hand the impact and ongoing turmoil, as well as the inner conflict that it generates in women regarding expectations of themselves. The gap between the ideology and reality of becoming a mother has also influenced my perception of the world. I have become a mother during my career and have found myself immersed in a world of unspoken rules, assumptions and expectations.

For those women experiencing motherhood for the first time, their beliefs and supposed knowledge is constructed and shaped through maternal ideologies and assumptions, arguably influenced by society and the media. As each experience is unique, this places them at greater risk of developing an unrealistic and unattainable view of motherhood. Health services, in particular those that support women during the antenatal period through to postnatal care, do not alleviate such beliefs. The majority of time, women's care is standardised and based upon 'one size fits all', a conveyor belt of pregnancy, labour and birth. In my experience, its rationale is driven by a desire to reduce risk to organisations, yet ironically in doing so remains in 'high risk mode' due to its lack of investment in prevention. There have been a number of high-profile cases, which will be discussed in later chapters, where it is suggested mothers may have been prevented from harming their children if professionals had intervened earlier. Findings highlight the perceived inability to cope with becoming a mother and lack of professional intervention.

First-time mothers are at particular risk as their view of motherhood is constructed through the observation of others and the objects around them. They are unable to draw upon any direct experience of the phenomenon. Haapio et al.'s (2017) study of childbirth education identified that the fear of the unknown is high in first-time mothers. Fear generates the flight or fight response and first-time mothers' observations of motherhood become more intense and significant.

As a health visitor (HV) a review of my own practice records during the antenatal period (first-time mothers on my caseload) highlighted the unrealistic notion of motherhood: 'I'm not worthy of taking on such a role' or 'my mum wasn't very good at it, so I don't think I will be'. There is an assumption that physical preparation is aligned to the psychological transition. This is further compounded by social media presenting 'perfect' images and messages regarding motherhood. Ayers and Pickering (2005) studied the differences in expectations and experiences between nulliparous and multiparous women. They found that first-time mothers were over idealistic or unrealistic in their expectations of themselves and others.

My own practice experience dictates that supporting women through motivational interviewing, effective history taking, holistic assessments and education all contribute to positive outcomes. However, in my experience this is rarely applied within the context of sleep deprivation as sleep is not a specific focus of HV contacts. This thesis discusses this concept further.

This study explores a particular aspect of motherhood: 'sleep' and how it transcends into contextualisation of the attitudes and beliefs of women, and specifically how it defines them as a mother. The rationale unfolds as this chapter develops; however, although sleep research has developed significantly over the past couple of decades this predominately focuses upon the population as a whole and/or under laboratory conditions. This is particularly true of sleep deprivation, which produces a range of symptoms that can be 'measured'. Rechtschaffen et al.'s (1983) study of sleep deprivation in rats found those deprived of sleep suffered severe health consequences and ultimately died. Rechtschaffen et al.'s (1983) study ultimately captures 'what we already know', that sleep deprivation can have a detrimental effect upon humans (Benington and Heller, 1995; Czeisler, 2004). This thesis accepts what is already known and does

not add to the body of research that 'measures' sleep deprivation in its volume or effects. It readily accepts that the effects on mothers may not be distinguishable from other studies. The aim of this study is to explore sleep deprivation within the context of an expected and natural occurrence following birth, through natural waking episodes primarily due to caregiving. Consequently, this places sleep deprivation within a 'normal life event' cycle. Therefore, only by exploring women's attitudes, beliefs, values and perceptions of the phenomenon can we begin to understand how they make sense of the experience and begin to provide support to manage the effects. This area is significantly underrepresented in research. This study is also crucial to support future mothers, improve professional practice and generate further studies.

Although I am able to offer personal insight into the experience of sleep and motherhood, it is perhaps my role as a HV that has intensified my desire to explore the topic further.

Exploring my professional role

Reflecting upon my own role as a HV was crucial when developing the research question. This is primarily attributed to trying to challenge my own understanding and assumptions of sleep deprivation and to implement any learning from the research into developing HV practice. HVs are registered nurses/midwives who have additional education in community public health nursing. HVs support delivery of the Healthy Child Programme (Department of Health, 2009). Their work is delivered through various domains: Universal, Universal Plus and Universal Partnership Plus. Each reflects the frequency and intensity of the support that may be required. They engage with community initiatives, accessing resources available to them, e.g. children's centres and self-help groups (NHS England, 2014). The universal service is offered to every new mother and child and includes parenting advice and child health checks delivered at home or in community clinics. HVs have a role in discussing sleep hygiene habits that promote sleeping well. Universal Plus offers packages of support for specific issues such as postnatal depression, weaning or sleepless children. Universal Partnership Plus requires HVs to provide ongoing support (NHS England, 2014). They often take the lead on multi-agency packages of care for families with complex needs. The National Maternity Review (2016) acknowledges the

specialist skills of HVs, citing them as key to supporting children and families when there are difficult issues (The National Maternity Review, 2016). HVs are alert to risk factors and signs and symptoms of child abuse, and follow local safeguarding procedures where there is cause for concern (Department of Health, 2007).

A government review of the health visiting service, Facing the Future (Department of Health, 2007), recommended that HVs should focus on young children and families, where their public health nursing expertise can identify need and risk early. As a HV, my work has been dominated by Universal Partnership Plus. As my career has spanned many years, it would be reasonable to conclude that no single event triggered my desire to undertake this study. However, I do recall quite clearly the moment when my research question shifted from curiosity to active engagement.

The moment is captured below. Having read loosely around the research, my initial motivation and rationale for undertaking the study appeared to conflict with my understanding of what research is. The literature often dictates that when one is developing a research question it is important to find an interesting research topic that is relevant and researchable. This does imply that research is personally motivated and my own experience reflects this; however, I had completely underestimated the strength of feeling that generated the question. This was not initially a positive experience; my motivation developed out of personal and professional conflict, frustration and a desire to give women a voice. I had reached the point where I was exasperated with practice. I was, however, through research able to channel my feelings into something extremely positive, believing that practice will be improved in some way even if just for one individual.

Below is an excerpt of the conversation that created a turning point in my career. It's impact driven by emotion rather than theory or practical training. The full details are not provided to protect the identity of the family.

Telephone call from a HV manager:

'Hi Jo, we have received notification that a child has died. It sounds as though her mother has killed her. We think her mother drowned her on Monday, she phoned police on Wednesday ... It's a child that's been on your caseload, yes on your caseload I think ... Her name is Evie Brown [pseudonym]. Can you seal the records and bring them to head office so safeguarding can review them please?'

As a HV, there is nothing that quite prepares you for hearing that a child has come to harm, worse still hearing that the child has died. This was not the first child death that I had experienced on my caseload; on the contrary as an experienced HV working with predominately safeguarding, unfortunately it was not unusual to work with families where children had been harmed. This was, however, the first time I had experienced a scenario where it was openly reported the mother had killed her child. It was also the first time I was concerned regarding my reaction to the death. Rather than thoughts for the child or mother, my first thought was have I missed something? Has my documentation captured everything? In the months that followed, I questioned my personal and professional integrity and I initially concluded that over the years I had become desensitised to safeguarding.

Desensitisation is well documented, particularly in child death, usually manifesting in disagreements around multi-agency thresholds. It is often used as a term by the media to explain why professionals accept the unacceptable. It is frequently cited in serious case reviews (SCR, learning from child death), with its ongoing presence highlighting the challenge to address it. Lord Laming, who undertook a child protection review following the death of Baby P in 2007, highlighted the challenges of practitioners working in safeguarding, saying more support was needed (Laming, 2009); for example, more training and supervision around safeguarding thresholds. However, the recommendations fell short of a deep dive into practitioner decision making, and lacked opportunities to explore further. In 2011, Munro was commissioned to undertake a review of child protection, making recommendations for improvements. Munro shifted the focus away from collective reform to individuals, highlighting the need for improved support through polices, systems and critical reflection: 'Time and attention given to mulling over the experience and learning from it' (Munro, 2011:87). Munro

highlighted that the current system was too focused on the details of what happened and not why it happened.

There is a view that when individuals are exposed to a similar scenario over and over then individuals become accustomed to the issue. Gardner (2008) who was commissioned by the NSPCC (National Society Prevention of Cruelty to Children) to review child neglect reported that desensitisation and demoralisation of practitioners contributes to acceptance of child neglect. Consequently, they accept behaviours in themselves and others that an external observer may question. Davies and Ward (2011) echo this view. They reviewed 15 studies which aimed to safeguard children, drawing out key messages. Desensitisation was frequently found in practitioners who were dealing with cases of neglect and poor parenting.

Desensitisation is not an excuse for poor practice or to militate against professionals getting it wrong (Gardner, 2008). However, from my personal experience there is a willingness from HVs to learn from such findings, and a commitment to support families in prevention and early intervention. Easton (2009), who reported on the Baby P case, stated that the people we ask to spot the threat could hardly be more different from those who are motivated to harm children: 'natural carers, people who easily empathise with others'; 'In some ways, one might argue, there is a risk their belief in human nature might get in the way.'

The findings of SCRs often identify numerous missed opportunities to intervene, which in the cold light of day appear so obvious to the public and reviewing bodies. This distorted clarity only adds to the pressure for all professionals working with families. The SCR cases are reviewed in isolation, and rightly so; but for practitioners, they have often sat alongside other cases for some time with no obvious distinguishable features until it is too late. For example, if a HV has 20 Universal Partnership Plus cases, they are all considered high priority (needing a quick response and constant monitoring). However, the HV will need to prioritise within those cases as they cannot all be seen on the same day at the same time. This action begins to normalise the abnormal or minimise issues. I would suggest that prioritisation is frequently driven by an element of 'what if' visits, out of worry (consequences for client and one's own professional practice)

rather than need. This is further compounded by the disagreements regarding safeguarding thresholds across other agencies (education, social care), sanctioning 'interpretation' of what is acceptable and what is not.

Laming (2009) and Munro (2011) both completed reviews following children's deaths. They both identified that the lack of agreement across agencies in what constituted safeguarding concerns contributed to 'missed opportunities' to keep the children safe and free from harm. Pollock et al. (2002) studied the health and social factors for HV caseload weighting; they explored reliability, accuracy and current and potential use. Discrepancies were mostly associated with differences in interpretation of definitions, knowledge of recent events and changing circumstances. Health factors (parental drug/alcohol misuse, child or parental disability and child development) were at particular risk of being misinterpreted. This is evident in Redsell et al.'s (2010) study of HVs' perception of their role in the universal childhood immunisation programme. There were differences among the HVs in their perceptions of their roles, skills and knowledge and their communication strategies. It highlights the diversity of understanding within the discipline.

Experiences from my practice and Pollock et al.'s (2002) study highlight that emotion and feeling have a role in influencing and prioritising HV work. Therefore, after a period of further reflection I concluded that I was not desensitised (void of feeling or intuition), but I had the ability to normalise the abnormal. There are distinguishable features between the two. Both definitions remove one from the event to some extent; however, if desensitisation is defined as an emotion or a pain experienced less strongly than before (Cambridge Dictionary, 2018), then I do not believe this reflected my actions or response. I did have a strong emotional response, albeit initially shifting from the client to me.

My clinical supervision notes during this time captured two key questions:

- Why are we always in crisis with safeguarding?
- Were there clues that I could have picked up on earlier?

The instinct was to search for the answers in the mother's health record. I read through them meticulously.

I completed a chronological account (latest to earliest) of HV contact. Recent entries by a colleague stated that 'mum' had disclosed suicidal thoughts to staff in the hospital. She had been diagnosed with a mental health condition, reporting that she had not slept for days. This was two days before she killed her daughter.

As I went farther back in the records the intensity associated with the mother's behaviours in the last few days became diluted and the mother's story reflected most first-time mothers' experiences. Perhaps subconsciously I wanted her behaviours to stand out from other mothers. This would have brought a sense of reassurance and minimised my own anxiety that something obvious had been missed; reassurance that this could not happen again if we identified the trigger point. The reality is her early behaviours were no different than other mothers. As a first-time mother she had reported challenges on adjusting to motherhood, feeling tired with difficulty managing sleep disturbance, all considered very common issues.

The experiences around sleep problems were minimised by either the mother or HV, contextualised as a 'normal adjustment', or 'a fleeting episode'. There was a suggestion by the HV and the mother that everything would right itself through little or no intervention. This was also evident in other records reviewed. This is not a criticism of either the mother or the HV. Millions of women have this experience and for many women the effects are short term. However, it does raise the question of why some mothers cope with this transition and others do not.

Coincidentally, during this time I watched two television programmes which helped me contextualise my thoughts further. The first explored how women adjusted to ageing, defined as growing old gracefully or disgracefully. Although intended as a tongue-in-cheek take on women and beauty, it highlighted how societal attitudes compound our view of beauty and determines what is acceptable and what is not. Interestingly, women internalised their perceived shortcomings as their own failures even when confronted with Photoshopped images.

The second programme was on sleep disturbance and explored the negative effects it can have on individuals, physically and mentally. Although the primary aim of the programme was to entertain, it did highlight how sleep deprivation had

a significant impact on the human body. A meta-analysis undertaken by Pilcher and Huffcutt (1996) identified that people who are exposed to sleep loss can experience changes in mood due to a decline in cognitive performance. Belenky et al. (2003) found that even partial sleep restriction restricts cognitive performance. Ogawa et al. (2003) studied the effects on physical health and found sleep loss can lead to a rise in blood pressure.

My journal entries at the times captured my thoughts:

Getting old is normal and inevitable. Why is it unacceptable to grow old? Where do those beliefs come from? Is this the same for our expectations of motherhood?

Why do women blame themselves if they don't conform to expectations of themselves and others?

If sleep deprivation does this to you then why don't women... Why don't professionals think it applies when they have a baby?

Do women think becoming a mother provides an inbuilt coping mechanism for sleep disturbance?

Keywords – Norms, values, sleep, attitudes, beliefs, expectations of oneself and others, opportunities to share your thoughts, fear, HV, family support.

The journal entries guided the next stages in developing my research topic. The key message I had taken away was that there was a gap between our expectations (societal) and the reality of any given experience, and that any negative feelings generated were often internalised by individuals. This knowledge shifted my focus from researching 'crisis' (after the event) to exploring what we potentially overlook every day; those things in life we consider normal. This approach helped me make sense of my experience when I had reviewed the mother's records. I had been unable to identify triggers for the event that unfolded. However, I had been looking for the moment of 'crisis' I thought we had missed. Upon reflection what I actually wanted to know was how that mother had made sense of her experience of becoming a mother; what were her beliefs, values and attitudes regarding that experience? Were any of those beliefs distorted? Could we have helped her contextualise those feelings?

With this new knowledge I revisited local safeguarding HV records, identifying common themes. The overwhelming issue for first-time mothers was managing tiredness, sleep problems, feeding issues and postpartum depression (PPD, a mental health issue associated with motherhood). Postpartum depression was frequently referenced by professionals for the mother who had killed her child; however, she had also said she wanted to harm herself. The tool used to identify PPD does explore if mothers have thoughts of harming themselves. However, in my professional experience even though there is a correlation between suicide idealisation and infanticide (the intentional killing of infants) for most new mothers, including those without mental health difficulties, thoughts of harming their babies is not uncommon (Jennings et al., 1999). This is often a very scary moment for the mother and something that generates immense guilt and shame as it is not something they would ever actually do.

Following a review of 20 safeguarding HV records (those records easily accessible and time available to review) the recurring theme that linked PPD, suicidal thoughts and, as in this case, infanticide were sleep issues. At this early stage it was a 'word link' only. For example, in the records HVs had documented, 'mum tired not sleeping', 'lack of sleep, feeling tired', 'discussed getting some sleep'. I found it difficult to contextualise the meaning further due to such brief references. Upon reflection I concluded this was probably attributed to 'sleep' being an umbrella term that could be applied to a vast number of scenarios and causes. I could not see any immediate meaningful correlation. I was trying to find patterns regarding causal factors in sleep deprivation. However, I did feel sleep could be significant. When I reviewed the records again (revisited after a couple of days), I was drawn to sleep within the context of 'crisis'. In the two days away from the records I had been working on two serious case reviews, with intense focus upon crisis. Therefore, I was instinctively drawn to safeguarding triggers: comments regarding home conditions and drug use. I could now see 'mum depressed, not sleeping' 'some days I just want to get on a train and leave him, I'm not sleeping I'm exhausted' (quotes from records). I instinctively wanted to stay in the safeguarding role as this is what I was familiar with. However, although the information was contextual, one of my personal goals from undertaking this study was to try and look at sleep deprivation differently, within the context of something 'normal' as part of caregiving duties. I found a wonderful quote from

my public health training days which kept me on track. 'Instead of pulling people out of a river upstream go to the other end and find out why they are falling in!' (Author unknown). The origins of this quote are difficult to clarify, although public health principles of prevention use the term or a variation frequently. It is often described as an upstream downstream theory. Upstream includes those factors considered in life beyond our control and downstream those factors we can influence.

It was only when I reviewed universal records of first-time mothers that sleep began to take on meaning. I compared relevant comments from safeguarding notes and universal records. For example, 'I'm exhausted not sleeping' being present in both. There was no indication in the safeguarding notes (self-reported or asked about by HVs) of any early discussions about sleep deprivation or how women coped. It could be argued that this was attributed to safeguarding issues being prioritised; however, in the universal records there was also a lack of discussion. The universal records did, however, highlight a positive discussion between the mother and professional if sleep deprivation was discussed within normal caregiving duties and mothers were given an opportunity to contextualise their feelings. This shifted my focus to attitudes towards sleep rather than exploring the causes or contributory factors to sleep deprivation.

A literature search did not yield any studies that drew attention to this specific issue. There was a plethora of research around casual factors and effects (discussed in Chapter 2). However, there was nothing pertaining to mother's attitudes towards sleep deprivation, or how the normalisation of this phenomenon influences beliefs. I was surprised as it potentially affects millions of women. I accept that for the majority sleep deprivation will be short term and self-managed seemingly without significant impact. However, in my professional experience, for others, the experience generates strong feelings and shapes women's view of themselves as mothers, having far reaching and potentially life-changing implications.

I had wanted to ask the mother who killed her child about her own experiences. I felt this could only be explored further by giving other mothers a voice, an opportunity to tell their story. In doing so I would be able to capture something rich and meaningful, something that could potentially develop HV practice.

Aims and objectives

1. Linked to my professional experience and insight from my own professional practice, the aim of the study is to develop an understanding of the experiences of first-time mother's attitudes to sleep deprivation in the postnatal period.

Guided by paradigms associated with interpretative phenomenological analysis (IPA) (Smith et al., 2009), this study draws upon the philosophical assumptions of IPA, to represent, interrogate and construct the experience of sleep disturbance by focusing on the voices of first-time mothers. Therefore, the objectives of this study are to:

2. Through semi-structured interviews, capture the reported experiences associated with sleep deprivation as contextualised by mothers' own understanding.
3. Using interpretative phenomenological analysis, identify dominant themes surrounding mothers' attitudes to sleep deprivation.
4. Use learning from the findings to contribute to reviewing health visiting practice.

Thesis structure

This thesis is divided into eight chapters. This first chapter has provided a synopsis regarding the rationale for the study including, its aims and objectives.

Chapter 2 draws upon a plethora of literature pertaining to general sleep deprivation, narrowing to the significance and justification for further methodical investigation into first-time mothers' attitudes to sleep deprivation. The complexity of sleep deprivation for mothers is reflected upon. This informs Chapter 3 and development of a research strategy most appropriate to explore the topic further.

Chapter 3 provides a rationale for why interpretative phenomenology IPA was the most appropriate strategy to guide and inform my study. Evaluation of my own epistemological and ontological position also offers further clarity regarding the methodology chosen.

Chapter 4 focuses upon the method used for the data collection process, including the sampling strategy. Ethical consideration underpins this chapter

including the appropriate use and storage of data. The chapter offers clarity regarding the sampling utilised to recruit participants, and rationale for semi-structured interviews.

Chapter 5 applies the IPA framework of analysis to each testimony. It provides examples of how themes were developed and analysed to identify master themes and sub themes through interpretative analysis.

Chapter 6 shares the findings from the study, providing details of the way in which mothers make sense of their experience of sleep disturbance. It presents the key themes drawn from individual and cross-referenced testimonials using extracts from each interview to support interpretation in the discussion chapter.

Chapter 7 presents a discussion of the findings using wider literature to support understanding of the issues.

Finally, Chapter 8 explores the implications for practice, making recommendations for future research, education and practice. It reflects on the findings presented and summarised through earlier chapters to consider how the testimonies presented could, and should be used to support developments in HV practice.

CHAPTER 2 – REVIEW OF THE LITERATURE

Introduction

The aim of this chapter is to explore the literature regarding sleep deprivation. The chapter begins by explaining how the literature review was undertaken. It then explores what sleep is, including the effects upon an individual's physical, cognitive and mental health. The review of this literature draws out salient points acting as a catalyst to delve further into maternal sleep deprivation. Subsequently, this informs further review of the literature regarding attitudes and norms regarding those events in life that are considered normal, for example 'caregiving duties' for mothers. Findings from the review of the literature are then considered within the context of professional support linked to national policy and guidance.

Reviewing the literature

Based upon my professional experience sleep deprivation is a phrase used interchangeably with sleep disturbance, sleep debt, and sleep hygiene. All describe a 'lack of sleep'. This is also reflected in many government papers that reference parenting and sleep (Department of Health, 2004, 2009). Using this knowledge, during my initial search of databases I used *sleep** to capture such variances. I accessed a number of databases considered credible within the context of research, SCOPUS, CINAHL, PsycINFO, and Medline (EBSCO). Their selection was based upon my previous study experience, those frequently cited in journal articles and those present in other theses.

The initial search yielded thousands of results. This created a challenge as it was highly likely I would miss relevant studies if all were not reviewed. I decided to use the term *sleep deprivation* to narrow the search.

Table 1 –Literature search

Search term & Data base	SCOPUS	CINAHL,	PsycINFO,	Medline EBSCO
Sleep*	289,974	59,195	77,373	192,803
Sleep deprivation	17,868	3,981	7,041	11,968
Sleep deprivation effects	6,145	1300	3700	6,113
Sleep deprivation attitudes , perceptions	333	129	260	198
Sleep deprivation attitudes, perceptions mothers	18	14	8	12

Although this yielded numerous results again, I was able to determine (by reading the title of studies) that research loosely fell into two main categories. Studies either researched ‘why’ individuals needed to sleep, or explored the ‘effects’ if individuals didn’t get enough sleep. My research accepted that we need to sleep regardless of why; therefore my search steered me toward the effects of sleep deprivation. A new search was undertaken using the term *sleep deprivation and effects*. The volume of results reduced. I was able to determine from briefly reviewing the results that ‘measuring’ the effects of sleep was popular amongst researchers. These were primarily quantifiable studies. Although they provided useful insight into the negative impact sleep deprivation can have on individuals they did not help me understand how individuals make sense of sleep deprivation. I changed my search strategy to *sleep deprivation attitudes and perceptions*. This yielded hundreds of results rather than thousands. However, as my study was exploring *mother’s attitudes* I included this in a new search. This reduced the number of studies to fifty two. Although these studies highlighted attitudes to sleep deprivation they were done so within the context of child / mother illness, child / mother disability, effects of medications, and perceptions of infant sleep patterns. As my study explores attitudes to sleep deprivation within the context of routine care giving the remainder of this chapter explores this in further detail.

Sleep

Sleep, like breathing, is a biological requirement. However, there is still much debate regarding what it is and why we need it, allowing the phenomenon to be moulded to specific perceptions and interpretation. Understanding why we sleep has captivated many scholars and theorists over the years. Hippocrates, a Greek physician, believed that sleep was necessary to allow blood to retreat to the inner regions of the body. Aristotle, an ancient Greek philosopher and scientist, believed warm vapours rose from the heart during digestion and concluded that sleep was a time of physical renewal. Both attempted to offer insight into the mystery surrounding sleep. With advancing science and technology, such views may appear implausible; however, sleep retains as much mystery now as it did then.

The Oxford Medical Dictionary (2016:675) defines sleep as

‘A condition of body and mind which typically recurs for several hours every night, in which the nervous system is inactive, the eyes closed, the postural muscles relaxed and consciousness practically suspended’.

Most definitions allude to a necessary but inactive process. The Sleep Council defines it as ‘a mysterious shift in consciousness that our bodies require every day’ (Sleep Council, 2016). This belief is aligned to a theory developed in the 1950s when our understanding of why we sleep shifted from non-active organ restoration to acknowledgement of the restorative element of brain function and stages of sleep.

Aserinsky and Kleitman (1953), key scholars in early sleep studies, found electrical activity in the brain during sleep. This discovery led to the terms slow wave (NREM) sleep and rapid eye movement (REM). Both describe stages of sleep, each defining various functions and processes including the restoration process that involves both physical and neurological changes (Shapiro and Flanigan, 1993; Maquet, 2001; Xie et al., 2013). Although this chapter makes reference to the key theories of sleep it does not set out to explore in detail why sleep is necessary. This thesis accepts that it is required to enable humans to function adequately in their day-to-day lives, and that when interrupted it can have a detrimental effect on the human body.

Sleep is regulated by two processes which both have a restorative element: homeostatic (reflects the duration of sleep) and circadian (24 hour rhythm and the timing of sleep) (Achermann, 2004). The interaction between these two processes determines the holistic sleep cycle.

The terms sleep interruption, sleep disturbance, sleep debt and sleep deprivation are all used interchangeably to describe either or both processes when impaired. For the purpose of this thesis, 'sleep deprivation' will be used as an umbrella term to reflect all terminology. The rationale is attributed to all definitions, within the widest context, defined as episodes that deviate from the 'normal' sleep cycles required for humans to function adequately. There will be times when specific descriptions need to be drawn out for further analysis and discussion and this will be reflected throughout this thesis.

Sleep deprivation can refer to partial sleep deprivation, defined by both the length and frequency of the sleep schedule, or total sleep deprivation, which reflects the length of time since the end of the last sleep period. The restorative element of sleep is applicable to both experiences. Although sleep deprivation is subjective, with duration varying considerably between individuals (Shneerson, 2000), the average period for adults is between seven and eight hours per day (Sleep Council, 2016; Carskadon and Dement, 2005; Kronholm et al., 2006). Horne (1988) suggests the first four to six hours are the most important from a restorative point of view. These hours are considered the optimum amount to enable a human to function in their day-to-day activities. A review of sleep duration by the Sleep Foundation (Hirshkowitz et al., 2015) found that Individuals who sleep outside the normal range may exhibit signs of serious health problems and may compromise their health and well-being.

Sleep deprivation can occur for various reasons: environmental, behavioural, sleep disorders, underlying medical conditions and lifestyle (Bonnet and Arand, 2003). This study focuses upon maternal sleep. Therefore, the above is contextualised within any maternal episode during the postpartum period (defined as birth up to and including 12 weeks of age) of partial or total sleep deprivation that occurs primarily through infant waking. Three months is a key developmental milestone for babies. It is a time of rapid physical growth with many babies sleeping for longer periods (Department of Health, 2009). My own practice

experience dictates that by the age of three months most babies have settled into more of a sleep and feeding routine. I would suggest that this dilutes the intensity of sleep deprivation for mothers.

Hunter et al.'s (2009) review of maternal sleep characteristics in the postpartum period found that the most common reasons for maternal sleep deprivation are related to the frequency of newborn feeding and sleep patterns. A review on sleep in women by Bei et al. (2015) supports this view, finding chronic sleep fragmentation in the immediate postpartum period, as well as disrupted sleep during the first few months after childbirth. My practice experience suggests that sleep deprivation, usually partially, is very common in the postpartum period. Further analysis shows that it is frequently dismissed or minimised by mothers and professionals, and viewed as natural. Consequently, it is viewed as expected and self-limiting, leading to a sense of immunity that does not require intervention.

Effects of sleep deprivation

The overall effect of sleep deprivation is increased fatigue, sleepiness and negative mood. Consequently, there is a decline in the ability to perform everyday tasks (Angus and Heslegrave, 1985). Mikulincer et al.'s (1989) sleep study, which explored the effects of 72 hours of sleep loss on adults, found that subjects' motivation to perform or initiate new tasks decreased. If asked to perform something new, this led to irritation, tension, anxiety and unhappiness.

The Royal Society of Public Health (RSPH) Waking up to the health benefits of sleep report (Royal Society of Public Health, 2016) broke this down further by suggesting the impact of sleep deprivation fell into four categories (see below):

Table 2 – Effects of sleep deprivation

Physical	Behavioural	Performance	Mental
Weight gain	Alcohol and drug dependency	Impaired attention and concentration	Depression
Reduced immunity	Increased sedative and stimulant use	Decreased memory	Mood fluctuation

Metabolic abnormalities	Less likely to attend appointments	Reduced multi-tasking	Higher risk of suicide
		Impaired decision-making	Anxiety and hyperarousal
		Reduced socialisation	Chronic fatigue
		More likely to be on benefits	Impulsivity

The Royal Society of Public Health (2016)

Although the RSPH report captures the effects of deprivation upon the population, there is no indication that new mothers are less affected, or immune from the effects. However, a study by Gress et al. (2010) of maternal subjective sleep quality and night-time infant care found that a mother has the ability to prioritise her child's needs over her own and is less likely to blame their child for sleep deprivation. This may be influential in her perceived management of the issue. They found that the number of times a woman's sleep is disrupted by attending to her infant is a significant predictor of her perceived subjective sleep quality; however, once caring for her infant, the perceived impact on sleep quality diminishes.

The instinct for mothers to prioritise their baby's needs is frequently contextualised within the hormone changes women experience during pregnancy, labour and birth. Maternal programming is a term used to describe the increase in hormone levels in pregnancy. Its purpose is to optimise maternal behaviour in preparation for sensitive care when the child is born (Pearson et al., 2011). Oxytocin and prolactin are key pregnancy related hormones, each having a role to play in the physical requirements during labour and post birth. Prolactin is a protein that enables mammals, usually females, to produce milk (Cox et al., 1996; Johnson, 2012). Oxytocin is responsible for signaling contractions of the womb during labour. The hormone stimulates the uterine muscles to contract, so labour begins (Kennedy and Martin, 2009); high oxytocin levels are also

associated with maternal bonding and attachment, with increased levels generating a desire in the mother to protect and guard the baby (Feldman, 2007; Strathearn et al., 2012; Kohlhoff, 2017).

Physical effects of sleep

Sleep of sufficient depth and duration is necessary to prevent physiological changes that may negatively affect health outcomes for individuals. Sleep deprivation may cause weight gain, obesity, diabetes and hypertension, as well as increased mortality (Gottlieb et al., 2006; Goel et al., 2009).

Sleep is generally thought to be conducive to healing (Adam and Oswald, 1983). Even after just a short period of reduced sleep, people are more vulnerable to infections. Systemic effects of total sleep deprivation include activation of the hypothalamic pituitary, often termed the fight or flight response (Irwin et al., 1999), and the adrenal axis which releases cortisol to manage stress (Leproult et al., 1997; Spiegel et al., 1999). Both can have a negative impact upon the healing process and leave individuals feeling fatigued.

The transition to motherhood includes a physical process. Thompson et al. (2002) explored prevalence and persistence of health problems after childbirth. They found that women experience a range of issues including backache, bowel problems, perineal pain, excessive/prolonged bleeding and urinary incontinence. Although for the majority of women physical issues resolve with basic self-care and professional support, this can only happen with appropriate healing processes (Bick and McArthur, 1995; MacArthur et al., 2006). In my professional experience, women and professionals frequently relate physical problems with the birthing experience. They do not routinely consider the role of sleep in the healing process.

Behavioural effects of sleep

Sleep deprivation can alter one's behaviours. Armstrong et al. (2015) studied sleep deprived mothers in the postpartum period and driving. The results showed that a high proportion of mothers reported fatigue and sleepiness impacting their functioning. Of concern, a high proportion of driving journeys undertaken by the mothers were during high levels of sleepiness placing them at greater risk of

accidents. Arguably this lack of knowledge regarding the effects of sleep deprivation, or the necessity to drive, places them within a domain of 'risk-taking behaviour'; this contradicts, for the majority of women, the desire to protect and care for their child. These findings are interesting as many safeguarding cases (mother and child) do focus upon risk factors and the ability of a mother to prioritise her child. It does raise the question of other behaviours considered 'risk taking' or neglectful and how sleep deprivation influences them. For example, although missed health appointments may not be considered a risk-taking behaviour, they are often generated to assess and review a child's development. Frequent missed appointments could have a detrimental effect upon a child. A report by Gardner (2008), which explored the response by professionals to manage emotional harm, highlights the significance of missed child health appointments as an indicator of neglect. In the safeguarding arena, missed appointments are given significant weighting in assessments. If sleep deprivation is a contributory factor in missing appointments, then in my practice experience mothers are being labelled as neglectful needlessly.

Performance and cognitive effects of sleep

Sleep deprivation can significantly impair learning and cognitive processing. In the widest context, cognitive impairment describes when a person has trouble concentrating, remembering, learning new things or making everyday decisions (Peterson et al., 1999).

Van Dongen et al.'s (2003) study of chronic partial sleep deprivation of six hours or less per night produced evidence of cognitive performance deficits equivalent to up to two nights of total sleep deprivation. Belenky et al.'s (2003) evaluation of partial sleep deprivation found the less sleep obtained due to sleep restriction, the more cognitive performance is impaired. Cognitive performance can include hearing and visual attention and working memory (short and long term), addition and subtraction tasks, retaining information and reaction times. Rinkenauer et al.'s (2004) study found that although people can switch their attention between two areas requiring focus, concentrating on improving one aspect leads to the deterioration of the other.

Van Dongen et al. (2003) suggest that partial sleep deprivation may be an issue for most of the population at some stage. However, mothers are at particular risk.

This is attributed to the transition into motherhood, which is likely to be the ultimate challenge in cognitive processing. A study by De Groot et al. (2006) of differences in cognitive performance during pregnancy and early motherhood found general speed of information processing is significantly compromised during early motherhood. In my experience, professionals, family (particularly grandmothers) and friends, albeit well intended, compound the issue by bombarding mothers with new information, expecting them to make decisions regarding their own and their child's care. A study by Reid et al. (2010), which explored a grandmother's influence over feeding, found that the mother/grandmother relationship is complex, with many grandmothers trying to balance potential risks (seen as taking over) and rewards (mothers benefiting from their advice) when interacting with the new family. Although support from grandmothers could be positive, mothers may be set up to fail through the expectation of others to absorb such information. Potentially mothers are at risk of being 'labeled' negatively. They are not seen to be proactive in meeting their child's needs. In my experience, this can affect a mother's emotional health although mood may be affected by impaired cognition. Cognitive impairment is known to affect mood (Durmer and Dinges, 2005; McEwen, 2006). Pilcher and Huffcutt's (1996) meta-analysis found that mood is more affected by sleep deprivation than either cognitive or motor performance and this impact is greater if individuals are partially sleep deprived as opposed to long-term sleep deprivation.

Beck's (1967, and Beck et al., 1985) cognitive model suggests that cognitive processes help balance the interdependency between emotional experiences and life events. Emotional responses stem from systematic biases or distorted beliefs in these cognitive processes. For example, in depressed individuals, these biases can manifest in a negative way through themselves, the world and the future (Beck, 1967, 1976). For those individuals experiencing anxiety, cognition is frequently characterised by extreme feelings of threat or danger (Sokal et al., 2014). This may intensify a mother's feelings of her need to instinctively protect her child causing chronic increases in her levels of stress. Chronic exposure to stress can affect adrenaline and cortisol levels (hormones related to stress), leaving women in a permanent state of anxiety. The longer term impact not only affects mothers. According to Lupien et al. (2018), who explored the effects of

chronic stress on the human brain, the lifecycle model of stress, particularly if experienced in the programming years (aged 0–2), can have a negative impact upon children at a time of rapid growth. This can then affect their ability to adapt to the transition to adulthood.

Maternal mental health and effects of sleep

By far the most frequently cited association with sleep deprivation is the effect upon mental health and well-being. The relationship between sleep deprivation and depression is well established. However, it is often presented as the 'chicken and egg' conundrum: sleep deprivation as a risk factor for the development of depression (Chang et al., 1997; Germain and Kupfer, 2008; Szklo-Coxe et al., 2010) and depression as a cause of sleep deprivation (Tsuno et al., 2005; Mayers and Baldwin, 2006). Between 50-90% of individuals with depression report some form of sleep deprivation (Tsuno et al., 2005). It has therefore been argued that the relationship between sleep and depression is bi-directional (Riemann et al., 2001).

Maternal mental health is an umbrella term used to describe a range of conditions. Common issues associated with motherhood include mild to moderate (maternal blues, anxiety and postnatal depression) to moderate to severe (postnatal depression to psychosis). Although categorised, the aim is not to minimise the fear and/or intensity of feeling anyone experiencing these conditions may have. It is more likely to reflect the level of urgent intervention required. Sleep deprivation is frequently referenced as a contributory factor in the severity of mental health conditions. A study by Hiscock and Wake (2002), which introduced an infant sleep intervention to improve maternal mood, found it reduces maternal depression at two months and four months.

Maternal blues is a common condition following birth (Hapgood, 1988). It generally begins three days following birth and is defined by the sudden onset of crying spells, anxiety and feeling overwhelmed (Burt, 2006). Sleep deprivation during this period is likely to be contextualised within the physical aspect of giving birth, subsequent recovery, change of environment (hospital) and basic caregiving requirements. Approximately 60-80% of all new mothers suffer from the blues, which rarely require medication and normally subside with support and

education Manjunath and Venkatesh (2011). It is considered self-limiting and hormone related.

Postpartum depression (PPD) also known as postnatal depression is a common condition affecting 15-20% of mothers within the first year of giving birth, although it is most common within the first three months (Cox et al., 1987; O'Hara and Swain, 1996). O'Hara and Swain's (1996) meta-analysis of 51 studies reported 13% as the average prevalence rate. Kendler et al. (1999) found that a third of women will experience depression at some point in their lifetime. Murray and Lopez, (1996) reported that by 2020 The World Health Organization has projected that depression will be the highest health related condition in women. First-time mothers are at particular risk. Almost 60% of primiparous mothers experience some level of depression (Dorheim et al., 2009; Lanzi, 2009; Tsai et al., 2012).

It can be a serious condition affecting the mother's ability to cope with a new baby and has a wider long-term impact upon family relationships if not treated (McMahon et al., 2005). Maternal depression can affect child and adolescent emotional behavioural problems (Cummings, 1995; Cummings et al., 2000; Rohde et al., 2005).

It is not generally known what causes PPD; however, sleep deprivation is synonymous with its presence. Assessing women's sleep throughout pregnancy and the postpartum period, Lee et al. (2000) found that sleep deprivation is greatest at one month postpartum, particularly for first-time mothers. Nonacs and Cohen (1998) reported that screening for PPD can be difficult due to the similarities in symptoms associated with having a new baby and those of depression. They include cognitive impairment, irritability, tearfulness, anxiety and difficulties with problem solving, decision making and memory (Pilcher and Huffcutt, 1996; Dennis and Ross, 2005). Distinguishing between depressive symptoms and the supposed 'normal' events following childbirth, which are often short term, is a challenge that further complicates clinical diagnosis (Newport et al., 2002; Stewart et al., 2003).

At three months, postnatal sleep deprivation is likely to be taking its toll on new mothers due to the ongoing exposure and will present as a chronic issue. As the effects are likely to reflect most domains previously highlighted, it is extremely

challenging for mothers and professionals to distinguish between depression and sleep deprivation. Mothers are worried about the stigma of mental health (perceived failings as a mother) and therefore are unable to raise the issue with professionals (McIntosh, 1993). A study of 1000 UK mothers conducted by BabyCenter in 2015 found that 'the stigma attached to mental illness stopped women from seeking treatment and support for their depression.' Mothers were worried about being labelled mentally ill (Baby Centre, 2015).

Goyal et al.'s (2009) maternal study identifies that women are more likely to report issues with infant temperament, rather than discuss their own emotions. Dennis and Chung-Lee (2006) explore this further and found that women's 'inability to disclose their feelings', is often attributed to the mothers' emotional and practical needs not being responded to by health professionals'. I do believe this is acknowledged to some extent in practice. Professionals use anxiety and depression tools to explore maternal emotion further, particularly PPD. The tools focus upon the symptoms of depression and anxiety. However, in my professional opinion they are too heavily relied on to 'diagnose' PPD. This is problematic as women who are sleep deprived will demonstrate similar symptoms to anxiety and depression. Only through further discussion and exploration can the two be distinguished. In my practice experience women may be misdiagnosed with depression when actually they are sleep deprived. Both require different strategies to provide support: PPD counselling or cognitive behavioural therapy (CBT), and sleep issues benefiting from education and practical support.

Postpartum psychosis (or puerperal psychosis) is a severe episode of mental illness that begins suddenly in the days or weeks after having a baby (Royal College of Psychiatrists, 2018). While the occurrence of postpartum psychosis is relatively rare, it has been estimated at 0.1%-0.2 % of postpartum women (Kendell et al., 1987). A review of postpartum psychosis by Vanderkruik et al. (2017) concurs with the prevalence rates identified by Kendall et al. (1987). Symptoms can include high mood (mania), depression and confusion. Postpartum psychosis is a psychiatric emergency (Royal College of Psychiatrists, 2018). Sleep deprivation during an episode is likely to include episodes of complete sleep deprivation. Women may experience delusions and hallucinations. The Royal College of Psychiatrists (RCP) (2018) report there are likely to be many factors that lead to an episode of postpartum psychosis. The

RCP cite genetic factors, diagnosis of bipolar or schizoaffective disorders, changes in hormone levels and disrupted sleep patterns. The extreme effects of sleep deprivation have been presented as mitigating circumstances in child infanticide cases across the world (Sit et al., 2015).

The Home Office Homicide Index highlights that there were 518 homicides (murder, manslaughter and infanticide) recorded in 2015 in England and Wales. As in previous years, children under one year old had the highest victimisation rate (Office for National statistics, 2016). Health visitor (HV) caseloads (usually safeguarding) can reflect parents citing their sleep deprivation as a problem in the child. This places children at greater risk of harm as the natural occurrence of sleep deprivation through caregiving takes on a more negative connotation with the child being blamed for generating the negative feelings in the mother. In my practice experience, many mothers have experienced a fleeting (not psychotic) episode of wanting to harm their child. This is often a terrifying concept and creates extreme anxiety in mothers. A study by Barr and Beck (2008) exploring thoughts of infanticide that did not lead to the act among mothers with postpartum depression found that mothers are more likely to mention their suicidal thoughts than their infanticidal thoughts in order to obtain health care. A meta-analysis of sleep deprivation and suicidal thoughts by Pigeon et al. (2012) found that sleep deprivation is significantly associated with an increased relative risk for suicidal ideation and suicide attempt.

Attitudes to maternal sleep deprivation

It is readily accepted that sleep deprivation is common in new mothers. However, in my experience women also appear to develop the view that they are, or should be, immune from the effects simply due to transitioning into motherhood. This idea does not appear to be based upon scientific evidence, rather an attitude that is influenced by self and others, including professionals. Sleep deprivation is an issue 'hiding in plain sight', having the potential to significantly affect a mother and child's health and well-being negatively, often impacting on the extended family. Furthermore, a lack of understanding by professionals can lead to misdiagnosis and inappropriate interventions. This study aims to explore a mother's journey in managing sleep deprivation, particularly understanding how women's views are constructed to help a mother make sense of the experience,

and how they inform their behaviour and feelings. Knowing this will enhance professionals' practice in managing the issue. This thesis accepts that women's experiences of 'sleep' will be unique. However, it is envisioned that through the chosen methodology themes will be identified leading to recommendations to help us understand the issues differently.

A brief literature search using the term 'sleep deprivation' yielded numerous results, although further exploration identified that very few explore maternal attitudes to sleep. If they do, it is often within the context of medical sleep problems with a child and/or mother/child disability (Meltzer and Mindell, 2006; Tauman et al., 2015; Heazell et al., 2018). This does offer some insight into understanding the impact of sleep deprivation regardless of cause. However, it does so within a context of something 'abnormal'. Sleep deprivation through infant waking and caregiving is considered a 'normal' event; therefore, it is difficult to make any meaningful or relevant comparisons.

Understanding women's attitudes to sleep deprivation will help us understand how mothers socially construct their views, opinions and beliefs regarding the phenomenon. In doing so, I hope to add to my knowledge and understanding of the issue, based on their thoughts and feelings that can develop HV practice and subsequently support mothers in the future.

Attitudes and norms

The study of attitudes has a long and complex history in social psychology. Attitudes can be considered within three domains: affect, cognition and behaviour (Bohner and Wanke, 2002). Affect refers to a person's evaluation of, liking of, or emotional response to some object or person (Clore and Huntsinger, 2008). According to Zimbardo (1977), cognition is defined as the beliefs, opinions and thoughts a person has about a given object or person. Behaviour involves the person's overt behaviour directed towards the object or person. These three components are closely related, although not synonymous with each other. It is interesting to note that sleep deprivation can affect all three components and is perhaps relevant and influential within the context of women's understanding of sleep deprivation in the postpartum period.

Bohner and Wanke (2002) suggest that attitudes can be analysed at an individual or group level through perception and thinking. If we know others' attitudes, the world becomes a more predictable place. Unpredictability creates conflict. Through shaping the social world for individuals, groups and societies, attitudes are most relevant for everybody's daily life (Bohner and Wanke, 2002). Because of their crucial role in our social lives, attitudes have been a central concept in many areas we would consider 'normal' life events.

Normal can be defined as 'conforming to a standard: usual, typical or expected' (Oxford Dictionary, 2017:489). Something that is normal is usual and ordinary, and is what people expect (Collins Dictionary, 2017). Although the above define 'normal' in its simplest terms, it is acknowledged that various theoretical and philosophical frameworks would challenge such superficial definitions. However, for the purpose of this thesis the term is highlighted to demonstrate that those life issues we believe are 'normal' (aging, eating, breathing, sleeping and motherhood) are commonly overlooked and minimised because of their frequency. For individuals who are challenged by 'normal events', they may be perceived as exaggerating or self-limiting due to their generalisation to the population. In doing so, there is a missed opportunity to explore in more depth or recognise the significance and influence over our ability to manage such events. The relevance and/or impact of normal are contextualised further throughout this chapter.

The continued desire to gain 'control' over these normal experiences is likely to be driven by positive and negative feelings. During times of uncertainty, individuals will look to social norms to gain an accurate understanding of, and effective response to social situations (Cialdini, 2001). Social norms are the rules of behaviour that are considered acceptable in a group or society. They are based upon values, beliefs, attitudes and behaviours. These can change over time according to the environment or situation people find themselves in. People who do not follow these norms may be shunned or suffer some kind of consequence.

The prefix used before the word 'norm' offers further clarity regarding meaning. For example, a descriptive norm is based on our perception of the behaviour of the people around us: 'If everyone is doing or thinking or believing it, it must be a sensible thing to do or think or believe' (Cialdini et al., 1991:203). Conversely,

injunctive norms reflect your perception of whether a behaviour will be approved or disapproved of by a given group. Injunctive norms constitute the morals of a group (Jacobson et al., 2011). Norms can be communicated explicitly – written or spoken openly; implicitly – not openly stated (although you find out when you disobey them); subjectively – expectations about how we will behave; and personally – standards we have about our own behaviours (Xenitidou and Edmonds, 2014).

If individuals are not sure how to behave, then they may follow the lead of others. The motivation for this sense of belonging is captured in Deutsch and Gerard's (1955) study regarding the social influences upon individual judgment on eating habits. They found that following a norm enhances affiliation with a social group and being liked, and generates bench marking for one's own habits. Saam and Harrer (1999) suggest that norms are introduced to achieve a desirable social order avoiding and solving conflicts, make agreements, and reducing complexities.

A study by Choo and Ryan (2016) exploring the social norms that influence the intention of first-time mothers to feed their infants indicates that, while social norms stipulate the motherhood ideology, many first-time mothers have their own social norms or set of values to respond to their anxiety of failing to breastfeed, including justification of actions to avoid to be seen as deviating from their 'mother' role. Mothers do not want to or be seen to deprive their children of basic needs (Hong and Park, 2012). The findings demonstrate the complexity in how mothers form attitudes.

Hjalmlhult and Lomborg's (2012) study exploring how mothers manage the first period at home with a newborn offers further insight into factors that influence a mother's attitude. The findings indicate that mothers are primarily concerned about developing competence as a mother by preserving control and integrity in their new situation. The mothers sought information about what is normal in childbirth, motherhood, the baby and relationships, and compare themselves to these norms. This reflects my own experiences in practice. However, the context of norms described above is on the assumption of the ability to form an objective rational view. This requires the ability to review one's behaviours, achieve optimum physical and mental health, and have full cognitive ability. In my practice

experience, mothers who are sleep deprived and not aware of such effects will try to conform to a model of motherhood that is totally unattainable. The stereotypical images of motherhood are already challenging. Heilman (2002) reports that stereotypes become the basis for faulty reasoning that might lead to biased feelings and actions, and the association or disassociation of others not because of what they are or what they have done, but mostly because of the perceived groups others belong to.

Hey and Bradford's (2006) study of working class mothers focused upon attitudes to motherhood within the context of stereotypical image of mothers by society. The mothers were aware of being stigmatised as irresponsible and unable to provide for their children by society. The women responded through mobilising a discourse of 'self-improvement' revealing ways in which, they self-regulate against normative discourses, which continue to position them as unworthy. The findings highlight that personal insight and awareness of how one is perceived leads to self-improvement and self-regulation, both drivers in changes and positive outcomes. For many new mothers, they will be able to 'rationalise and contextualise' between the fantasy and reality of being a mother. However, mothers who are sleep deprived may not generate the level of self-analysis required to accept that they are affected. Consequently, they may not seek support. Hey and Bradford (2006) may offer some hope as their findings indicate that if women understand the effects of sleep deprivation it will support them in developing positive attitudes to manage it, rather than internalise negative feelings or project such feelings onto the child. My own HV practice records appear to agree with Hey and Bradford (2006) as they highlight that mothers do behave in such a way. However, I would argue that this is more likely due to a reluctance of a mother to admit that she is having negative thoughts about her child to a professional for fear of being judged, rather than because she understands the impact of sleep deprivation.

My practice experience suggests that attitude is reinforced by family, friends and professionals. Mothers are sometimes reluctant to seek support from professionals: 'Under the health visiting "gaze" women may feel they need to present themselves as good mothers' (Peckover, 2002). Peckover (2002) captures my own and my colleagues' experience in HV practice that women do seek advice from friends. Although the advice may be well intended, there is a

danger that the general views of family and friends introduce a wider set of norms and societal beliefs that the mother has to make sense of. Such influence from family and friends suggests that women's attitudes are defined by the body of existing knowledge around them. This is not a new phenomenon or exclusive to mothers. Bricolage is a term that captures such a belief. It is the construction or creation of a work from a diverse range of things that happen to be available, developed by Lévi Strauss (1968). However, in Hester's (2005) study that explored consumer responses to the oral contraceptive pill, Lévi-Strauss's bricolage is challenged as Hester (2005) found that women develop new knowledge. Hester (2005:2) makes reference to women using 'toolboxes' to generate new forms of understanding. The 'toolbox' uses pre-existing tools and/or knowledges at hand, including women's 'body-selves', which have been transmitted in advance, to reconstruct and rework. They create new knowledge based on their own embodied signs, which then provide new frameworks for decisions about contraceptive use.

A study by Tarkka et al. (2000) highlights that mothers who assessed themselves to be coping better with caring for their baby were those who went home from hospital feeling rested and in a good frame of mind. They reported positive experiences of child care in the maternity ward influenced by social networks and professionals. This process also contributes to the individual level of analysis as suggested by Bohner and Wanke (2002). Stern (1995) reports that new mothers have three preoccupations: her relationship with her own mother; her internal view of herself, especially herself as a mother; and thoughts and feelings about her new infant. There is a plethora of research that confirms that social connectedness and access to support networks are important for mothers (Logsdon and Davis, 2003; Bunting and McAuley, 2004; DeVito, 2007). As sleep deprivation is expected following birth, the drive for social connectedness may be stronger for mothers who are struggling to cope; a desire to normalise their experiences. This may be detrimental if met with a generalised view that sleep deprivation is self-limiting and easy to manage.

Professional support for sleep deprivation

HVs have a key role in offering evidenced based support and advice to new mothers regarding numerous health related topics. Safe sleeping (baby

positioning) and breastfeeding are a particular focus, driven by national guidance and local targets. The National Service Framework for children (Department of Health, 2004) stipulates that advice should also be driven by parental need, for example establishing a routine, feeding and safety issues (e.g. the prevention of sudden infant death, etc.).

Reviewing my own area's practice records and clinic contact cards when sleep is discussed, the advice by the HV says, 'advice given', 'readjustment following birth', 'reassurance given', 'advised to try to get some rest', 'advise try to sleep when your baby sleeps'. These comments highlight the diversity in advice and support. Comments range from evidence based (sleep when baby sleeps) to personal opinion (it will right itself). This may be attributed to HVs subconsciously accepting that sleep deprivation goes hand in hand with becoming a mother therefore an assumption of 'natural adjustment'. This view is not exclusive to HVs. Insana and Montgomery-Downs (2013) and Insana et al., (2013, 2011) found that through antenatal care and when preparing women for delivery, women are frequently informed that there will be a lack of sleep and they will become psychologically prepared to handle the issue. This message implies 'natural' or 'instinctive' processes aligned to the wider transition to motherhood.

The diversity in advice may also be influenced by the lack of practice guidance for HVs around managing sleep deprivation. The National Institute for Clinical Excellence (NICE) maternal postnatal care: Antenatal and postnatal mental health (National Institute for Clinical Excellence, 2014) advises that pregnant women who have a sleep problem should develop good sleep hygiene (having a healthy bedtime routine, avoiding caffeine and reducing activity before sleep). The National Institute for Clinical Excellence publication of postnatal care up to eight weeks after birth (National Institute for Clinical Excellence, 2006) does acknowledge the impact of sleep deprivation. However, it is viewed as a symptom of low mood following birth, rather than a cause of low mood as suggested in the Royal Society of Public Health report (2016). The National Institute for Clinical Excellence (2006) advises that women should be encouraged to help look after their mental health by looking after themselves. This includes 'gentle exercise, resting, getting help with caring for the baby, talking about their feelings and accessing social support networks' (National Institute for Clinical Excellence, 2006:15). The Department of Health's Healthy Child Programme (Department of

Health, 2009), which is the programme that drives forward HV work, also refers to sleep. The programme acknowledges that positive mental health is influenced by developing sleep routines. However, this is in reference to the habits of the child rather than the needs of the mother.

Collectively, the HV guidance suggests that sleep deprivation is to be expected, easy to manage and self-limiting. It places emphasis upon mothers to manage the issue. However, it makes assumptions that mothers have someone to talk to about their feelings and can handover caregiving to someone else. The HV role is minimised and may account for the lack of consistency in advice. However, as HVs feel it necessary to draw upon their own personal experience evidence to fill the gap, this suggests that there is a need to revisit the formal advice set out in policy. This is to ensure professionals have access to information that is evidence based, consistent and equitable in delivering key messages. In doing so, drawing upon and sharing personal experience by a professional may be positive and instinctive, potentially enhancing the relationship with the mother. However, this is different from sharing ones thoughts to compensate for lack of knowledge around the subject.

CHAPTER 3 – METHODOLOGY

Research strategy/methodology

This chapter discusses the methodology implemented in undertaking this research: interpretative phenomenological analysis (IPA). It provides the rationale for IPA including why it is considered the most appropriate methodology to support my study's aims and objectives. It also captures my theoretical thinking within the context of the ontological and epistemological positioning of IPA.

Aims

1. Linked to my professional experience and insight from my own professional practice. The aim of the study is to develop an understanding of the experiences of first-time mothers' attitudes to sleep deprivation in the postnatal period.

Objectives

2. Through semi-structured interviews capture the reported experiences associated with sleep deprivation as contextualised by mothers' own understanding.
3. Using interpretative phenomenological analysis, identify dominant themes surrounding mothers' attitudes to sleep deprivation.
4. Use learning from the findings to contribute to reviewing health visiting practice.

Epistemological position

In the widest context of qualitative research Elliot et al. (1999) highlight the importance of a researcher providing a comprehensible account of their own values and assumptions to allow the reader to interpret the quality of the analysis and also to generate alternative interpretations of the data. Creswell (2003) suggests these assumptions can help explain the researcher's stance towards the nature of reality (ontology) and how the researcher 'knows what they know' (epistemology) (Creswell, 2003:16). Grbich (1999:65) suggests that this can be achieved through reflexivity involving, 'a process of self-awareness that should clarify how one's beliefs have been socially constructed and how these values are impacting on interaction and interpretation in research settings'. IPA supports

this approach as it assumes an epistemological stance whereby, through an interpretative methodology, it becomes possible to access an individual's cognitive inner world (Biggerstaff and Thompson, 2008:215). IPA explores how people make sense of their experiences in their interactions with the environment.

Epistemology is the philosophical term for a theory of knowledge and is frequently referred to as 'how do we know what we know' (Crotty, 1998:8). Phenomenology endeavors to understand ideas, situations and problems from the perspective of how individuals perceive their world. Phenomenology helps researchers to explore those experiences, thoughts and feelings through an individual's own language and helps elicit the meaning underlying how people behave (Austin and Sutton, 2014). However, Robson (1993) notes that an interpretive epistemology embraces the importance of things that we cannot see, such as thoughts and emotions and how these influence our behaviour.

Crotty (1998) argues that an epistemological stance implies an ontological position and vice versa. Willig (2008) states that ontology discusses the nature of the world, the question driving ontology is, 'What is there to know?' (Willig, 2008:13). As my epistemological position believes there is no objective truth to be known, the study leans towards a relativist ontological position. Knowledge only comes to light through individual interpretation and all interpretations are based on a particular moment, context or situation, and can therefore never be duplicated. They are open to re-interpretation and negotiation. I believe truth is ever-changing and multi-faceted and therefore agree with Hugly and Sayward's (1987) view on relativism and ontology: it is open to a magnitude of variation that can be applied to the world.

I believe this position supports the aims of the study to understand the 'experience' for mothers, acknowledging that this will be unique. It allows for movement beyond description, and subsequent literally transference into meaning. In doing so, it will be more aligned to how we as humans communicate. Therefore, we are able to develop learning that can be applied in practice in a way women and professionals understand. I would argue that humans do not routinely communicate literal meanings. Our spoken words are presented, contextualised and influenced within other meanings, emotions, cultures, environments, beliefs and values. Therefore, I feel my chosen methodology is not

only suited to answer the research question from a mother's perspective, but also aligned to my own epistemology and ontological position as an interpreter of the research findings.

As I was seeking an individual's 'meaning' of their experience, there was a natural progression to the question 'what is perception?' and what is attitude? An attitude is a predisposition to respond positively or negatively towards an idea, object, person or situation: emotionally, how it makes you feel; cognitively, your thoughts and beliefs about the subject; and behaviourally, in how it influences your behaviour (Ajzen and Fishbein, 2005). This was crucial to understand sleep deprivation as it is something considered normal following child birth. Consequently, it is minimised and often sits within other dominating issues e.g. mental health. Therefore, it was important to choose a methodology that nurtured the diversity that may be reported whilst providing a framework to ensure the data collected reflected 'the voice' of the participants during analysis.

Within qualitative research there are a plethora of approaches. To determine the most appropriate methodology I considered a number of factors in addition to my own philosophical stance. It included the best approach to answer the question, sample size, how I was to complete data collection and the time I had to complete the study. To aid my decision I considered my incentive for the study and what I hoped to achieve. I knew it was important to understand the experience of mothers and explore the meaning of this experience. This had been a motivational factor from the very first time I had the idea for the study. This is intrinsically linked to my second reason, to hopefully contribute to the knowledge pool of what we understand about sleep deprivation so it may support development of health visiting practice. It is important because often HV practice is driven out of literal meanings (if you are tired go to sleep), shaped by policy (all new mothers have a six-week contact) and procedures sometimes generated to minimise risk to professional practice (hospital stay minimum five days following caesarean). Standardising care means there is less room for litigation. The problem with this approach is that we are supporting human beings with diverse needs who are not standardised. We seek to understand the world we live in, in a way that is meaningful to us. In my practice experience, there is a void between what mothers need and what we as professionals provide and I would question if

we (professionals) really do bring anything of benefit or meaning to mothers other than snippets of information.

Credibility

In the widest context, credibility in qualitative research reflects how well the participants from which the data is gathered represent the population the study is meant to reflect (Roller and Lavrakas, 2015). Daly (2007) developed this further by suggesting credibility is not only concerned with procedures but also outcomes: the way projects are planned and designed, in relation to the guidelines of the methodology and the assessment of the results as the project comes towards an end.

When reflecting upon one of the outcomes of this study, to improve knowledge and understanding for all mothers and professionals, I considered Lincoln and Guba's (1985) model for credibility. Lincoln and Guba (1985) propose four criteria for judging the soundness of qualitative research: 'credibility, transferability, dependability and confirmability' (1985:43). They offer these as an alternative to more traditional quantitative criteria such as validity. Despite such guidance, qualitative research is, by its very nature, subjective in comparison to quantitative research. Literature often highlights an aspiration to align qualitative research to the perceived objectivity that quantitative research brings through validity and reliability (Patton, 1999; Noble and Smith, 2015). Cavanagh (1997) suggests that the rigour of qualitative research findings can be judged using criteria constructed to test the validity of results from quantitative studies. In my opinion this suggests that quantitative research is viewed as the gold standard (the most valuable and meaningful to research and human beings).

I would challenge this view as I feel each offers us very different learning and that the credibility should be aligned to studies that have similar philosophies. For example, sleep deprivation is constantly 'measured' in a quantitative domain. Findings can offer us insight into the detrimental effects on the body. It can tell us how many individuals it can affect. However, it does not tell us how people 'feel' about sleep deprivation or how they develop 'resilience' or why some individuals can cope better than others when they appear to have had a similar experience. Although it could be argued that 'never the twain shall meet', I feel this would remove the opportunity to explore our world using all the research available to

us. For example, when reading around the subject of sleep deprivation I accessed quantifiable studies that confirmed my view that sleep deprivation had a detrimental effect upon the human body (Kuriyama et al., 2010; Weisner et al., 2015). This information was crucial; it confirmed my view that we (HVs) underestimate the physical and psychological effects of sleep deprivation in new mothers. The quantifiable studies were able to include large numbers of participants. This helped me understand that there were no 'cohorts' of individuals immune from the effects of sleep deprivation, which confirmed my belief that neither were new mothers. However, the studies did not offer any insight that would support me to achieve my aims and objectives for this study. I therefore support the notion of qualitative research credibility, but within the context of other qualitative studies and not as a hierarchical competitor to quantitative research.

Noble and Smith (2015) suggest that the trustworthiness of the findings can be strengthened by researchers incorporating strategies to enhance the credibility of a study. This is captured in truth value, consistency and applicability.

I have attempted to acknowledge and include evidence of credibility throughout this thesis:

- Excerpts from my personal journal capture my curiosity regarding the 'normalisation of life events'; those things expected or considered normal in life, for example growing old and sleeping
- Each chapter reflects upon my professional role
- Open and transparency regarding how participants were recruited and my method of interviews
- The use of rich and thick verbatim extracts from testimonies
- Development of the methods and reporting of findings
- Participants received a copy of their transcripts – 'member checking'
- A sequential approach to emerging themes is provided and discussed.

I do not believe qualitative studies can be truly replicated even if we could observe the same thing twice. Results will always be different due to the nature of the methodology. However, I do believe that another researcher may be able to transfer my results to a different context that has meaning for them. Confirmability refers to the degree to which the results can be confirmed or validated by others (Anney, 2014). For example, I have attempted to show a systematic approach to

developing themes, which hopefully highlights the procedures I have taken for checking and rechecking the data throughout the study.

Interpretative phenomenological analysis (IPA)

Interpretative phenomenological analysis (IPA) was first introduced in the 1990s by Johnathan Smith (Smith, 1996). It has gained momentum over the past decade, especially in health psychology. IPA explores the study of experience through a lens of phenomenology, hermeneutics and idiography (Smith, 2004; Reid et al., 2005; Larkin et al., 2006; Smith, 2007; Smith et al., 2009; Shinebourne, 2011). Silverman (2000) says the choice of methodology is often influenced by the nature of the problem or phenomenon under discussion. Such elements appeared well suited to my desire to select a methodology that captured the 'perception' and experience of sleep deprivation.

I came across IPA opportunistically during a conversation with a colleague regarding the increase in requests for court reports seeking a health visitor's (HV) opinion (views on parenting style) rather than health facts (immunisation status, developmental review completed). We discussed how opinion could be viewed as judgemental. However, we acknowledged that we do this every day to some extent or other through the contacts we have with parents and the experiences we have as practitioners. She gave me a copy of Smith et al.'s (2009) book on IPA. This generated my interest to explore further. I looked at IPA studies and a few points appealed to me. IPA moved away from descriptive studies. The researcher's interpretation was included in the research process and there appeared to be tangible results that could generate learning for HV practice.

In her IPA study of childhood cancer, Griffiths (2009) interpreted a participant's desire for cancer treatment to end as wanting to go back home because they wanted 'normality', their routine and freedom. It could have been viewed literally as wanting to be out of pain. However, through interpretation it captured the emotion and complexity of children's experiences. It generated thoughts about my own experiences of working in safeguarding. On paper a parent has neglected their child. However, when you meet parents you observe the complexity of human nature and are thrown into a world of alleged mitigation and emotion. I wanted to capture this emotion in my study as HVs spend their days interpreting what others say and do; it is not exclusive to safeguarding. I felt that HV would

be able to relate to this methodology and acquire new knowledge that may develop practice. McDermott's (2016) IPA study of the experience of suicidal behaviour found that the results had a dual benefit not only by adding to research in the area, but also potentially changing practice or generating more development for practice.

Although these studies led me to believe IPA was the most appropriate methodology for my study, I was not fully committed as I had initially found it difficult to distinguish the difference between description and interpretation. I did feel that phenomenology went some way to support the aim of my study. However, I was uncomfortable with the notion of 'bracketing', suspending judgment about the natural world to instead focus on analysis of experience. In addition to reading other studies, I used excerpts from testimonies in Bailey's (2011) study of travellers to practise my 'interpretive skills', applying it to a subject I knew little about. I then compared my analysis to Bailey (2011) and recorded my findings in a personal journal. I repeated this with the other IPA studies referenced. However, it became apparent that although many studies are defined as IPA many were too descriptive, not achieving the level of interpretative analysis required. This conclusion highlighted my ability (developed over numerous months) to see obvious distinguishable features between description and interpretation, although upon reflection it highlights an ongoing personal learning experience even as this thesis reaches its conclusion. Bailey's (2011) study added another dimension in helping me understand the wider elements of interpretation that we all experience daily, regardless of our appointed professional status.

Whatever the topic of study, all IPA researchers start from a position of believing that human beings socially construct their worlds (Eatough and Smith, 2017). This was probably the most dominant feature that appealed to me. I believe that each experience for individuals is unique, socially constructed through complex belief systems. In essence, truth is whatever we say or believe it to be. My view could be described as social constructionism and perhaps considered a weakness in this study. Constructionism is a paradigm or philosophy of research in which objective reality is constructed by humans, partly through social interactions (Browning, 2009). Jorgensen and Phillips (2002) describe one aspect of social constructionism heavily weighted towards nurture. For example, 'if I say in the

morning that I am a man, then that is what I am; if I, then say in the afternoon that I am a woman, then I am' (Jorgensen and Phillips 2002:175). Although I believe I would respect an individual's right to believe this, I am not sure I would fully believe this to be true. This generates an uncomfortable feeling for me as I feel I am minimising someone's belief, experience or feelings. However, upon reflection I would say that my own beliefs sit somewhere between nurture and nature. I am not sure that I could fully ignore the biological influence transitioning from male to female requires. This is probably attributed to my nursing (medicalisation) background, but also my background in child development. Having knowledge of how babies develop both physically and cognitively.

Reflecting upon the content of this thesis I can now see that my own beliefs have also influenced my inclusion of the biological effects of sleep deprivation in my literature review. Until writing this section I had not realised that I had captured both the nature and nurture effects in this way. I do not think my beliefs compromise my study; on the contrary, one of the reasons for choosing IPA was an acceptance that I could not be detached from the research process.

IPA as a methodology

IPA is a method of qualitative inquiry which over the past decade has predominately been used within psychology. However, Smith et al. (2009:5) have highlighted its appropriateness for anyone concerned with 'the human predicament'. IPA is centrally concerned with exploring an individual's experience and associated meaning of their world (Smith, 2011). Willig (2001) says that for those who do not have a philosophical background, the clear and systematic guidelines to identify and integrate themes make it an accessible phenomenological methodology. Although Willig (2001) does suggest the framework of IPA is positive, he challenges whether 'meaning' can ever be accurately captured as what we actually capture are our own opinions of the experience. I would suggest that Willig (2001) is alluding to the need for logic when exploring experience. Although I would agree with Willig (2001) that an opinion can be formed not necessarily based on fact or knowledge, I would argue that this is integral to understanding any experience. Even if one has experienced something from a physical perspective, it is our environment, social norms,

culture and perceptions of that experience that will give a researcher insight to the topic being explored. Human nature is not logical.

The philosophical roots of IPA are to be found in phenomenology, hermeneutics and have an ideographic focus, which would suggest our predilection for order can mean that we look too quickly to fit things, putting our consciousness into categories (Husserl, 1982, 2012). Husserl, a German philosopher frequently described as the father of phenomenology, believed our consciousness is based on the meaning of an individual experience. To understand the experience, perception and attitude requires reflexivity; the transition towards inward perception rather than looking out at the world for answers. Husserl believed that this would stop us taking for granted our experience of the world. We are able to disengage from the activity and focus upon the taken for granted element. We achieve this through a process of description and reflection.

Husserl moved away from positivism (a philosophical system that believes objectivism is achieved through scientific verification) by arguing that individual experiences are subjective; however, by suggesting there are experiences that are common to all people, he argues that as in positivism, objectivity can still be achieved. There is an objective world that is really out there. His work is primarily known as descriptive phenomenology. He would argue that we can contextualise our feelings upon reflection therefore no further exploration of the statements is needed.

If Husserl's theory is applied to the interviews from this study, then when asked about sleep deprivation, if women all reported similar management strategies, 'I just did what I had to do', 'I am quite practical about it', 'I just got on with it' collectively they are all describing a pragmatic approach to managing it. Husserl uses the term eidetic reduction to describe the technique in studying the 'essences' (basic components of phenomena) with an emphasis upon reduction to remove what is perceived, leaving only what is required. Therefore, unique and essential components to our experience can be abstracted from experiences without a consideration of context, supporting the argument that objectivity is possible. This can be achieved by the researcher 'bracketing'. 'Bracket out' is the term used when a researcher puts their own views or prior knowledge of the phenomena to one side (Drew, 2004).

However, Husserl's theory leaves unanswered questions and does not offer any explanation for two women crying when giving their answers, or immediately following those statements going on to say, 'is it ridiculous not to be able to cope with it?', or 'I should be able to manage it shouldn't I?' Husserl would suggest that the researcher's observation does not need to be contextualised even though there is a clear contradiction between the women's descriptive account and their facial expressions and tone of voice. Husserl's theory would suggest that the researcher has been unsuccessful in bracketing.

Albeit Husserl's phenomenology acknowledges individual experiences, other philosophical theorists would argue that understanding the true phenomenon requires the ability to interpret (for both the researcher and the participant), a notion that participants do not always have the ability to contextualise their feelings fully without a level of interpretation. Therefore, it is paramount to incorporate the researcher as part of the process.

IPA and hermeneutics

Interpretive phenomenology focuses upon interpreting the hidden meanings in the phenomenon that are not immediately obvious to guide the analysis (Omery, 1983). Although IPA is aligned with Husserl's theory of phenomenology, it moves away from the descriptive commitments towards a more 'interpretative and worldly position' (Smith et al., 2009:21). This concept is supported by the work of Heidegger (1996, 1999) and Merleau-Ponty (1962) who introduce us to different paradigms of consciousness, share and acknowledge the concept of hermeneutics (interpretation). Heidegger's view is that experience and judgement cannot be suspended; therefore, it is impossible to be completely objective. Hermeneutics seeks meanings that are embedded in everyday occurrences and so moves beyond the description of experience. Human beings are thrown into a world of objects, relationships, culture and language through interpretation (Heidegger, 1996, 1999).

Giddens (1987:20) highlights a two-way process between researcher and participant and says we often consider the way 'in which concepts obstinately intrude into the discourse of social science' but 'few have considered the matter the other way around'. Smith et al. (2009) describe this as double hermeneutics: 'The researcher is trying to make sense of the participant trying to make sense of

what is happening to them' (Smith et al., 2009:3). Merleau-Ponty (1962), a phenomenological philosopher, also acknowledges the significance of double hermeneutics and its position to the idiographic nature of interpretation. However, he does suggest that it may never be entirely captured or absorbed, but must not be ignored or overlooked.

Smith and Osborn (2003) elaborate upon the process. First, the participant offers their interpretation of the phenomena and meaning via their language. Secondly, the researcher endeavours to interpret and understand the participant's comments. This does support Husserl's general concept of reflexivity as it acknowledges its dependence upon the researcher's own standpoint. However, it is utilised in IPA to include rather than bracket out: sanctioning a process of self-awareness that should demystify how one's beliefs and how these values are impacting on interaction and interpretation (Grbich, 1999).

It is worth noting that Smith et al. (2009) make reference to the importance of interpretation emerging from the reflexive relationship between the researcher and participant, not through initially comparing participants with each other or comparing participants with another group. Smith et al. (2009) cite this as a common misconception when using IPA. Making a comparison within an IPA study is challenging and would require greater numbers of participants, potentially leading to study results that are primarily descriptive and lack depth. To remain true to the idiographic nature, Smith et al. (2009) suggest that each interview is analysed in isolation before moving on. Once completed, master themes can be identified across all interviews.

Idiographic is concerned with the particular, as opposed to generalising claims about a group or human behaviours. It refers to the approach of studying individuals in a personal, detailed way to achieve a unique understanding of them (Smith et al., 2009).

'How we see another is always from a position of difference, the grief and danger of another never quite have the same significance for him as they have for me. For him the situations are lived through for me they are displayed.' (Merleau-Ponty. 1962:415)

Smith et al. (2009), Merleau-Ponty (1962) and Giddens (1987) emphasise the importance of the relationship between the researcher and participant in hermeneutics.

In terms of attitude and perception, Husserl's work underpins the importance and relevance of an experience. However, Heidegger and Merleau-Ponty move away from description towards a more interpretative and worldly position with a focus on understanding human involvement in the world, embedding individuals in a world of objects and relationships, language and culture, projects and concerns (Langdrige, 2008). To contextualise our consciousness, understanding of 'being in the world' requires a level of interpretation that explores what is absent (our expectations), the influence of others on our feelings (self-consciousness) and reflexivity to understand our differences. The previous section has provided the rationale for why IPA is best suited to this study.

CHAPTER 4 – DATA COLLECTION

The previous chapter has provided a rationale for the choice of research strategy and methodology. This chapter includes the more pragmatic issues surrounding the study including data collection, sampling and subsequently the process of analysis. It also reflects the stages of moving from an interview transcript to a position of interpretation.

Ethical considerations

Smith et al. (2009:53) suggest that ethical research practice is a 'dynamic constant process', which needs to be monitored throughout testimonial collection and analysis. This definition appealed to me as it suggested a tangible ongoing process rather than a standalone checklist used at the beginning of a study. Interpretative phenomenological analysis (IPA) explores individuals' feelings; therefore, an ongoing process would be in keeping with my desire to ensure all my participants understood what they were involved in and my belief that they should be able to 'walk away' from the study at any time. Although opting out at any time could compromise my study, I knew that the study had the potential to generate emotive feelings for the participants. My professional experience and knowledge generated an overwhelming sense of responsibility in ensuring all women were supported throughout the study, particularly pre and post study.

Such a belief generated a view that 'checkpoints' were necessary. These checkpoints support Smith et al.'s (2009) suggestion of monitoring in ethics. The checkpoints are highlighted throughout this chapter and influenced by a number of factors in addition to my own experiences. Participants communicated what I would describe as 'natural checkpoints', for example if they became upset I would ask if they wanted to continue. Through the National Research Ethics Service (NRES) and various ethics committees, checkpoints were identified (confidentiality, consent); they are discussed in more detail below. Full ethics approval for the study was obtained from the North West Research Ethics Committee (REC) and governance bodies within the community trust. The study was also reviewed and approved by Manchester Metropolitan University's ethics committee (Appendix 1).

Confidentiality

Smith (2010) suggests that achieving confidentiality in IPA research is unrealistic as confidentiality could only be achieved if the testimonials collected cannot be revealed, therefore making little sense. Although I acknowledge such a view, I would suggest that Smith (2010) draws our attention to one definition of confidentiality (not necessarily relating to research) pertaining to a situation in which information must be kept secret and private. I agree with Smith (2010) in revealing testimonies; however, I believe this can and should be within the context of retaining participant anonymity.

Each participant was given an appropriate pseudonym to ensure they could not be identified. This was maintained throughout the research process. Although taking these steps did retain the anonymity desired, if I had identified a safeguarding issue then information about the participant would be shared with relevant health and social care practitioners in a position to support, for example the general practitioner (GP) or social services.

Consent

Written consent to participate in the study was gained from each individual (Appendix 2). Flick (2009) and Thompson (2002) emphasise the importance of individuals having clarity regarding their role as a participant in the research study including being informed how the information they provide will be used, and who will have access to it. Consent was gained to record and transcribe interviews and permission sought to publish anonymised quotations (Appendix 2). Each participant was informed about the full aims of the study, including how their information would be used, four to six weeks prior to data collection by a health visitor (HV), either during routine home visits or at baby clinics (participant information packs and an invitation to speak to the researcher if they had any questions) (Appendix 3). Thompson (2002) says it is only after this information is provided that people can willingly give informed consent whether to be involved or not.

Although I had taken steps to ensure informed consent was gained, I had not prepared for potential participants contacting me to say they would be willing to participate in the study even though the information had not been available to them. They had been told about the study by friends. However, they did not meet

the inclusion criteria of being a first-time mother. I explained the rationale for the study including how the findings would be disseminated into practice and made a commitment to disseminate the findings in a wider forum that all parents could access. In one instance based upon a discussion with a mother, with her consent I referred her to her HV for emotional support. This experience alerted me to the willingness of people to participate, despite not having all the information. I had naively assumed that individuals would not be influenced by anyone other than the person recruiting them.

I reflected upon the position of informed consent and confidentiality and concluded that although both were sought, gained and explained prior to the study the willingness of participants to join without all the information could have potential implications during the interviews if participants went on to share personal information. This experience reaffirmed my belief that ethical considerations should be applied continuously throughout the study to ensure participant and researcher are in agreement with every phase. This was also used as an example when I delivered a presentation to HVs regarding the study and their role in the recruitment of participants. Their role was to give out the information packs; they were not involved in the recruitment of participants.

Houghton et al. (2010) added another dimension to confidentiality by highlighting that although this must be discussed as part of informed consent, not all participants may have equal rights to confidentiality. This is particularly pertinent when considering potentially sensitive issues that may arise in the study (maternal mental health or safeguarding) that would require support from external agencies. I felt this would require periodical review of consent and all participants were made aware of this before the study commenced.

Prior to each interview, I revisited informed consent and explained that if a disclosure was made and the mother or I felt additional support would be beneficial, or if a safeguarding disclosure was made, then I may need to identify the most appropriate person to offer that support. Potential action was placed within the context of the Children Act (1989, 2004). My extensive experience in managing safeguarding ensured that I was aware that such topics are often disclosed during one-to-one discussions. All participants retained their named HV, who they had already met in the antenatal period, and they were available to

offer support for the duration of the study. If anxiety was suspected or observed during the interview, the interview was stopped so that I could clarify if the participants wished to continue. I have professional experience in responding to non-verbal communication in practice. Non-verbal communication observations were included in my research notes to capture general impressions and participants' responses. This information was then used when interpreting the data. My approach addressed the unpredictability of interview outcomes highlighted by Shaw (2008) who stated that researchers do not know how a person being interviewed might be affected, therefore should remain vigilant. No safeguarding issues were identified during the study. I ensured confidentiality and informed consent was maintained throughout the study.

Participants and recruitment method

Identifying individuals to participate in my study and how they would be recruited was achieved through sampling. Sampling describes the selection of a specific population for the purposes of undertaking research (Clandinin and Connelly, 1998; Denscombe, 2007). The sampling methods chosen are influenced by the research strategy used to inform and guide the enquiry. IPA uses purposive sampling to select a homogeneous group for whom the research question will be significant (Smith et al., 2009). Participants are experts in the phenomenon being explored and IPA facilitates the subjective thoughts and experiences being investigated (Reid et al., 2005). This allows for a deeper critical evaluation concerning the population parameters that the study is interested in (Flick, 2009). A small sample number is considered acceptable to capture the richness of individual accounts and the commitment to the level of analysis (Smith and Osborn, 2003). Smith et al. (1999) suggest that 10 participants would be at the maximum end of the recommended sample size for IPA. Smith and Osborn (2003) suggest sample sizes of between five and six people for novice researchers. I read a number of IPA studies (Grigoriou, 2004; Nunn, 2010; Denovan and Macaskill, 2013) when considering the methodology and they all aligned to the recommended number of participants. Smith (2010) suggestion provided a framework for the researcher in considering numbers. However, as this chapter explains, the final number (six) was also influenced by the results of the pilot exercise, the interview schedule and the time the researcher had available to complete the study.

Participant eligibility and recruitment

Information regarding the participants is included in Table 2 below. Six participants were recruited for the study. The inclusion criteria were:

1. First-time mothers over 16 years old. In Wirral those mothers younger than 16 are recruited to the Family Nurse Partnership programme and were therefore not considered eligible to participate. In addition, many first-time mothers under 16 on the Wirral are supported through a multi-agency framework. The purpose of the study was not specifically focused upon children. It was to explore views without any previous known significant factors that detracted from the overall discussion of sleep deprivation within a caregiving context (for example domestic violence, living in foster care, child protection orders). Therefore, under 16s were excluded from recruitment.
2. Any mother regardless of first language. Wirral has a small group of women from other ethnic backgrounds whose first language is not English (less than 2% of annual births). An interpreter who had been informed about the study was available and an agreement had been made (between the researcher and the agency) that they would be available for the interview.
3. A homogenous group of participants with an understanding of the experience being explored further; this was considered important as the purpose of the study was to explore first-time mothers' attitudes.

Recruitment process

The original plan for information about the study to be given to mothers during the standardised HV antenatal contact at 36 weeks of pregnancy changed due to a modification in the community NHS trust's antenatal protocol (targeted antenatal only). This caused a delay in undertaking the study. Consequently, it affected my timeline for completion. The community NHS trust had also agreed a time period for the study to be completed. This was to ensure any other research or proposed research taking place within the trust did not overlap with my study. However, changes to my work commitments and substantive post also contributed to altering when information packs were distributed.

The information packs were given out at the universal postnatal birth visit between day 10 and 14 by the HV. The HV gave a brief overview of the study including an explanation of what was in the pack (information leaflet, consent form, contact details for researcher). I had previously delivered a presentation and held a meeting with HVs to explain the study and to clarify their role in the study. They would not be involved in the recruitment process. I emphasised the importance of the HV not encouraging or dissuading women from joining the study. If women wanted further information about the study the HV would advise mothers to contact me. Following a review by the North West Ethics Committee the decision was made not to automatically inform HVs that their client was participating in the study unless a mother needed additional support. This amendment to the original plan was to reflect the Research Ethics Committee's recommendations. This decision also included not routinely informing the GP. All the details for opting into the study were provided in the pack. The packs contained information about the study, consent forms and the researcher's contact details.

An administration support worker who had expressed an interest in supporting the study and was released from daily duties by their manager collected the completed packs from those mothers wishing to participate. Women had telephoned either the number in the pack if they wanted to participate or dropped the expression of interest into their local child health clinic in a sealed envelope. The administration support worker then contacted the mothers to arrange the interview and all mothers were invited to speak to the researcher if they had clarification questions. Those mothers who met the criteria were selected on a first come first served basis. For those mothers who expressed an interest after the participants had been selected, I contacted them thanking them for their interest, and explained that the required numbers for the study had been reached. I gave a commitment to contact these mothers once the study was complete to inform them of results and a contact list was compiled by the administration support worker and stored along with participants' details.

Participant demographics

Table 2 below provides details of those women recruited to the study. Each mother has been given a pseudonym. The inclusion criteria for the information

provided in the table is drawn from the demographic data often found in qualitative studies: age, gender, religion and ethnicity. Job prior to birth was added following the analysis of data as it was significant for women in the testimonies they gave and subsequent findings in redefining self.

Table 3 – Participant demographics

Pseudonym	Age at interview	Ethnicity	Current context	Job prior to birth
Sarah	23	White British	Lives with partner, good support from extended family	Teacher
Elizabeth	32	White British	Lives with partner, good support from extended family	Police
Samantha	19	White British	Lives with her grandmother Not in a relationship with baby's father	Student
Georgia	22	White British	Lives with partner No extended family support	Not working
Jane	20	White Irish	Lives with her mother Not in a relationship with baby's father	Not working
Kerri	27	White British	Lives with partner, good support from extended family	Solicitor

Interview schedule

The interview schedule consisted of the topic guide and the semi-structured schedule. Creating a topic guide was beneficial as although questions were open

ended, allowing the participant to interpret the topic in a way that was meaningful to them, it provided an opportunity for me to discuss sleep deprivation in more detail by following up points of interest. Although it could be argued that this created parameters, it ensured that I did not impose my understanding of the phenomenon on the participants' narratives. The schedule was designed to maximise the chances of seeing different aspects of the participants' experiences, therefore being more likely to achieve the aim of the study exploring attitudes. I utilised Smith and Eatough's (2007) suggestion of asking a series of open-ended and non-directive questions to encourage participants to discuss their expectations and experiences of sleep disturbance.

Questions

Consideration was given to two approaches to the interview structure, unstructured and semi-structured. Both approaches are in keeping with the IPA approach. Unstructured interviews are non-directive (Bailey, 1994). There are no restrictions on the questions asked and the lack of structure aligns itself to an informal schedule. Participants can give as little or as much information as they wish. Denscombe (2007) states this approach is more suited to an experienced researcher, one who is well-practised in interviewing skills. Although appealing, within the context of allowing mothers to share their experiences solely determined by them, I was not confident that my experience in research was sufficient to 'manage' the discussion without going off on a tangent; that is, totally losing focus from the topic being explored. Therefore, my desire to have structure primarily reflected my own needs; it is for this reason unstructured interviews were rejected.

The semi-structured interview is the most widely used interviewing method in health and social research (Wengrath, 2001). It allows the researcher to ask a number of open-ended questions, still providing enough flexibility for participants to give as little or as much information as they wish. It also allows the researcher to remain focused upon the topic under discussion. Smith (1996) suggests that a research schedule can be used as an 'aide-memoir' to capture similarities and differences with each experience. The schedule appealed to me as I felt it would encourage a 'conversational' approach through its flexibility. This was probably attributed to a style I was comfortable with through my professional practice with

clients. Being mindful of promoting a 'conversation' supported my aim to achieve Smiths et al.'s (2009) ideology of the semi-structured method, acknowledging the 'relationship' between the researcher (included in the discussion) and participant (able to share their experience in a way meaningful to them). This approach influenced my decision to introduce an element of ordering in the opening and closing of the interview. The rationale was attributed to the view that most people find it easier to discuss less abstract topics earlier on (Smith et al., 2009). Smith et al., (2009) describes this as 'relationship building' as participants do not feel challenged by the researcher. The pilot (see below) explores development of the questions in more detail.

Conducting the interviews

The interview schedule incorporated clarifying with participants immediately prior to interview that they understood why they were being interviewed, and what aspects of their experience I was interested in. I asked participants to confirm that they had received and understood the information sheet and clarified that they had signed the consent form. Confidentiality including anonymity was explained in accordance with the Data Protection Act (Data Protection Act, 1998). I explained that participants' anonymity and confidentiality would be retained unless we identified anything we felt would benefit from sharing with other parties, for example safeguarding disclosures or supporting maternal mental health issues.

Emphasis was placed upon each participant only answering questions they were comfortable with and explaining that the questions could be interpreted in whatever way was appropriate to the interviewee. I explained that there were no right or wrong answers and they could stop the interview at any time. I reminded them that the interview would be recorded using a Dictaphone and gained verbal consent to continue. Each interview lasted for between 20 and 60 minutes. In each case, the duration was determined by the person taking part. Upon reflection, as I became more familiar and confident with the questions it could be argued that I became more skilled in keeping the conversation flowing. For example, towards the last interview, if mothers stopped speaking after answering the question I was more confident to prompt ('Can you tell me more about...'). However, I revisited the sequence and timings of interviews and concluded that

my lack of confidence had not influenced the duration of interviews as the timings had not increased when reviewed chronologically.

Interviews were transcribed verbatim by an administration support worker. Wherever possible, notes of observations (body language, pauses, crying) were made during the interview; however, immediately following each individual interview I documented my thoughts and reflections on the interaction between interviewer and interviewee. IPA is not prescriptive in determining what should be captured; however, as interpretation is a key component to the study, I felt that it would contribute to the analysis stage. The participants determined if interviews were conducted in a clinic or home setting. Only one individual requested a home visit. Childcare was available for all mothers participating. This provision was offered by the NHS trust.

Pre-interview feedback

A pilot was used to explore various aspects of the study. Sample information packs were given out to mothers in a child health clinic asking them for their views. Feedback was sought on the format of the information available; questions included whether there was too much jargon or too much or too little information.

The original consent included GPs routinely being informed of women's participation in the study. Women felt that this was unnecessary unless they needed support so this aspect was removed. The research committee also highlighted this as unnecessary. The rationale for inclusion reflected my own experience in practice, being aware that there was often a delay in women receiving support. The aim was to raise awareness with GPs to ensure a smooth transition of care if support was needed. However, upon reflection I have concluded that this could have been viewed as creating a 'fast track system' to the GP when actually any woman should be seen as soon as possible, and if there is a problem in getting support, then this is a wider service delivery issue that should be addressed in a broader context. Women may also have not wanted their GP to know they were participating in the study.

Although I had opted for semi-structured interviews, I wanted to ensure that my lack of experience did not compromise the flexibility of exploring the participants' experiences. This is in keeping with the requirements of IPA; questions should

be directed to meaning. Smith et al. (2009) advise that the interview questions should not impose too many theoretical constructs upon the phenomena being discussed. This advice contributed to a review of the interview questions. For example, when piloting the questions with mothers the original schedule asked 'have you experienced problems with sleep disturbance?'; this elicited a simple 'yes' or 'no' response. This required a change to an opened-ended question that encouraged the participant to provide a more detailed account in response to the questions asked.

The evaluation of the pilot with three participants (influenced by participant availability and a timeline set to commence the full research study) highlighted the importance of reorganising the format of the questions. The final schedule started with a broad question that allowed the speaker to recount a broadly descriptive account of their experience and ended with a question that encouraged dialogue to capture the phenomenological essence of the experience being recalled. In this way, it was hoped that the participants were able to feel comfortable whilst talking about their own memories. The remaining questions focused upon the analytical and evaluative nature of the interview. The pilot highlighted that the first and last question did not require any prompts; however, the more analytical questions did. Table 3 below details the questions asked.

Table 4 – Interview questions

Final Interview Schedule – Semi-structured Questions
<p>1. <i>Understanding the mother</i></p> <p>I am really interested in your pregnancy and birthing experience, can you tell me more about it?</p>
<p>2. <i>Views on sleep deprivation</i></p> <p>What were your thoughts/expectations during the antenatal period regarding sleep deprivation?</p> <p>How does this expectation compare to the reality once your baby was here?</p> <p>Can you tell me more about your experiences of sleep deprivation following the birth?</p> <p>What things do you think cause sleep disturbance for mothers in the postnatal period?</p> <p>Prompts – Can you tell more about that? Why do you think that?</p>
<p>3. <i>Maternal feelings</i></p> <p>I am really interested in knowing more about your emotions during your pregnancy and following the birth of your baby and what things you think contributed to these feelings</p> <p>Prompts – Can you tell me about this? Have you experienced low mood during pregnancy or following birth? Have you or are you receiving support? What do you think makes women feel low after they have had a baby? How do you view sleep disturbance in the context of affecting maternal mood?</p>
<p>4. <i>Support seeking behaviours</i></p> <p>I am really interested in finding out about your experiences of seeking or being given support for sleep deprivation or other parenting issues since having your baby.</p> <p>Prompts – Can you tell me about this? Can you tell why you made that decision? How did that make you feel?</p>
<p>5. <i>What helps?</i></p> <p>What do you think are some of the things that would help or not help mothers manage sleep deprivation? What would have helped you?</p>
<p>6. <i>Opportunity to share more about their experience</i></p> <p>Do you think there is anything else you think is important for me to understand regarding your experiences that we haven't discussed today?</p>

Protection and storage of data

After each interview, an administration support worker transcribed the recording verbatim within 24 hours and any information that may have identified the participant was removed. The original interview recording was saved onto an NHS password protected computer. The NHS IT team ensured that only 'researcher' access rights were available. The computer could not be accessed externally. I was required to complete trust mandatory training in information governance and have a working knowledge of the Code of Conduct for Handling Personal Identifiable Information and the Caldicott and Data Protection Policy. I also met with the Caldicott guardian and governance lead in the trust to provide assurance regarding storage of data. To aid the process of cataloguing each interview was assigned a code, for example 'Interview 1' with the date that the interview was completed. All interviews took place on separate days. Transcribed interviews were only accessible by the administration worker and me. Each participant received a copy of their own coded transcript to support credibility.

CHAPTER 5 – IPA ANALYSIS

Introduction

This chapter captures the detailed process of IPA analysis. It uses the interpretative phenomenological analysis (IPA) iterative and inductive analytical cycle to demonstrate how I have moved from note taking to developing themes through interpretation. This is captured through a combination of handwritten notes and tables providing excerpts of theme development. This is shown throughout this chapter. This chapter also reflects my comparison with others who have used IPA helping to guide my own decisions in using the framework.

IPA provides 'a systematic and practical approach to analysing phenomenological data in a structured way' (Barker et al., 2002:81). This could be viewed as a criticism of IPA as it can imply a level of inflexibility (Braun and Clarke, 2006). Although, the structure is tempting for a novice researcher as it offers reassurance in terms of stages to research. However, I would suggest that the structure brings a level of openness and transparency supporting credibility in qualitative research. The interpretation required in IPA also ensures that the framework to analyse the data refers to a process rather than being prescriptive in how the data is used.

Given IPA's idiographic commitment, there are no set rules of analysis (Smith and Osborn, 2003). However, although IPA does not include a single step of data analysis, it does offer a framework (Cooper et al., 2012). Furthermore, Smith et al. (1999, 2009) do offer two possible approaches. Smith et al. (1999) suggest that themes may be carried forward from the first participant, to be built on with subsequent participants' accounts. Smith et al. (2009) emphasised the need to approach each case on its own terms, to do justice to its own individuality and this is the most common. Willig (2001) suggests that case-by-case analysis allows 'more room for creativity and freedom' than other approaches. He suggests that this may be of particular importance when the sample involves unusual groups, situations or means of data collection.

I did not feel comfortable with Smith et al.'s (1999) earlier suggestion around analysis, mainly attributed to my lack of experience in interpretation. I was concerned that I would default to trying to interpret and/or make assumptions to

alleviate my insecurities. For example, creating and carrying themes forward that I had interpreted through my professional health lens. Biggerstaff and Thompson (2008) highlight the importance of researchers acknowledging that our beliefs and expectations may be outside the perception held of healthcare professionals. I would agree with Biggerstaff and Thompson (2008) as my own reflections have revealed a level of social constructionism that supports 'health perceptions' from a medical (nature) perspective.

However, Smiths et al.'s (2009) later model of IPA does acknowledge the challenges of bracketing. The term bracketing is used to describe the setting aside of the researcher's assumptions (Theobald, 1997). This perhaps shows the evolving nature of the IPA approach, with enhanced guidance emphasising the rigour to following steps and acknowledging the role of the researcher in the analysis (Smith et al., 2009).

It could be argued that this approach contradicts the core of IPA as the focus of IPA is interpretation not prescription. However, Smith et al. (2009) would argue that they are advocating a clear, auditable, systematic process, rather than a rigid, prescriptive one.

IPA iterative and inductive analytical cycle

To focus on the specific method of analysis, the IPA framework is highlighted below. Choosing the first case to be analysed was based on the assessment of the testimony that appeared to be the most detailed, complex and engaging as advised by Smith et al. (2009). This contradicts other studies that appear to have adopted the shortest and easiest first (Bailey, 2011; Harris, 2012). I had concluded this was personal preference, although the most detailed interview was towards the end of my study; therefore, upon reflection, probably the one I could remember most vividly at the time.

1. 'Close line-by-line analysis of the experiential claims, concerns, and understandings of each participant.
2. Identification of emerging patterns within this experiential material, emphasising convergence and divergence, commonality and nuance, usually for single cases, and then subsequently across multiple cases.

3. Development of a 'dialogue' between the researchers, their coded data, and their knowledge, about what it might mean for people to have these concerns, in this context leading in turn to the development of an interpretative account.
4. Development of a structure, frame, or Gestalt, which illustrates the relationship between themes.
5. Organisation of all this material in a format which allows for analysed data to be traced back through the process, from initial codes on the transcripts, through initial clustering of thematic development, into the final structure of themes.
6. Use of supervision, collaboration, or audit to help test and develop the coherence and plausibility of the interpretation and explore reflexivity.
7. Development of a narrative evidenced by a detailed commentary on data extracts, which takes the reader through the interpretation, usually theme-by-theme, and is often supported by some form of visual guide (a simple, table or diagram).
8. Reflection on one's own perceptions, conceptions, and processes should occur.'

(Smith et al., 2009:79-80)

Stage 1 (reading) and 2 (noting)

Smith et al. (2009) believe that through reading and note taking the analyst is examining the content and language used on a very exploratory level. The aim is to maintain an open mind and note anything of interest within the transcript. Steps 1 and 2 merge as the analyst is making notes when reading, and then as they get more and more familiar with the transcript they make further notes. The actual words, phrases placed under the 'notes' section are not prescriptive. Smith et al. (2009) describe it within a similar context to free textual analysis. There are no rules about what is commented on and no requirement to divide the text into meaningful units. Analysis should be concerned as much about engaging with the transcript as with the outcome. In preparation for note taking and considering

Smith et al.'s (2009) views, I read a number of IPA studies with particular reference to their note taking (Grigoriou, 2004; Harris, 2012). There were no significant distinguishable features between the notes made. Primarily they were handwritten notes capturing comments perceived by the researcher to be interesting and words that were seen to be pertinent to the participants' experiences.

Reviewing my own notes, I was aware that unlike the comparative studies I had made notes regarding non-verbal communication (body language, appearing agitated and upset). Reflecting upon my rationale, I recall being mindful that I was undertaking a number of interviews and I was concerned that I would not remember the intensity of feeling that some women portrayed. I also felt that recording body language and nonverbal communication would help me visualise the participant when trying to recall their testimony.

Smith et al. (2009) emphasise the importance of reading and rereading transcripts to ensure familiarity. There is no specific guidance on frequency; therefore, I read each interview a number of times. This rationale was due to awareness that when first listening to tapes I was thinking as a health visitor (HV). Although HVs are encouraged to 'listen' to clients and facilitate solving one's own problems, solution-focused activities were dominating the researcher's thoughts rather than trying to interpret what the participant was saying. For example, a participant mentioned how she would like to join groups. My initial notes reflect my thoughts about where those groups were and on what days, writing 'wants to go to groups' 'local'.

On the second and third occasion there was a shift in my thought process. To understand why, I reflected upon my own experiences before and during the study and highlighted and compared a number of factors, which included the following. As the study progressed I became more familiar with IPA as a methodology, immersing myself in literature and actively engaging in the data by reading it over and over. This can be seen when comparing my first attempts at making notes with subsequent ones.

Participant – 'I want to join groups, get out a bit'

The first note made was 'wants to be social', 'wants to go to groups'. 'Groups' was not to reinforce what the mother had said; rather, I had some ideas of where they may be. Revisiting for the second and third time I added 'isolated and lonely'. On the second and third occasion there was a shift away from the descriptive word (literal meaning), and an attempt to understand the mother trying to make sense of her own feelings. Consequently, making notes on the mother's body language and tone of voice, for example 'was rubbing her hands together', and 'looked sad'. The language the mother used either side of the statement 'I want to join groups, get out a bit', for example 'I moved to the area recently' helped contextualise the comments further. Deciding at which point to stop making notes was difficult, but as my second and third reading were similar (they were read opportunistically a week apart) this informed my decision to stop.

Once I had acquired this skill, examining the content and language used on an exploratory level was the most time consuming aspect, but this process ensured a growing familiarity with the transcript confirming my belief that an individual's experience is complex (Smith et al., 2009). I used Smith et al.'s (2009) suggested descriptive, linguistic and conceptual framework to engage with analytical dialogue. My own reflections encouraged self-analysis and questioning to understand the context of the transcript; the framework added a new dimension to exploring the transcript further.

The descriptive element focused upon describing what the participant had said (normal font). In general, these were key words, phrases the respondent used, things that mattered to the participant, key objects, events and experiences. This level of initial note taking was about taking things at face value.

The linguistic comments focused upon exploring the specific use of language (italic) and how the transcript reflected the ways in which the content and meaning were presented: pronouns, pauses, laughter and repetition.

The conceptual comments focused on delving further to a more abstract level (underlined). These move away from the explicit claims of the participant, moving the researcher's focus towards the participant's overarching understanding of the matters they are discussing. This leads the researcher to reflect and refine ideas which will draw on professional knowledge (Smith et al., 2009)

As an example, an excerpt from one interview in response to questions 1 and 3 has been used and applied to the framework (see Table 4 below)

Table 5 – Descriptive, linguistic and conceptual framework

Interview Transcript	Notes
<p>Question 1</p> <p><u>I wanted to be active</u> and I wanted a water birth but because I was induced and I had to be linked up, <i>I couldn't</i> have the water birth which ...see it was a disappointment (<i>pauses looks tearful</i>), <i>I just accepted me</i>, I think I've got quite a pragmatic view of things that I was in the hands of them. If they told me I couldn't do something or I needed something <i>I was just following their lead</i> because <u>they've got the knowledge, they've got the experience, they've done it thousands of times, I'm in your hands</u>. If you tell me to do something, yeah I'll go and do it. <u>I wished I'd been a little bit more active</u></p>	<p>Wanting to be active – Wanting to be involved or included feeling excluded from the experience – detached from physical self</p> <p>Feeling disappointed – Looks tearful Will this have a long-term effect on mental health – PND?</p> <p>Reliance upon others – influence of others on one's own behaviours – control of others or one's own lack of control – disempowered</p> <p>Use of <i>I</i> in the context of <i>couldn't</i>, <i>was just</i>, used when struggling to explain or understand – coping mechanism through minimisation of the event</p> <p>Unable to challenge – significance and reliance upon professionals' knowledge, the expert – Authority – power</p> <p>Vulnerability – <i>I'm in your hands</i></p>
<p>Question 3</p> <p>She breastfed initially... I wanted to breastfeed... initially and... she... took it first and then she had the second feed in recovery and then it just started to get more and more difficult with her and erm <i>it was just ended up being a battle</i>, I was getting upset and stressed because in my</p>	<p>Found it difficult to breastfeed – battle-frustrated</p> <p>Should something natural or straightforward be easy?</p>

<p>head thinking <i>it's the most natural thing in the world</i> that they should latch on even though I know... surely <i>it should be straightforward, baby's got this instinct in her to feed, should know what to do</i>. She was sort of part latching on then <u>getting bored she was upset</u> and it was stressful for her 'cos she was hungry, <u>she wasn't getting what she wanted because she didn't know what to do</u> one nurse and she wasn't a midwife, she was an auxiliary nurse (<i>raises eyebrows</i>) and <i>she made me feel bad</i> and like I was being told off</p>	<p>Bored? (implies choice) – baby making conscious decisions</p> <p>Baby didn't know what to do – expectation of child's ability – instinct is to feed She didn't know what to do – rejection of mother</p> <p>Hierarchy given to professional role – positions of power authority</p> <p>Being observed uncomfortable – being told off</p>
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Developing emergent themes

Once this milestone had been reached (note taking), the transcript took on a totally new meaning. I was able to identify various concepts. The detailed exploratory commenting of stage two meant that the amount of information and analysis grew substantially. In the next stage I was required to consider theme development. Two researchers trying to make sense of the same participant making sense of their world may derive variations in results. Whilst Smith et al. (2009) set out a framework for developing themes it is not prescriptive in terms of how interpretation is achieved.

One of the challenges I faced as the analysis deepened was how I would demonstrate the pathway to an abstract level of interpretation to allow the reader to form their own opinion about the work undertaken. I was entwined in the data, frequently revisiting parts of a transcript, looking at it as a whole, then cross-referencing with a group of transcripts. This happened on different days at different times. Although the complexity of this process offered some reassurance that I was progressing to a more interpretative level of thinking, it presented a challenge in demonstrating how that level was achieved. The hermeneutic circle (understanding a whole by reference to the individual parts and how they then fit with the whole) goes some way in explaining; however, reflexivity also enabled

me to identify two areas that may offer the reader further insight into the process that evolved.

First, by making reference to one interview transcript cited throughout this chapter (Tables 5 to 7) the reader can move back and forth across chunks of the transcript, just as the researcher has. Secondly, through Tables 5 to 7 I have highlighted in bold two early themes and shown how they have made their journey onto the master theme table.

The following process was used to develop themes

1. Individual transcripts were analysed independently (broken down into sections). Tables 5 and 6 give an example of these sections showing how the themes have been identified through cross-referencing notes, looking for patterns and connections
2. The sections were then put back together and the individual transcript viewed as whole. Table 6 shows how master themes emerged from one interview
3. Stage 1 and 2 were repeated with all the transcripts from all the interviews. This was the most time consuming element of the study
4. Cross-referencing across all transcripts to develop master themes (Figure 1)

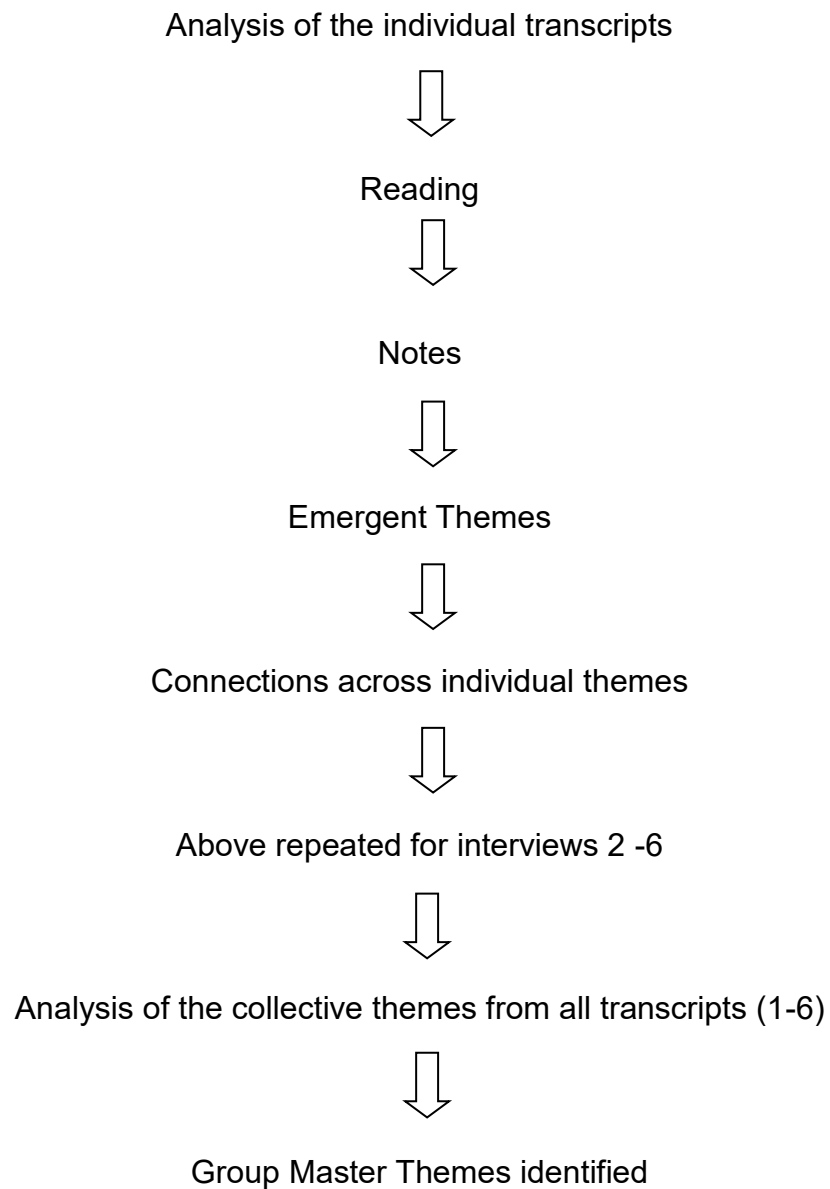


Figure 1 – Guide to analysis

Developing themes – individual transcript

In developing themes, Smith et al. (2009) said mapping the interrelationships, connections and patterns between exploratory notes to emergent themes requires breaking up the narrative flow of the interview into discrete chunks, but recalling what was learned through the whole process of initial note taking. This embraces the hermeneutic circle capturing what is crucial in the parts (notes) but contextualised as the whole. This not only focuses upon the original words, but the analyst's interpretation.

There are no rules for how many themes are appropriate, but a smaller number of themes tend to represent a more synthesised analysis (Biggerstaff and Thompson, 2008). Smith et al. (2009) suggest that when developing emergent themes there is an inclination for students to present too large a number of descriptive themes. Although I was aware of this, I was concerned that being preoccupied with the number of themes that could emerge would interfere with the process. Therefore, by constantly asking 'is this theme too descriptive?' *after* the theme had emerged, led to a natural selection of smaller more meaningful data that could be used (Tables 5 and 6). The risk in doing this was a temptation to start grouping together the themes emerging and dismissing some for reasons that they 'didn't fit' rather than they were not appropriate. This was avoided through only looking at the chunk of the transcript that needed analysing, then as Smith et al. (2009) suggested bringing it all back to together as a whole at the end. The number of themes was reduced further, once patterns and connections were cross-referenced across the whole transcript.

INTERVIEW	NOTES	THEMES
<p>I wanted to be active and I wanted a water birth but because I was induced and I had to be linked up, I couldn't have the water birth which ...see it was a disappointment, I just accepted me, I think I've got quite a pragmatic view of things that I was in the hands of them. If they told me I couldn't do something or I needed something I was just following their lead because they've got the knowledge, they've got the experience, they've done it thousands of times, I'm in your hands. If you tell me to do something, yeah I'll go and do it. I wished I'd been a little bit more active</p>	<p>Wanting to be active – Wanting to be involved or included feeling excluded from the experience – detached from physical self</p> <p>Feeling disappointed – Looks tearful. Will this have a long-term effect on mental health – PND?</p> <p>Reliance upon others – influence of others on one's own behaviours – control of others or one's own lack of control – disempowered use of <i>I</i> in the context of <i>couldn't</i>, <i>was just</i>, used when struggling to explain or understand – coping mechanism through minimisation of the event</p> <p>Unable to challenge – significance and reliance upon professionals' knowledge the expert – Authority – power</p> <p>Vulnerability- <i>I'm in your hands</i></p>	<p>An 'observer' to own birth experience</p> <p>Feeling excluded emotionally and physically from the experience of birth</p> <p>Authority – Power of others</p> <p>Disempowerment of self</p> <p>Trust in others linked to hierarchal professional position</p> <p>Confused by own response (physical and emotional) to giving birth</p>

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Table 6 – Individual transcript analysis

INTERVIEW	NOTES	THEMES
<p>She breastfed initially... I wanted to breastfeed... initially and... she... took it first and then she had the second feed in recovery and then it just started to get more and more difficult with her and erm it was just ended up being a battle, I was getting upset and stressed because in my head thinking it's the most natural thing in the world that they should latch on, even though I know... surely it should be straightforward, baby's got this instinct in her to feed, should know what to do. She was sort of part latching on then getting bored. She was upset and it was stressful for her 'cos she was hungry she wasn't getting what she wanted because she didn't know what to do, one nurse and she wasn't a midwife, she was an auxiliary nurse and she made me feel bad and like I was being told off</p>	<p>Found it difficult to breastfeed – battle-frustrated</p> <p>Should something natural or straightforward be easy?</p> <p>Bored? (implies choice) – baby making conscious decisions</p> <p>Baby didn't know what to do – expectation of child's ability – instinct is to feed. She didn't know what to do – rejection of mother</p> <p>Hierarchy given to professional role – positions of power authority</p> <p>Being observed uncomfortable – being told off</p>	<p>Power of baby over mother</p> <p>Loss of control</p> <p>decision making projected onto baby – fear of rejection</p> <p>decision making projected onto professionals</p> <p>Feelings of 'self' contextualised within authoritarian position of others</p>

Searching for connections across emergent themes

Smith et al. (2009) suggest that the next stage of the analysis involves development charting and mapping of how the researcher sees the themes fitting together. Reflecting on these themes, I continued to cross-reference commonalities, and then reorder them in a more systematic way. Although the themes had emerged from the transcript during this phase, I frequently reflected upon the participant/researcher interaction during the original interview and considered my interpretation. For example, once the theme of authority of others had emerged, I questioned how the mother had viewed my authority during the meeting; this is explored further in the findings chapter. Langdridge (2007) reports that reaching this point in the analysis should allow for a table of themes to emerge, which link directly to the originating text through reference to specific key words. Once the themes have been identified a level of abstraction occurs, identifying patterns between emergent themes called master themes (Table 6, below).

Table 7 – Connections across emergent themes – individual transcript

Individual Theme	Master Sub Themes	Keywords/phrases
The birthing experience	<p>Observer of one's own birth through another making decisions</p> <p>Desire to have control – empowerment</p> <p>Losing control – Disempowerment/vulnerability</p> <p>Feeling excluded emotionally and physically from the experience of birth</p>	<p>Accepted it in my head</p> <p>Unfazed/excited</p> <p>Disappointed</p> <p>In their hands</p> <p>Baby knows what to do</p>
Adjusting to feelings in motherhood	<p>Questioning of self in previous 'role' to contextualise motherhood</p> <p>Drawing upon previous knowledge of self to contextualise current feelings</p> <p>Looking to others to 'contextualise self'</p>	<p>My previous job was demanding</p> <p>High pressure</p> <p>I am pragmatic</p>
Mother's expectations of others following birth	<p>The child as a decision maker</p> <p>Decision making projected onto baby</p> <p>Shift of power to professional</p> <p>Trust in others linked to hierarchal professional position</p> <p>Advice from friends and family</p>	<p>She should know what to do</p> <p>I was naughty</p> <p>She said it was ok</p> <p>They've got the knowledge</p>

Moving to the next testimonial

This study reflected experiences of six people; therefore, steps one to six were repeated. Smith et al. (2009) offered two approaches to analysing the remaining testimonies. The first requires themes to be carried forward from the first participant, to be built on with subsequent participants' accounts. This is in addition to looking for new themes. As a novice researcher, I was concerned that I would not always 'be alert' to new themes, potentially having a 'default' position to making assumptions about individual worlds based on professional experience. Therefore, I favoured the second approach suggested by Smith et al. (2013) by starting the whole process afresh with the second or subsequent interviews and producing a list of themes for each interview. Treating all cases on their own terms in order to do justice to their own sense of individuality is paramount in IPA.

Perhaps naively, there was an assumption that making a decision to adopt the second approach would somehow prevent the themes identified in the first transcript influencing analysis of the second. Upon reflection, I concluded that it is quite challenging not to apply previous knowledge to new data; however, I followed steps to try and minimise this:

1. Reflexivity – Having insight into what is occurring allowed the researcher to make conscious effort to stop, reflect, question and 'reposition', to allow interpretation to occur.
2. Leaving gaps between each analysis (days) and not going back to the previous transcript. (Smith et al., 2013)

Looking for patterns across testimonials

The next stage of analysis involved looking for patterns and connections between the lists of themes, including those that appeared to be the most powerful. This process was relatively straightforward, but Smith et al. (2009) emphasise that the researcher should also identify themes that could illuminate different cases. This did occur, but not during the first analysis. Upon reflection, I have concluded that in the first round I was looking for homogeneous attributes, and having 'got to grips' with all the interview transcripts I had already, to some extent, formulated connections and themes prior to revisiting the transcripts as a group. For

example, I knew that 'birth and the influence of others' was important, but had not yet explored it in any depth. At this stage I found the connections were attributed to the frequency that they had appeared when systematically working through the transcripts. Smith et al. (2009) refer to this as numeration, frequency with which emergent themes appear. However, they suggest that the frequency of a theme does not necessarily mean it is more important than other themes. Themes must be considered within the context of other parts of an individual's account, adding to its richness. This did occur when I analysed the transcripts as a group in more detail.

Following the hermeneutic circle, when I revisited the group data polarised views around the same topic or those themes that stood alone emerged. For example, I identified contradictory views amongst mothers of their baby. Some mothers viewed their baby as a decision maker and others as a helpless newborn. It was only through interpretation that they were defined within the context of 'the relationship between mother and child' placing them within the same theme. Interpreting this information required going back to the original transcripts to consider the text surrounding the comment. The themes were typed out then I cut them out individually. Using floor space I initially clustered together those that looked similar then revisited the themes over a number of days and at different times. Handwritten notes were used to bring the information together. The figure below provides an example of the handwritten notes. I was inclined to 'tidy them up' for the reader, but I felt there would be a temptation to make changes, therefore they are as written on the day. I highlight that the heading at the top does say 'Clusters – First thoughts/observations'. From this analysis I strove to generate a table of master themes that would explore the phenomenon.

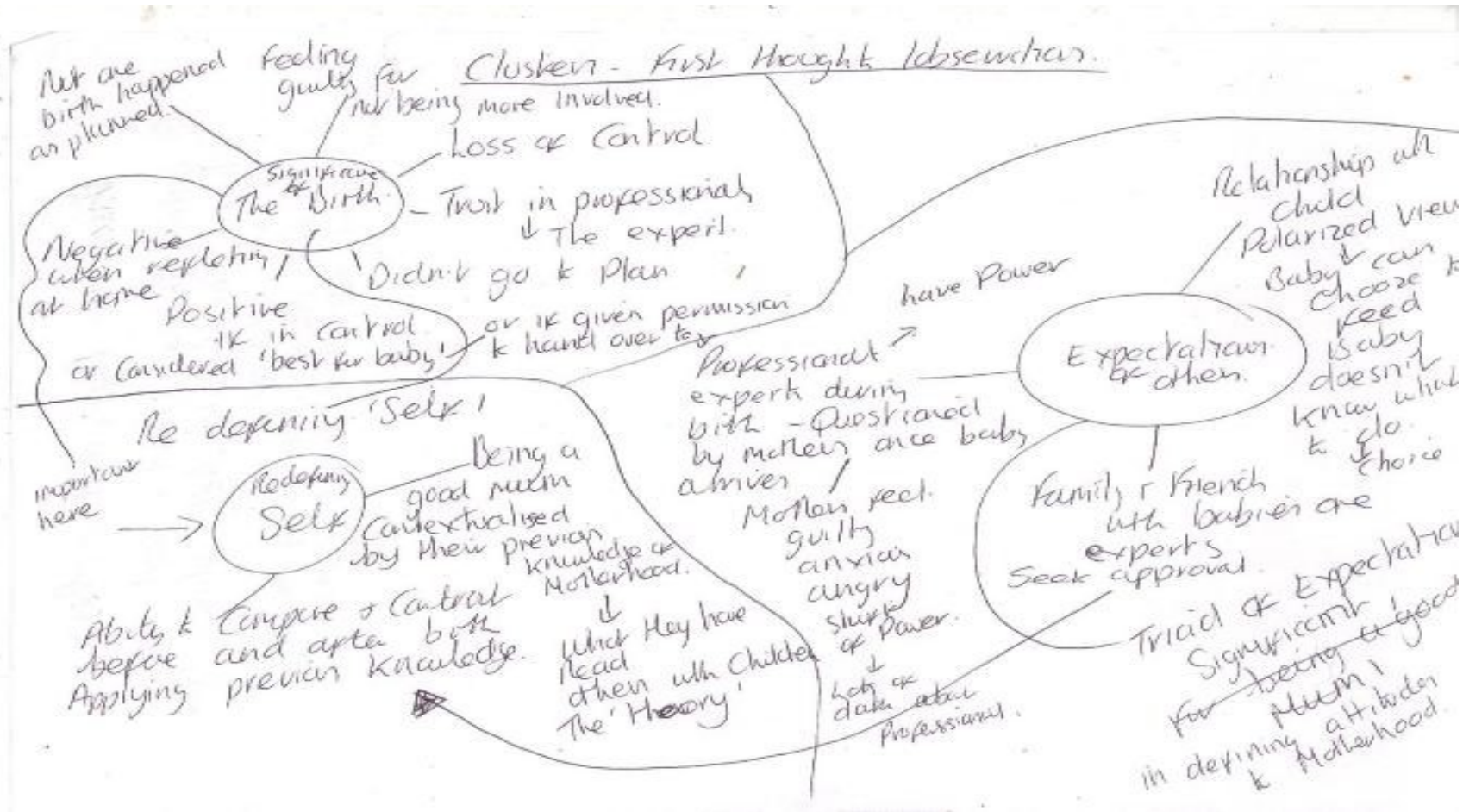


Figure 2 – Cluster thoughts – patterns across testimonials

Generating the master themes

Reflecting upon Figure 2 (above), the theme of *decision making projected onto baby* is still present (Table 6); however, through further analysis and identifying polarised views, I had interpreted this as being significant in the mother's 'relationship with child'. *Trust in others linked to hierarchical professional position* (Table 6), moves to 'power of the professional' in Figure 2 as it is present in 'significance of birth', 'redefining self' and 'expectation of others'.

Three master themes emerged (present in all of the interviews) that appeared to capture the attitudes of mothers,

- Power of the professional
- Relationship with the child
- Transition in redefining self

Once the master themes had been identified, I broke them down to create sub themes, themes that appeared to group together under those headings, again looking for similarities and differences. This required me to go back to the original testimonials at times to help contextualise comments. I was surprised by the master themes that emerged. I had perhaps at the start of the research expected to identify themes more reflective of the effects of sleep deprivation as this appeared to be something women struggled with.

Although themes are listed succinctly, this did not reflect how they appeared in the transcripts. The nature of IPA analysis embeds the researcher in the process, therefore themes also emerged through 'getting to grips with the data', frequently moving across testimonials, analysing sections, reviewing the whole interview, leaving for an extended period of time then revisiting the transcripts. When writing up the findings section, there was a requirement to revisit all the testimonies to clarify context and understanding. During this review another theme emerged, idealism vs reality. This supports a common view in IPA that analysis continues even when writing up (Schleiermacher, 1998). This is discussed further in the findings section along with the three master themes identified above.

Consideration of the themes in relation to the findings is also captured in the discussion chapter, enabling participants' experiences to be brought together with an examination of the master and associated themes that cross over the

interviews. Pseudonyms have been used throughout the findings section to protect the identity of those participating.

CHAPTER 6 – FINDINGS

Introduction

The previous two chapters gave a detailed explanation of the systematic enquiry to draw out the experiences for first-time mothers and sleep deprivation. This chapter explores the key findings that emerged from the study in order to provide further understanding of the phenomenon and will inform the discussion chapter.

Unlike most other qualitative results Smith et al. (2009) suggest that this section is the most important part of an IPA study. It needs to be substantive as the interpretation of a participant's experience depends solely on the understanding of the testimonies they provided. This can be achieved by ensuring the findings constitute transcript extracts, with the remainder consisting of detailed analytic interpretations of the text.

Findings are therefore presented direct from participants' transcripts to justify, highlight and explain the findings. Women's voices are captured without reference to the literature to allow their experience to be considered in its purest form. This is in line with Smith et al.'s (2009) belief that presenting with reference to extensive literature could minimise the reported experience. Where appropriate and through my own interpretation, punctuation has been carefully added and all pauses and repeated words, unless crucial to understanding the excerpt, have been removed. Ellipses have been used to denote pauses.

The table below provides a summary of the themes and findings to allow the reader to see how themes have emerged. Each theme is then presented through the participant's 'voice', taken directly from transcripts, followed by my interpretation.

Table 8 – Final list of master themes

Master Themes	Sub Themes	Findings
Power of the professional	<p>As a navigator of emotion</p> <p>As an expert pre and post birth</p>	<p>Professionals lack skills in identifying and supporting mothers with sleep deprivation</p> <p>Mothers move through stages in disclosing sleep issues</p> <p>Mothers' attitudes to sleep deprivation are influenced by professionals' attitudes, believing they can make sense of, and influence their emotions</p> <p>Professionals 'knowing best' changes from acceptance in pregnancy to challenging postnatally due to inconsistent messages and drawing upon their own beliefs and values</p> <p>'Knowing' or having a relationship with one professional generated a positive attitude towards sleep deprivation</p>
Relationship with the child	<p>Routines and planning</p> <p>As a participant or decision maker</p>	<p>Managing sleep deprivation is viewed as something predictable antenatally. Strategies to manage are developed around this belief. The subsequent unpredictability of feelings and emotions during the experience caught women off guard and had a negative effect upon their attitude.</p> <p>Positive or negative attitudes towards sleep and the ability to cope were influenced by child seen as helpless, instinctive or a decision maker.</p>
Transition in redefining self	<p>Physical and Emotional</p> <p>Previous role</p>	<p>Women believed the physical transition to motherhood was associated with the ability to cope with sleep deprivation</p> <p>The opinions of others influenced women's view of sleep deprivation as self-limiting or a long-term problem</p> <p>Women's attitudes to sleep deprivation were strongly influenced by their own views of other mothers prior to their own pregnancy and their previous roles</p>

Idealism vs reality	What helps	<p>Women believed that support, education and reassurance could alleviate the negative feelings they experience</p> <p>Women readily accept the effects of sleep deprivation cannot be changed. However, women believe that professionals can prepare them for, and distinguish between fantasy and reality</p>
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Power of the professional

This section highlights the perceived influence professionals have over mothers. This is particularly relevant in the immediate move from labour to post birth. A mother's sense of identity is defined through the relationship with the professional having the ability to generate positive or negative strategies to manage sleep deprivation.

As a navigator of emotion

All women in the study reported that the relationship with their midwife or health visitor (HV) was an influencing factor in whether they discussed their feelings about sleep deprivation. The lack of relationship, or 'knowing' their health professional, generated negative emotion and a reluctance to engage in any verbal discourse regarding the topic. At a superficial level, women reported a level of inconvenience in having to repeat their story. Sarah captures the group's feeling 'you spend the first 20 minutes of every visit going over the same ground'. This inconvenience moved along a continuum of negative emotional impact. Georgia's testimony describes her ability to avoid discussion of sleep deprivation by saying what she thinks the midwives want to hear.

So I think I was given the facts [lack of sleep and healing] but not necessarily... But I don't think they prepare you for the emotional part of it in antenatal classes... I had different midwives visiting me so I didn't want to say anything. I knew what to say, you know to make them think I was ok ... I mean I wasn't ... ok. (Georgia)

Georgia's testimony highlights her expectations of the midwives in preparing her for the emotional impact of sleep deprivation during antenatal sessions. She sounds somewhat surprised and disappointed by their perceived failing. Although Georgia can pinpoint a single cause for the negative emotion, she projects this

feeling onto the whole midwifery workforce, rather than an individual. Such behaviour may indicate a lack of confidence in the midwifery services ability to alleviate or contextualise her feelings. However, Georgia does allude to 'knowing her midwife' as being a possible driver in changing her current view. Her behaviour contradicts her goal in achieving a relationship, as a midwife may be aware and sense Georgia's disengagement and negativity during subsequent visits, but not fully understand why. This can be seen as Georgia's interview continues.

I was just a number... just to say that I think the process is wrong... I think that, you know ... tick box... For that woman... she should have known what was going on with me [sleep problems] ... and maybe she'd have been a bit more empathetic and understanding ... (Georgia)

It appears that the midwives, unable to make sense of Georgia's feelings have reverted to covering standard topics (a tick box) during visits, unaware of how to build a relationship with her. Georgia has no insight into her own contribution to this experience and the midwife has not attempted to develop a discussion further.

Samantha's testimony offers further insight into this phenomenon. She tries to make sense (two months following the birth) of why she feels her HV thinks she is not a 'good' mother. Samantha is puzzled that her anger is directed towards the HV, when her feelings are primarily related to the trauma of the birthing experience.

I don't know whether it was because of what had happened around the birth itself and the things that happened afterwards... or whether it was just through tiredness because of no sleep... but I felt angry toward her for quite a long time... she hadn't said anything about it [HV] so I don't know why I thought that ... I probably would have said something if she'd asked me how I was feeling... don't know why she didn't. (Samantha)

Although Samantha appears confused by her feelings, she still believes that the HV should have been able to make sense of her experience. This suggests that mothers believe either professionals are trained to detect such behaviours, or it is so common to all women that professionals have enough experience to see

what is happening. Furthermore, women believe that professionals have the power to change or alleviate such negative feelings.

For Samantha and Georgia there is a clear emphasis upon the professional initiating the discussion regarding feelings around sleep deprivation. There is an expectation that professionals can 'see through the haze' and must take the lead. Unfortunately such reliance upon the professional can be detrimental as previous testimonies highlight professionals are not always in a position to receive or interpret the signals that mothers are trying to convey. This is captured in Kerri's testimony below.

It wasn't meaningful you know... They asked if I felt low... I did but I wasn't depressed just tired because I wasn't sleeping..... No one's really asked about the sleep or anything like that... it's just how you're feeling and there's a list that they go through of are you feeling x, y, z are you doing this and they tick off and ask how you're feeling in yourself... but it's the one question you say yeah fine I'm ok... I said I'm tired its hard work... I wanted her to ask me more... but she just nodded; I felt embarrassed I'd mentioned it. (Kerri)

Kerri's experience highlights a 'task orientated' approach. Routine questioning regarding mood places emphasis upon depression and anxiety, with sleep cited as a symptom. As sleep deprivation was the cause of her low mood, Kerri did not feel she could relate to the question, or it had not been framed in a way that Kerri could respond too. Kerri's belief that the mood question was the one question you should say you are fine to implies that there are consequences to answering anything other than 'I'm Ok'. The rationale is captured in Samantha's testimony below.

I just wasn't prepared for the lack of sleep at all... I think it can be quite hard. You're not a good mum and that's the thought that stayed with me... especially telling a professional because you know... I said... I'm tired... it does cross your mind... You know... they're gonna take me baby away from me 'cos they think I'm not capable. (Samantha)

There is an association between managing sleep deprivation and being a good mother. The consequences for not managing are extreme. Despite the fear of such consequences, both Samantha and Kerri attempt to 'test the waters' with the HV. Unlike Georgia, they initiate further discussion around the topic. They make statements to the professional as a 'test of the waters'. 'I'm tired... its hard

work' (Kerri); 'I'm tired' (Samantha). In both instances the professional did not pick up on the underlying message. This response towards sleep deprivation minimises its significance for both mother and professional.

Testing the waters is captured further in Elizabeth's testimony below.

... How can you tell a stranger... a [HV] that you are struggling with the basics... Everyone knows that you don't get sleep... And everyone else manages it don't they? ... you know you must be on top of the world and so proud and all the rest of it when in reality you really don't feel like that... My HV was nice but I didn't really know her ... So what am I going to... you know... say to her? (Elizabeth)

Although it appears that she cites the issue within herself, during the interview Elizabeth presents a number of rhetorical questions, remaining wary of my 'perceived' judgement or interpretation of what she is disclosing. Elizabeth clearly feels that she must be in a position to 'present her case' to professionals, to me, and ready to justify her position. It is important for Elizabeth to try and understand the social context of the professional's world (beliefs, values) to work out how to pitch it.

Prior to the interview Elizabeth was keen to know my own professional background and during the interview she paused for quite some time following her answers to observe my own response to her statement above. Only when satisfied that my response was non-judgmental, would she move on. Elizabeth believes that she has the ability to influence the professional's view of her. She uses a combination of questioning and observation skills to gauge how the discussion should progress. Sarah's testimony supports this to some extent. However, she feels that her sphere of influence can only be achieved if one is also able to offer mitigation around certain topics.

You've got somebody coming into your own house that you don't know and don't know whether they're going to be supportive or just rude to you... You're not going to say... I had a really traumatic birth and I really don't feel like I'm coping amazingly well... saying to somebody that you... don't know whether they're gonna judge you or whether they're going to brush things off and just go ah well you know... and trivialise what problems you have had. At least I could say the birth was traumatic, but sleep, well it's just one of those things... it's embarrassing. (Sarah)

Mitigation regarding one's own experiences and subsequent feelings is presented as black and white. According to Sarah, sleep deprivation cannot offer any mitigation for her inability to cope. Sarah's reference to 'embarrassing' suggests that her sleep deprivation is something to be ashamed of. This implies that either Sarah is not aware of the effects of deprivation, or expects a form of immunity being a mother, or is comparing herself to her peers who appear to be managing, reluctant to admit her own perceived failings. Sarah's strong emotive response also highlights the 'power' that professionals have. Going into Sarah's home magnifies this power as this is her 'space'.

Sarah believes that the judgement and reaction of the professional in determining her ability to cope will either be supportive or rude. This is evident in the expected response regarding the birth and sleep deprivation. Sarah feels able to defend her position regarding the birth as it was traumatic. As in previous testimonies there is an inherent belief that a professional can relate to certain experiences and feelings regardless of their own personal or professional background. Like Georgia, professionals are viewed as 'one' which immediately contradicts the individualisation mothers crave. Talking about sleep deprivation is not acceptable as Sarah believes this would be viewed as trivial and 'brushed off'. She believes that her feelings will only be mirrored by the professional. The perceived mirroring of emotion by a professional can be detrimental to mother's attitudes to sleep deprivation. However, if professionals are able to show empathy that is not entirely 'like for like' in behaviour, speech and thought then mothers report positive experiences.

The ability to empathise in this way broke down Jane's view that professionals are 'one'. The HV set herself apart from others in her ability to remember what was important to Jane when they last met:

I probably wouldn't have felt as comfortable with different people but the type of person I am I wouldn't tell me problems to anyone... Do you know what I mean? ... she remembered you know... She remembered what I'd said [about sleep]... Obviously she must see a lot of people but she remembered you know my story and whatever... so it meant a lot. I was crying all the time... she asked me when I last slept ... I hadn't really... but because she asked I knew she was expecting it... I got help... (Jane)

Jane was given permission to share her thoughts without feeling threatened. The combination of forming a 'relationship' and the professional being empathic meant that Jane could be supported in managing sleep deprivation. Continuity of care was a key feature in Jane's ability to disclose her feelings. All women believed that knowing their professional would be positive, despite many of the testimonies highlighting inadvertent barriers created by professionals and mothers. Although Georgia's earlier testimonies highlight this challenge she was able to 'connect' with a HV once the relationship had been built up over a period of time. This allowed her feelings to be contained.

If I didn't have that support it would have carried on... the first couple of weeks, not sleeping ... I couldn't have a conversation with her [HV] like this [referring to her composure during interview]... without being in just... tears. I just could not... stop crying you know... Because it made it look as if I wasn't enjoying her and I was... My HV just listened. She said how I was feeling was normal... (Georgia)

This shift in attitude towards sleep highlights the significance of trust in the relationship. This is built over a period of time. Once this was established both mother and HV were receptive to discussing sleep deprivation. The HV was able to contain Georgia's feelings within a positive context through her ability to 'normalise' the experience. This ensured Georgia did not feel different from her peers and opened the door to acceptance from the HV, which was important to Georgia.

As an expert pre and post birth

Findings from the women's testimonials highlight the shift in appointed power and decision making given to midwives and HVs during the antenatal and postnatal period. This influenced women's attitudes to sleep deprivation. Sleep was discussed during the antenatal period; however, following the birth this was inconsistent. During the antenatal period women seldom challenged the advice, support or information given by professionals. There was an unequivocal belief in the skills of the professionals and them 'knowing best'.

Antenatal visit I was told my body would adjust to lack of sleep, I wasn't going to bring it up again. (Jane)

Women felt that the information and advice (albeit limited) regarding the effects of sleep deprivation antenatally was useful and believed that overall they would make the decision to follow the advice or not. For example, sleep when baby sleeps, rest through the day. However, upon reflection and as the pregnancy progressed, for some women the advice became very directive.

She was just going on... you must do this... you must do that ... before baby was born. (Jane)

And that was the only frustrating thing... I mean the midwives were great, they were dead supportive you know... but just like... no you can't... and do this... do that... I was like alright fair enough but you know... come on! (Elizabeth)

Women reported that this directness became stronger once in labour and their willingness to follow instruction gathered momentum the more vulnerable they felt. The rationale is offered within the context of bringing their baby safely into the world. However, both Jane and Elizabeth share an element of unease when reflecting upon the experience, and when questioned further describe how out of control they felt. Samantha's testimony captures this unease.

I was just following their lead because they've got the knowledge... they've got the experience... they've got the power... they've done it thousands of times... I'm in your hands... If you tell me to do something, yeah I'll go and do it. (Samantha)

These reflective experiences highlight a crucial time between giving birth and the postnatal period when women's attitudes to sleep change as they attempt to regain control of their thoughts and feelings. There is a significant shift towards challenging professional knowledge and advice, which may have implications for the way information is shared with them during this time. Elizabeth's testimony offers the first glimpse of this transition.

I didn't mind them telling me off [fell asleep] cos I needed to know but it did make me feel a little bit anxious about feeding him ... constantly looking at me watch and worrying about it ... (Elizabeth)

Although Elizabeth still retains a belief that professionals may know best, she now starts to question the way she is being communicated to. This generates anxiety, which Elizabeth feels is unnecessary. Consequently, Elizabeth feels that she is being monitored because of her perceived 'error' not waking when her

baby needed to be fed, and believes questions are now being asked around her suitability to be a mother. Like Elizabeth, Sarah feels frustrated with the advice she is given.

She wasn't waking up for dirt..., wet nappies and she wasn't waking up for feeds. I was like well she would surely be telling me what she needs... and I was quite happy... just to sleep but it was the overheating [being implied by staff] and the being told off at 3 am that pissed me off ... telling me she's warm [baby]... and ... she's overdue her feed. (Sarah)

Both Sarah and Elizabeth believe they are being chastised by professionals. There is a shift in their attitude towards the professional no longer 'knowing best' and although both feel frustrated, neither is confident enough to challenge the way they are being communicated to directly. This changes as women increase in confidence in their own ability to care for their child, feel they are gaining control over their thoughts and feelings, and/or they 'find their voice'.

Like Sarah and Elizabeth, Georgia felt that she was being monitored. Georgia reflects upon her experience of being exhausted through a persistent lack of sleep and then being told to try and breastfeed her baby.

I was tired [woken up by midwife] but knew in my heart of hearts cos I'm not a silly person I knew... that I thought right... I'm not... she [midwife] then started pushing me sayin' come on so we did and we sat there ... And he was absolutely red in the face screaming an cryin'... An I was crying... It was just horrendous and I just in the end ... I just said I'm really sorry I'm gonna have to leave it. I can't do this... it was just the wrong person at the wrong time ... With the wrong approach. (Georgia)

Georgia's account highlights that the longer women have not slept the more intense their feelings towards staff become. However, in her reference to not being a silly person Georgia was able to tune into her own values and beliefs and apply to the current situation achieving the outcome she wanted. The time gap between Georgia's thought and the outcome was filled with professional advice, and still 'knowing best'; however, Georgia's reference to 'having to leave it' removed the focus from the individual midwife to the situation allowing Georgia to avoid direct confrontation.

Kerri also describes how she felt towards professionals after two weeks of interrupted sleep; feelings which she believes had intensified by seeing different

midwives. This weakened her belief in the professionalism of the practitioner as messages were inconsistent. The excerpt below captures one of the latter visits when the advice and guidance offered by a professional was challenged.

I'd had enough ... There was a standoff ... she was trying to brainwash me [midwife minimising lack of sleep] – if I was a young vulnerable person then she might have got away with it – well what I was doing wasn't good enough ... it really stressed me 'cos of the way that it was worded to me... the way she was looking at me ... different midwives saying different things... I told them straight...
(Kerri)

Kerri had reached a point where the combination of tiredness through the effects of chronic sleep deprivation and lack of belief in the system culminated in a direct challenge to the professional. As her tolerance reduced through lack of sleep, like Georgia it heightened her desire to draw upon her own position in the world to challenge the advice she was receiving. Reference to a standoff and inconsistent messages implies that the professionals were influenced by their own beliefs and values, as topics for discussions on visits are quite prescriptive. Kerri's observation of a professional's body language may account for mothers feeling they are being watched.

Relationship with baby

For many women their attitude to sleep deprivation, and whether it was positive or negative was contextualised within their perceived relationship with their child. Women either viewed their child as a helpless infant, unable to contribute to the relationship, or as a decision maker.

Routines and planning

If a child was viewed as a passive participant in the relationship, a number of women felt that they had influence over managing sleep deprivation by systematically following their own routines. 'I'm into it now... I know what she likes and I know when I need to pick her up... that helps' (Sarah). This generated feelings of positivity. There was a sense of achievement influenced by their ability to meet the needs of their baby, and a perceived ability to set aside or manage the effects of sleep deprivation. This is captured in Kerri's testimony when discussing her struggles with getting enough sleep.

Oh my God... I don't know... you start feeling... then that started... I think I'm too tired... makin' my confidence drop a bit... 'Cos I'd think, I don't know how to be a mum.... I don't know how to look after him but I got the hang of it. (Kerri)

Kerri's experience highlights how mental fatigue through lack of sleep is affecting her view of her role as a mother. Kerri believes that establishing a routine has given her control over the situation. Although the exhaustion is still present, being able to 'predict' patterns offers some relief. This belief 'compensates' for any negative emotions generated through sleep deprivation. In Georgia's testimony below, she is striving for routine but has not yet achieved it.

You may get a feeling from speaking to me that I'm quite a... not a control freak... but I do like to be... Sort of aware and sort of plan things the way I'd like them to happen. I really am... unbelievably emotional like I've been hit by an emotion truck. ... That I just wasn't prepared for at all. I lost all my confidence, I felt terrified of him crying... (Georgia)

Georgia's testimony highlights the importance of her being able to plan things in her life and reflects upon a time prior to having her baby. She has assumed that planning is a transferable skill into motherhood and will limit the impact of sleep deprivation. However, she is unable to control or fully make sense of the surge in emotion attributed to a lack of sleep. The lack of confidence has an immediate impact and again, like Kerri, leads to questioning around her ability to be a good mother. Although she is fearful of crying, she cites the cause of the problem within herself as emotion and views this as an anomaly and within her gift to control.

Child as a participant or decision maker

Most women reflected upon transferable skills into motherhood, considered within the context of their relationship with their child. Although Kerri is able to report a positive experience, like Georgia she struggled with the effects far more than envisaged.

I'd say like when you think of it when you're pregnant... or... before you're pregnant you think, the baby wakes up... I'll feed him... he goes straight back to sleep and then I'll go to sleep ... thought it was every 4 hours that baby's fed but you know obviously that's not the case because you have to, he wakes up... you feed him, then you have to change his bum... wind him you know you might... 'cos its every 2 hours then you put him back down and then you know 45

minutes later he's awake again so it really is different to what I thought. (Kerri)

Kerri's belief highlights a one-sided relationship with her baby with an assumption that the baby is no more than a passive recipient of her care in response to the organic function of survival. Therefore, for Kerri this should be predictable. Kerri is surprised that her baby can be unpredictable, and that if A is applied, then B does not always follow. The belief in a transferable skill is a single function amiss of any feeling. Consequently, there is a belief that there is a level of immunity from the physical and psychological effects of sleep deprivation. This can be seen in Sarah's testimony below which highlights how this assumed predictability is also underpinned by professionals.

The antenatal classes... but it was just yeah your babies gonna wake up every couple of hours for feeding... an that's sort of about as far as it went... just sleep when you can... there was no how you're gonna feel... or what to expect... feel that you should be able to do everything but realistically you can't... (Sarah)

The antenatal period was a key time for women to absorb information. First-time mothers were particularly susceptible as they had not experienced motherhood before. As they were unable to make comparisons with previous experiences directly they were more likely to draw their knowledge from their surroundings and experiences of others. It is, therefore, reasonable to assume that when things do not go to plan and you view your child as helpless then you are more likely to believe the problem lies within. This can have a detrimental effect upon one's own attitude to managing sleep deprivation.

For those women who developed a belief that their baby was an active participant in the relationship, the attitude to sleep deprivation was different. Sarah's testimony highlights this.

I was being chastised 'cos the, 'cos of the tone she used... I felt like I was being told off and but I was sort of waiting for the cues 'cos all the antenatal were like oh your, your cues are from your baby, make sure you look out for these... I felt like got it wrong. (Sarah)

Sarah's testimony above highlights that for some women they believed that their baby had a set of inbuilt reflexes that could indicate their needs. This view sits somewhere between being a helpless infant and one that can actively make

decisions. Sarah's belief in the advice she had been given regarding cues led to negative feelings towards the professional. Upon reflection she feels her guilt was unnecessary as she had not got it wrong. She felt misled. It is unclear in what context these cues had been discussed or perceived as fact; however, regardless, Sarah believed that her baby would let her know what she needed. Sarah reports that she 'slept when she could' as she was waiting for her baby to guide her. This alleviated some of the pressure she felt to get it right and sleep deprivation was not viewed negatively, but expected and manageable. This created an element of routine although, unlike Georgia and Kerri, it was initiated by the baby.

Most women viewed their relationship with their baby as fluctuating between routine and instinct. For a couple of women there was a belief that the baby's behaviour had a positive or negative influence on their chronic lack of sleep. Samantha's testimony below describes a night-time waking episode when she was trying to minimise her sleep disturbance through developing a routine. However, she believes her baby was not making the right choices, and consequently this was having a negative effect upon Samantha's chronic sleep deprivation.

I was frustrated and upset... because she was upset... and it was stressful for her... because she knew what to do... and she pushes me you know... and again it just made things even worse... to the point where she would scream for about 3 hours before even attempting to latch... because she just was all for the idea of a bottle instead. (Samantha)

Samantha is trying to breastfeed her baby as she believes it is what is best for her. She also believes that this will support better sleep for both of them as she does not have to prepare bottles. However, Samantha thinks that her baby is choosing not to conform and as a consequence the baby is upsetting herself. This indicates that the baby is solely responsible for her own feelings (stressed, upset) and can control them. Consequently, the baby is choosing to keep her mother awake at night. This has a negative impact on a mother's attitude to sleep deprivation.

Jane's testimony strengthens this concept when she describes how sleep deprivation is impacting upon her.

I think I've just expected motherhood to be difficult and demanding and basically I've got to give up my life now for him... it's what I wanted so... I think because I'm expecting to be driven by him and meeting his needs and sod mine... (Jane)

Jane is feeling lost and resentful. She is describing her perceived punishment for wanting her baby. Although she reports that her son is driving the agenda, unlike Samantha she does not say at this stage if she believes this is intentional or by default. Prioritising her baby's needs over hers (by self or others) is generating negative feelings. As the interview progresses it becomes apparent that Jane believes her baby can make choices.

I think the first 4 weeks or so I was thinking this is really great this isn't too hard... and then it's been up and down ever since [being sleep deprived] ... he wakes himself in the night ... and then he gets upset ... and I tried to help and he wasn't having any of it... fine for everyone but me... (Jane)

Jane's lack of desire to offer further context or mitigation for her baby's behaviour suggests that she believes he is choosing to keep her awake. This affects Jane's attitude to sleep deprivation as the problem is cited in the baby who she believes can alleviate or reiterate her feelings. This in turn leads to a belief that her baby does not like her, which according to Jane is confirmed through the positive interactions she observes when he is with strangers. For Jane and Samantha there is such reliance upon the baby being able to control sleep deprivation that they almost become the helpless participant in the relationship. In doing so they are unable to experience anything but negativity towards the phenomenon, which is likely to be sustained if there is no external influence to counterbalance or contextualise further.

Transition in redefining self

Physical and physiological

Following birth women underwent a period of transformation, which influenced their attitudes to sleep deprivation. This moved along a continuum of physical to mental health and well-being, influenced by their previous role and others around them. There was an assumption by women that the physical transformation to motherhood would compensate for the effects of sleep deprivation. The reality or lack of adjustment took many women by surprise.

I just had it in my head that's what happens.... your body does the work... because you know it changes doesn't it ... looks different... I wasn't that big but ... I couldn't do it... waiting for my body to kick in.... not going to admit I can't cope with being up all night too... worst time, feeling sad... thought I'm not meant to be a mum. (Kerri)

Kerri's belief that a coping mechanism kicks in turns to anxiety when it does not happen. She interprets this as a flaw within herself and an indication that she does not have the necessary biological requirements or sufficient physical transformation to be a mother. She associates her physical appearance with her ability to cope with sleep deprivation. Her lack of understanding regarding the phenomenon ensures that she continues to view herself as unfit. This generates feelings of insecurity and guilt, which she does not feel able to share with others.

The 'kick in' that Kerri refers to is the hormonal changes women experience during pregnancy and birth. Elizabeth shares her thoughts regarding hormone changes believing they should create equilibrium to manage lack of sleep.

I was more apprehensive than I expected to be... just waiting for something to happen ... you had to deal with it, you just try to get on with it ... the physical change ... so that kind of was in the back of my mind ... it was kind of like oh right... ok just wasn't prepared you know the tiredness... crazy thoughts... thought hormones and my body clock would tie in ... It's not life or death but it feels it. (Kerri)

Elizabeth describes the intensity of feeling she experiences by drawing upon a life and death analogy. Her reality generated through lack of sleep and fluctuation in hormones, creates a fight or flight response influencing her decision to try to get on with it. Taking time to reflect enables her to make sense of the experience and give it further context. Kerri and Elizabeth use the term physical to refer to a physiological transformation. This denotes changes to the body's capacity to increase certain functions in response to physical changes. Neither of them distinguishes between the two. The physical element highlights physical changes that take place in the body (larger stomach) the physiological symptom might account for changes in behaviour (hormones). Understanding this may have alleviated Kerri's anxiety around her physical appearance being indicative of her ability to cope.

Both women describe the effects that hormones have on their thought processes and mood. Jane contextualises this further by associating the impact of sleep deprivation on her mood and feelings

I have had days where I'm a narky bitch and moody and maybe snapping at people... It's usually in response to something silly little things that normally wouldn't bother you... I just found that me tolerance levels are lower... you get wound up quicker probs hormones and that yeah... you just feel more human if you've had a decent night's sleep don't you... (Jane)

Jane has insight into how her feelings have changed in comparison to pre-pregnancy. She makes a direct association between getting enough sleep and fluctuating hormone levels. Jane views such behaviour as temporary and self-limiting.

Previous role and identity

The emotional impact is evident in Sarah's testimony; however, unlike Jane she views the feelings as long term. She is struggling with her sense of identity. This feeling is reinforced by the people around her.

I thought, the sleep thing... would be... hard, but completely manageable... Just from friends, people that had children kept sayin' your life will never be the same but they... no one focused No one really mentioned that the sleep ... can ... cause can really exacerbate that... that emotional side, that it's all like you know everything's based around and everyone says... oh your beautiful baby and how happy you must be and yeah you know you must be on top of the world and so proud and all the rest of it when in reality you really don't feel like that ... don't even know who I am ... (Sarah)

Sarah's reference to her identity reflects most women's accounts and reference to their previous roles. The testimonies reveal a shift in which their role went from being a woman to becoming a mother; however, the two roles remain intrinsically linked. This creates an internal conflict and unpredictable feelings regarding how this change should look, influencing their attitudes to sleep deprivation. This is captured in Elizabeth's testimony below.

You know before he came along the funny thing is I worked nights temporary so you would think I would be fine not sleeping... but I'm knackered... Not sleeping... well not sleeping is to be expected surely. He is part of me and I love him but I used to be this

independent person but I am not sure... [long pause] ... not sure really where I belong now. (Elizabeth)

Elizabeth draws upon her previous professional role to compare to her current status. Her reference to working nights provides insight into her view of sleep deprivation. She highlights a period of time through shift patterns when she experienced full sleep deprivation. She compares this experience to chronic sleep deprivation through infant waking episodes. As her conclusion aligns one to the other and there is nothing distinguishable between the two, she implies that the effects should be the same. Therefore, the strategy to manage would be the same. Her inability to cope would suggest they are not the same. This would suggest that Elizabeth's understanding of sleep deprivation is limited to tiredness. There is no further context required to understand the issue. This belief is also captured in Sarah's testimony.

Not prepared for the level of tiredness I've felt... it's just different because we've, so you're so used to having your long sleep and lying in on a weekend... I can lie in and I don't have to worry about anything else... I think some people may have their expectations but I'm realistic enough in my head to lower my levels... (Sarah)

Unlike Elizabeth, Sarah is able to adjust her attitude accordingly. She references that it's 'just different' suggesting her attitude is the same pre and post birth, including all associated feelings. This is contradicted as the interview progresses as she highlights the compromise she has made by lowering her expectations. Her reflection of pre-pregnancy and sleep is positive and care free. Having a baby brings responsibilities and worry and accounts for the view that her levels (standards) must be lowered. Sarah appears to have a pragmatic view that sacrificing her own needs for her child's is worth it; the ability to place another's needs above her own.

Although Sarah feels she lowered her expectations around sleep deprivation there was a clear transition from being a woman to becoming a mother, both requiring distinct yet equivocal roles in her time and commitment. For some women, when they reflected upon their previous role and thoughts of becoming a mother it generated a belief that being a mother was not a real job. This was significant in their attitude to sleep as they felt it could be managed because they

had been given the time off to manage it. This is captured in Kerri's testimony below.

Thinking I've got time off yeah and I'm not in my proper job so... no detriment to this ... its hard work ... but you have time off... I was thinking, I should be able to make tea, tea shouldn't be that hard, sometimes you don't realise how bad it is when you're in it ... just thinking I should be able to cope because I'm off work... I should be able to lie down and sleep when he's sleeping... I've only been able ... done that a couple of times, everyone sort of just thinks well... it's your job isn't it ... you know. (Kerri)

Kerri feels guilty that, despite having time to be a mother she is finding it difficult to complete tasks. Her association of being given time to sleep is a challenge as her image of being able to control when, where and how, is compromised through her own body clock and that of her child. Kerri introduces an added pressure through her perception of how others think of her new role, implying that it is considered easy. Kerri is not specific in terms of who 'everyone' is therefore she may be describing her own view of mothers when she was in her previous role, subsequently setting parameters in terms of what she finds acceptable and what she does not. Kerri's previous professional role involved managing staff. As she reflects upon her manager's role she appears remorseful regarding her thoughts and actions in trying to support

Yeah it's harder when you're in it... I probably would have ... would've been more sympathetic... done things differently... should've... I could have helped more... you know ... my manager... colleagues ... I took the same view as them... not good... I didn't say anything ... it was fair you know followed the policy ... but you know in my head couldn't understand what the fuss was about [new mothers being tired] ... (Kerri)

Kerri believes that only by being a mother yourself can you empathise enough to be supportive. Kerri believes that others around her (without children) now look at her in the same way she did with new mothers. Making reference to following policy, it was important that she was seen to be doing the right thing. However, this conflicted with her internal belief that mothers should not be sleep deprived because they are not in work. Her belief is strengthened from her peer group who shared her internal beliefs. She is an observer to their discussions; however, she does not feel able to be fully immersed in the group. Perhaps due to the hierarchal

structure or, as she was the one managing staff, not being seen as following policy would have personal and professional consequences for her.

Idealism vs reality

When writing up the findings there was a requirement to revisit all the testimonies to clarify context and understanding. During this review, another theme emerged. Although now obvious it had not been on any previous occasion, despite revisiting and analysing the testimonies hundreds of times. Upon reflection, I have concluded the following. Although the other themes highlight an element of what helps mothers in managing sleep deprivation, it had not been the dominating feature in women's testimonies. Once another theme had been established there was a tendency to focus upon this when revisiting any transcript. There was a time lapse between leaving and reviewing the testimonies in their entirety. I now felt more confident with the narrative and able to analysis further, probably attributed to having developed my interpretation skills when analysing other themes. This changed the 'way' I looked at the narrative not 'what' I was looking at.

Through all of the interviews, women shared their thoughts on the chasm between ideal and real and what they found helpful; more specifically, the advice or strategies that got them through managing their lack of sleep. This shaped their attitudes to the phenomenon.

Samantha reflects upon what would have been helpful to manage sleep deprivation.

It would have helped me if midwives and HV just reassured mums that you are gonna get upset... it is gonna be unbelievably hard... nothing can prepare you for it [sleep deprivation] no matter what anyone says... or the advice that's given... no one can prepare you for how you feel in that moment... but just reassure that yeah you are gonna be upset... you are gonna have days were you just wanna sit and have a bit of a cry but it's nothing against you [self] it's just how it is and it is hard work ... It never came ... I was too scared to ask because I started to question myself and my feelings.
(Samantha)

Samantha is seeking reassurance and acknowledgment that her feelings are 'normal'. Despite advice during the antenatal period, Samantha does not believe

that a first-time mother can be fully prepared for the experience therefore highlights the significance of discussing this postnatally. Samantha believes that early discussions during this period are important to prevent women internalising the negative feelings making it more difficult for them to talk. This belief is echoed in Kerri's experience although she believes the benefit of talking about it antenatally.

Like I say... but until you're actually in it... you don't know... you've got, nothing to compare I think they can prepare you for the level of tiredness, start introducing how it is in pregnancy talk about the feelings... say its ok... explain although you're getting sleep... it's not proper sleep... 'cos then you're listening out for them so it's... it's a lighter sleep than I've ever really known... (Kerri)

Kerri's review reflects the findings in other chapters. She highlights the void between the idealism and reality regarding attitudes to sleep deprivation pre and post pregnancy. She is suggesting that knowing the 'reality' of what is coming will generate a sense of realism that women can cope with. Sarah captures this concept further

Change the expectation... It's not a fairy tale ... you're not protected by this mum bubble ... just no sleep... like no sleep can bring you to your knees... not just tired... but messes with your head... it's not even hard to sort though... just help me ... what's comin'... tell me it's gonna be ok ... feel I was let down... that I beat myself up and if my HV had said this is what a lack of sleep does ... god knows it would have helped me [tearful] ... not made it go away but the guilt that I have carried has been awful and it was beyond my control... (Sarah)

Sarah believes that idealism and realism is captured through expectations. She implies that mothers create a 'fantasy world' that does not prepare one for the reality of motherhood. The attitudes of women towards sleep deprivation are wrapped up in this false ideology. She believes that this fantasy world is reinforced and affirmed through professional's behaviour and feels aggrieved that they had the opportunity and ability to burst this fantasy bubble. If professionals are shown to be supportive and able to support mothers in developing a realistic attitude to the phenomenon, then the women's attitudes are more positive.

I couldn't sleep when he slept ... I felt a failure... My HV said it was ok... it would get better... she'd... she'd told me before [antenatally]

...you know... So I was ok... but it was still good to hear ... you know just keep going... what I'm doin' is ok... (Sarah)

This chapter has outlined the significance of a mother's identity shaped through her relationships with others. The relationships influence both positive and negative attitudes towards sleep deprivation. These attitudes are transitional and significant from pregnancy to birth.

CHAPTER 7 – DISCUSSION

Introduction

The aim of this study was to develop an understanding of the experiences of first-time mother's attitudes to sleep deprivation in the postnatal period. Using interpretative phenomenological analysis (IPA) I carried out a number of semi-structured interviews to capture those experiences. Chapter 6 highlights the descriptive element of IPA by using direct quotes from participants. However, this chapter focuses upon the interpretation and subsequent theme development to determine what my study adds to current research and health visiting practice. Four themes were identified, power of the professional, relationship with the child, transition of self and idealism vs reality. These themes, along with the knowledge gained and shared in chapters 1 to 6 have led the discussion to a mother's identity, shaped through an allegiance or placement in a group. Maternal identity defined through a child, the ideology of motherhood and relational care. The rationale for each is discussed further in this chapter.

Contextualising findings within other research

In Chapter 2 the literature reviewed explored sleep deprivation within the context of what is already known. This section draws out further research within the context of what my study has found. My findings are not aligned to previous research in sleep deprivation if investigated within the context of impact and physical, cognitive or physiological domains. Research in this area primarily focuses upon the comparable relationships between the phenomenon and other issues. Neu et al. (2014) and Bourke-Taylor et al. (2013) both explored mother/child's disturbed sleep through maternal and/or child disability and illness. Malish et al. (2016) explored the impact upon sleep deprivation and cognition. Kent et al. (2006) and Hornell et al. (1999) explored sleep deprivation associated with breastfeeding, frequency and duration.

They all highlighted the impact of sleep deprivation (physical and cognitive) on mothers and children, which supports my study's findings. However, due to the focus upon cause and effect and the inclusion of self-assessment questionnaires and tools, they introduced an element of 'measuring sleep deprivation'. Consequently, there was a lack of further exploration and interpretation of how

mothers make sense of the experience. The experience for the participant was not fully captured.

I wanted to understand the experience of sleep deprivation for first-time mothers. Therefore, studies more aligned to mine were those that explored maternal sleep deprivation and depression. An exploratory study by Tammentie et al. (2004) found that there was great discrepancy between expectations and reality in the family dynamics of postnatally depressed mothers. Parents, especially mothers, strove for perfection, perceived the infant to tie them down and had high expectations of family life. Although the study concurs with my study's findings in that there is a void between the expectation and reality of motherhood, the starting point for Tammentie's (2004) study is that women already had a negative attitude to the phenomenon due to their depression; sleep deprivation is explored as cause and effect.

Tammentie et al.'s (2004) study, like many others, explored depression and sleep deprivation on the premise that depression is causing the sleep deprivation and not vice versa (Tsuno et al., 2005; Doering et al., 2017). My study has focused upon attitudes to sleep deprivation attributed to infant waking through natural caregiving duties. None of the mothers reported feeling depressed during my study; therefore, although sleep deprivation and depression in mothers does go some way to try to understand mother's feelings, they still fall short of exploring experiences for individuals from a more neutral starting point.

A study by Kennedy et al. (2007) explored mother's experiences of sleep during pregnancy and the immediate months after becoming a new mother through semi-structured interviews. The findings identified that sleep disturbances were common to all of the mothers, and sleep became a negotiated behaviour as they adjusted to the mothering role. They identified the benefits of pragmatic strategies to manage the effects of sleep deprivation, enlisting partners to facilitate naps and bed-sharing. The study was part of a larger randomised clinical trial on an intervention to improve sleep and well-being among new mothers. Qualitative software was used to manage the data. In doing so it fell short of 'interpretation', which IPA brings. My study goes further by exploring the process of how mothers make sense of the experience before they get to the pragmatic stage. In essence, what influences the negotiating behaviour? This is important for two reasons .The

first is that although women's experience of the practical support may be similar (partner helping), this study has found their attitude towards sleep may be completely different, subsequently affecting their ability to cope. Secondly, not all women will have partners to help yet they may cope better than someone with support. This information is crucial if professionals are going to provide meaningful advice and support to women. In my professional opinion and drawing upon my experience in practice making, assumptions that because women have practical support they can somehow cope is misleading.

Another study that explored motherhood was by Rudzik and Ball (2016). They explored perceptions of infant sleep and feeding with mothers. The study found that breastfeeding mothers expected and accepted the fragmentary nature of infant sleep as natural, while mothers who were formula feeding felt it was a problem to be fixed. This offers insight into the diversity of attitudes to something expected and common, raising the question of how and what do we draw upon to inform our values and beliefs. Mercer (2004) suggests that one's beliefs and values inform the roles we portray. This includes maternal identity.

Sleep deprivation sits 'within' the above studies, and is a bi-reference to the overall transition to motherhood experience, not given a specific focus. The 'self', defined through changes to maternal identity, can affect a mother's values and influence changes in decision making (James, 2008; Kanji and Cahusac, 2015). My study highlights the significance of changes to a mother's identity and the subsequent influence in attitude to sleep deprivation. Furthermore, my study highlights that immediately after birth there is a sudden change in attitude to sleep deprivation and maternal identity. This finding contradicts the 'transitional' or 'adjustment' term (occurring over period of time) often associated with motherhood.

A study by Darvill et al. (2010), which explored the psychological factors that impact on women's experiences of first-time motherhood, found that the change in identity and a new sense of 'self' is experienced as early as the beginning of the pregnancy. Shelton and Johnson (2006) found that first-time mothers experience a profound reconstruction of their identity. This often challenges them in ways they had not expected, intrinsically linked to the dominant ideas about what mothers are supposed to be like. My study has found that there is a sudden

shift in identity immediately after birth. It would be reasonable to assume that the sudden physical change (the act of giving birth) would align itself to a sudden change in maternal attitudes. However, this would contradict Arendell's (1999) and my own view that motherhood reaches deeply into the lives of individuals and family processes, shaping women's identities. I believe we socially construct our worlds. Therefore, I am reluctant to accept that the physical process of giving birth or associated physical changes to women's bodies could account for such an immediate shift in identity; particularly their attitude towards professionals. I am more inclined to support Hester (2005) in the view that new knowledge is created through reorganisation of previous knowledge. Therefore, during birth this recalculation and 'body' experience of knowledge occurs rapidly, changing women's attitudes. The following sections discuss the social aspect further.

Identity through the in/out group

Findings from my study found that women knew they would be sleep deprived to some extent or other. However, many women felt let down by professionals in not preparing or supporting them in the gap between the theory and the reality of the experience. Participants in my study struggled with the reality of trying to cope, reaching out to professionals for support. Such a gesture was often met with a perceived lack of skill and knowledge by the professional. Consequently, this affected the relationship between mother and professional.

These professional behaviours were detrimental, mothers in my study cited the benefits of 'knowing' (having a relationship with) their professional. In doing so they were more likely to share their greatest fears regarding sleep deprivation. Once out in the open, if met with a responsive professional, their negative feelings could be alleviated to some extent. They were able to form a positive, albeit realistic, attitude to the phenomenon in that it did not reduce the effects, but did help them make sense of the experience, which brought a sense of relief.

Participants in my study moved through stages in disclosing their struggles with sleep deprivation to professionals. There was an expectation that professionals would lead on the discussion to draw out women's feelings about the issue. If this did not happen, then women 'test the waters'. They may make reference to the associated feelings of sleep deprivation to see if the professional agrees or sympathises with them. They also ask rhetorical questions, for example 'every

other mum can cope with lack of sleep can't they?' If a professional did not respond in a supportive way either through minimisation or ignorance then women felt they were overreacting to the issue. They felt they were a bad mum or they became resentful towards the professional that they had not picked up on the issue. This is significant in that, albeit findings relate to this study it perhaps offers a clue to professionals regarding women's struggles with the issue, highlighting triggers for developing support strategies to be identified that will strengthen the bond/relationship between both. Although there were many influences in women's attitudes in this study, professional support or lack of it was a dominant factor in influencing women's attitudes to sleep deprivation.

In relation to women in this study who struggled with their relationship with their professional, Tajfel and Turner (1979) describe this as women defining their social identity by placing themselves and professionals in a group opposed to each other. Social identity theory proposes that a person's sense of who they are is affiliated to the groups they are in. Tajfel and Turner (1979) propose that there are three mental processes involved in evaluating others as the 'in-group' or 'out-group'. This process is sequential. The first is categorisation; we categorise people (including ourselves) in order to understand the social environment (Oakes et al., 1991; Tajfel and Turner, 1979). This is evident in Georgia's interview '*I knew what to say, you know to make them think I was ok*' (p. 78). The reference to '*them*' implies professionals are categorised as the other group. This next stage is social identification; we assume the identity of the group we have categorised ourselves to (Tajfel and Turner, 1979; Ashforth and Mael, 1989). Georgia believes that professionals view her as belonging to a general, insignificant group: '*was just a number... a tick box*' (p. 78). She is clearly uncomfortable with being in her new group (mothers). The final stage is social comparison; we compare the group we have identified with to other groups (Tajfel, 1981). Many of the women in the study believed that the professional group did not understand the women's struggles with sleep deprivation. This is captured in Elizabeth's interview '*don't know whether they're gonna judge you or whether they're going to brush things off and just go ah well you know...*' (p. 80). Where there was reference to the other group it was usually within the context of 'them' rarely associated to the individual professional. This may account for why

mothers in this study extend their negativity to all professionals rather than one professional with whom they have experienced specific challenges.

Tajfel and Turner's (1979) theory offers an explanation to some extent; however, it does not explain why women in this study want to constantly seek reassurance from a professional if they are the 'other' group. This extends further by the women in this study placing professionals on a 'pedestal', in terms of everything associated with motherhood, professionals have the knowledge. Women may feel vulnerable; willing to compromise on their needs to ensure their child arrives safely into the world. This willingness to rely on another group shows that regardless of whether we belong to one group or another, groups have a role in defining our self-image and are important for us to function in whatever we perceive to be a normal manner.

Sherif (1966), would say the groups are seeking the same limited resources (the ideal approach to motherhood). Realistic conflict theory believes this leads to negative stereotypes and beliefs, and discrimination between the groups. It could be argued that the limited resource is ultimately achieving the optimum health and well-being of the baby and only a single approach permitted. It is not important that there should be actual conflicts over resources so much as perceived conflict. This is interesting because where there is a perception there can be internal conflict and vulnerability for women especially during the pregnancy. Women may view taking a stance in their own group as risking their baby's health. Therefore, they compromise on their 'gut feeling' about what is right for them as individuals, instead allowing the experts in the other group to take over. My study found that a mother's attitude to sleep deprivation is strongly influenced by professional attitudes particularly during birth. For example, Samantha minimises her own views during birth giving sole decision making to the professional, *'I was just following their lead because they've got the knowledge, they've got the experience, they've got the power'* (p. 88). This led to a feeling of being out of control yet a willingness to trust in the professional implicitly, if it meant that her child was delivered safely.

The issue is further compounded by the perceived individualised care women in this study believe they can have, and in my experience what health professionals promote, contradicted by the standardised approach to care we deliver through

policy (Department of Health, 2009). It could be argued that professionals operate in a utilitarian way, aiming to achieve the greatest happiness for the greatest number (mothers and babies), seeing themselves as intrinsic to realising that potential. Women 'buy into' the model, which enables professionals to become more directive as pregnancy progresses. However, there is a point immediately post birth when women are no longer receptive to the professional advice or direction given. Elizabeth and Sarah 'find their voices' and negative emotion is directed towards the professionals '*I was being told off*' '*Midwife was pushing me, I said am going to leave it,*' (p. 83). If Tajfel and Turner's (1979) theory is applied, then post birth the definition of the mother group is now more defined. Following birth, women are often placed together in wards and opportunities may arise to share thoughts and experiences; perhaps moving towards a clearer 'them and us' attitude towards professionals. In this study there is an increased confidence in mothers being able to challenge the status quo and make generalisations about professionals' roles and knowledge. The findings of my study and my professional experience would suggest that professionals are oblivious to the shift in attitude and change in affiliated groups for mother's. The danger is that professionals will continue to be directive, increasing the likelihood of a poor relationship and connectedness between the professional and mother. Consequently, as this thesis has previously highlighted having a negative impact upon mother, child and professional.

The shift may also be attributed to women becoming disillusioned and feeling let down that the promises of happiness and fulfilment have not materialised. From a utilitarian position, more specifically Bentham's (1907:312) principle of utility, actions or behaviours, are right in so far as they promote happiness or pleasure, wrong as they tend to produce unhappiness or pain. Then, women are experiencing pain (physically and metaphorically) rather than pleasure as a result of the birthing experience. Secondly, having brought their baby safely into the world, potentially 'motherhood' kicks in generating a set of feelings and behaviours that now challenges the professional role through increased maternal confidence, or perhaps from the outset women are willing to manipulate their association with groups to maximise the best outcome for their child. It may be a powerful drive to ensure compatibility for life, but creates conflict with 'self', ultimately compromising one's values and beliefs. This may lead to resentment

for compromising on one's own group's expectations, feeling misled by the opposition unless 'euphoria' is achieved.

Identity shaped through the child

The findings highlight the significance of the child, and their perceived abilities, in determining whether mothers coped with sleep deprivation or not. This belief was intensified by a mother's view of pre-pregnancy skills that could be transferred into their current status post birth.

Within this context most women in this study believed that they possessed transferable pre-pregnancy skills that would support them to manage sleep deprivation. As those skills were only ever considered a function or task, and applied to predictable scenarios, there had been an assumption that women's responses to the events would also be predictable. For example, having a baby and lack of sleep is a predictable event. The reality, however, introduced a range of feelings in response to the task and function. Consequently, this generated unpredictability. This caught women off guard, unable to make sense of what they were experiencing. Consequently, they were unprepared for the physical and psychological adjustment to the problem. Although there is no evidence to suggest that the physical and psychological effects of sleep deprivation diminished, whether women felt able to cope was influenced by the role the baby played in the relationship. In this study a mother's relationship with their baby strongly influenced their attitudes to sleep deprivation.

The findings showed that there were three ways women viewed their baby, consequently leading to three variances of 'self'. For women who believed their child was a helpless being (unable to communicate their needs) a routine brought a sense of relief to the associated negative feelings. It offered a sense of achievement and control, counteracting the insecurity of being a mother and the unpredictability of lack of sleep. If a routine was not established the mothers tended to cite the problem within themselves, either feeling guilt and shame or seeking ways to improve their situation. If women perceived their baby as a helpless infant unable to contribute to the relationship there was a strong identity as a 'mother', offering a sense of achievement and control. Identity was clearly defined through a caregiving role. This finding supports the findings in Mercer's (2004) study of becoming a mother. Acquiring new skills helps women regain

confidence. Mercer (2004) places emphasis upon women having control over caregiving skills. My study found that attitudes towards caregiving and skills were contextualised and influenced by the relationship with the baby, rather than women's decision to master the skills.

In this study women who believed that their baby had instincts, there was reliance upon the baby to alleviate some of their struggles with lack of sleep. For example, their baby would cry if they needed something. Consequently mothers were more likely to try and rest in between crying episodes.

For mothers who believed that their baby could make decisions, there was also a reliance on them to alleviate sleep deprivation. However, they believed that the baby could control the level of sleep deprivation mothers experienced. This made the mother feel helpless. For these women there remained a perpetual cycle of negativity and a potential for long-term damage to the mother/child relationship. For mothers who believed that their baby could make decisions (choose to keep their mother awake), they felt that an identity was being forced upon them and they had little control.

The three distinct views held by mothers in this study in terms of the influence their baby had over sleep deprivation can be linked to maternal identity. Mercer's (2004) maternal identity theory says it begins with maternal commitment and attachment to the unborn baby. Lindgren (2001) states that this stage has been consistently linked to engaging in healthier behaviours that benefit both the woman and her unborn child, unlike bonding (which refers to the loving feelings parents have for their children, typically developed from birth or before, without conscious intent). Attachment refers to the special tie between a child and an attachment figure (usually the parent) based on the child's need for safety, security and protection. It develops over time, a learned phenomenon (Bowlby, 1969).

Bonding begins in pregnancy and can influence the expectations of a baby's abilities post birth. Salisbury et al. (2003) and Alhusen (2008) refer to it as mother-fetal attachment (MFA). It is a process whereby a pregnant woman experiences feelings and interacts with her foetus, developing a maternal identity 'connection' during pregnancy. Reflective function refers to the capacity to envisage mental states (thoughts, feelings, needs, desires) in oneself and others, and to make

links between mental states and behaviour in meaningful and accurate ways. Slade et al. (2005) highlight the importance of parents' capacity for reflective function, the ability to keep the baby in mind, linked to a range of positive outcomes. As described in a myriad of ways by Fonagy et al. (2002), our desire to try to understand ourselves and others is the most natural aspect of human functioning. This is achieved through mentalisation, the reflexive use of such understanding to try and make sense of emotional processes. This process, whereby internal experience, feelings and intentions are mentalised, leads to the development of structures crucial to defining self and identity (Fonagy et al., 2002). Although this study has not explored reflective function directly, it would be reasonable to assume that mothers who believe their child 'chooses' to keep them awake have not achieved a level of reflective function that is positive or meaningful. They are unable or unwilling to make links between their babies' states and behaviour in an accurate way. This can be seen in Jane's interview post birth when she says, *'I tried to help and he wasn't having any of it... fine for everyone but me...'* Jane believes that her baby is a decision maker, and it is therefore reasonable to assume that her expectations of her baby have not been mentalised in a realistic or positive way (Interview, p. 90).

Findings in this study would suggest that some women may be more receptive to MFA than others. For some women the thought of connecting with a foetus may be alien, and they may not be able to conceptualise attachment until the baby has arrived. This may account for the sense of achievement in routines once mothers in this study were able to care for their baby; 'caregiving' promotes positive attachment. Although MFA and maternal function focuses upon the attachment with the child, each mother may also bring a set of preconceived ideas and beliefs that will influence her starting position. Mercer (2004) acknowledges this influence by suggesting that mothers have to learn the social expectations associated with motherhood. MFA is influenced by numerous factors including mother's own attachment history and whether the pregnancy was planned and/or wanted. I would also add that from my professional experience, these influences can fluctuate, including the intensity of the effects of sleep deprivation which are shown to have an impact on cognition. Mercer (2004) highlights the strength of relationship with partner and family support can also have an impact within the context of family. The nuclear family is still

portrayed as an ideology in society. For example, midwifery and health visiting practice still captures the demographics of family in this way. However, we need to consider ways in which a family operates as a small group (Parke, 1990). Thinking 'family' is no longer a dyad or triad. There may be older siblings already present, as well as grandparents. Stern (1995) stresses the important role that maternal grandmother may play. Grandparents, especially the maternal grandmother, may have a very significant role, either directly or indirectly in influencing a mother's perception of herself as a mother.

The women in this study reflect the diversity of family. For example, both Samantha and Jane did not have partners and one lived with her grandmother. They both believed that their babies made a decision to keep them awake. The infrastructure required to support positive MFA was not present and their 'family' does not fit into stereotypical paradigms. The findings would suggest that they are more likely to look to society as opposed to family to determine and define their image of motherhood; in doing so they have socially constructed a view that babies are decision makers from birth. They have the power to intensify or alleviate the negativity and exhaustion the mothers feel. The longer term effects are unrealistic expectations of their children as they grow into toddlers, teenagers and adults. If a functionalist perspective is applied to this scenario, then it destabilises the status quo or contributes to wider societal problems. These adults will have a distorted view of parenthood. The cycle is likely to be repeated. From the functionalist perspective, if all is well in society there is order and stability; if all is not well, society must adapt to new forms of order (Zgourides and Zgourides, 2011). There are a plethora of government reports that highlight the effects of dysfunctional families on society. Cited from being 'dadless' (Social Justice Policy Reform, 2006) to being neglected, to being affected by poverty (Jacobson et al., 2010). The issue is complex and therefore it is naive to assume there is one causal factor. There are many stories of resilience and children excelling in the 'non-traditional' nuclear family. Perhaps more importantly, it is the parenting that has a significant impact upon children's holistic development; therefore, any distorted view of expectations regardless of what constitutes 'family' will be detrimental. Add to this the wider implications across education and health, then supporting women to develop positive MFA is crucial to avoid women becoming marginalised in society.

Ideology of motherhood through self

All women who took part in the study made reference to how becoming a mother impacted upon their definition of 'self' particularly within the context of their previous roles and role models. My study identified an assumption that a physical and physiological transformation prepared women to manage sleep deprivation. Women cited a problem within themselves if they could not manage the transition, suggesting a belief that psychologically accepting the transition was something within their gift to control. Women who viewed their sleep deprivation as solely related to hormone fluctuation embraced the idea that it was self-limiting. If women were surrounded by people who minimised its effects or contradicted the feelings women experienced, then women viewed it as a longer term problem. This had a direct impact on their 'identity' due to the building blocks of knowledge they had accumulated over a period of time regarding sleep deprivation. Many women in the study referenced past events or past experiences as shaping their current understanding of sleep deprivation '*I just had it in my head that's what happens... your body does the work, I probably would have been more sympathetic, helped more... you know*'. Kerri (p. 90) is describing how her view of mothers was influenced by her colleagues and manager.

A woman's previous role before becoming a mother was significant in how they managed the lack of sleep in this study. As sleep deprivation is a natural and common event following birth, all women believed it was something predictable. All women in the study had considered it, albeit fleetingly, but had contextualised it as something very manageable. For example, women thought that '*having time off*' (Kerri, p. 93) to be a mother or '*previously working nights*', (Elizabeth, p. 92) would equip one to manage the issue. None of the women had considered how they would respond mentally, behaviourally or cognitively to the experience; suggesting they considered the effects to be minimal (primarily tiredness). They had little tolerance in oneself or others in the inability to manage sleep deprivation.

This belief influenced how the women in this study had viewed other women prior to becoming mothers themselves. They believed that their previous role added 'worth and value' to their own position in the world and becoming a mother implied ease, sacrifice and/or putting others first (Damaske, 2011) '*meeting his needs*

and sod mine! I've got to give up my life now for him (Jane, p. 89), *'but you know in my head couldn't understand what the fuss was about [new mothers being tired]'* (Kerri, p. 94). These findings concur with other studies exploring motherhood. Women believing their previous careers to be of societal value, but as mothers they carried less prestige and lower rewards than in their previous jobs (Mainiero and Sullivan, 2005; Damaske, 2011). Hays (1996), who explored contradictions in motherhood, found that being perceived by others as placing material wealth on a higher level than the well-being of children was strictly forbidden by mothers. If done so, women were made to feel selfish. The same analogy can be applied to managing sleep deprivation. Prioritising one's own needs for sleep over their child's needs or complaining about the issue may appear selfish, preventing women disclosing problems. Johnston and Swanson, (2003) would say that our perceptions of motherhood prior to becoming one is a good mother is a happy mother and an unhappy mother is a failed mother. Responsibility for motherhood attributed to the individual, not the 'system'. Addressing this with mothers to ensure they understand they are not 'failing' could be challenging for professionals, as standardisation of care can often restrict the time available to support women. However, women's perception and ideology of motherhood is influenced by many factors. On one hand this can add to the confusion by introducing multiple opinions; however, it also does provides an opportunity for further support.

This conflict in the ideology of motherhood can be evidenced within the context of previous roles. There is a commonality in 'role modelling' and its influence on women's views of motherhood (friends, grandmother), and this study reflects such a view. Within sociology, role modelling frequently sits within the parameters of groups. Earlier in this thesis I reported how significant the in/out groups are in the relationship between professionals and mothers. However, a mother's identity and 'self' also has an emphasis upon individuals from a psychological perspective, with role modelling often attributed to another individual, particularly for behaviours one would want to emulate, underpinned by a psychological process. Each of us has different qualities we look for in our role models. This suggests that it is a complex process drawing upon a plethora of individual 'feelings', values and beliefs to determine who our role model should be. Morgenroth et al.'s (2015) review of the motivational theory of role modelling

found that there are three recurring, and interrelated, themes among existing definitions of role models.

The first is that they show us how to perform a skill and achieve a goal. This is interesting as this study found that women prior to birth sought this in professionals. This may account for why professionals are initially placed on a pedestal. This changed following birth; women perhaps moving to a position of being able to compare and contrast those skills. They had more in common with other mothers therefore their role model changed. Chung's (2000) study of role model affirmation found that inspirational role models were those mothers who already had children and displayed certain qualities and behaviours that appeared to integrate 'self' and a new career.

It is also possible that professionals still expect to be the role model following birth believing they still possess the best skills to ensure baby receives everything they need. In doing so it could be viewed that the role model is being forced upon the women rather than a personal choice being made and may account for the professional being viewed as directive. Georgia's experience pre and post birth captures the transition, prior to birth willing to be told what to do then shifting post birth: *'but knew in my heart of hearts 'cos I'm not a silly person I knew... that I thought right... I'm not...'* (Georgia, p. 84).

The second quality role models show us is that the goal is attainable. Women in this study were led to believe, or rather, not dissuaded by professionals that the ideology of motherhood and sleep deprivation management was natural, easy and rewarding. Women had a shock when the baby arrived and felt resentful towards professionals in not informing them of the reality, feeling the role of becoming a good mother was unattainable. Consequently, mothers no longer held professionals in high regard. Whether professionals could ever share an ideology that would meet women's expectations is debatable. Within the context of previous roles, the shift in power, freedom and financial independence to an image of motherhood as selfless and caring may always create the perception that women are giving something up to become mothers. Add to this that each experience is unique (attitude to sleep deprivation) then it is challenging to achieve such goals. Merleau-Ponty (1962 cited in Baldwin, 2004:155) reminds us that 'the grief and danger of another never quite have the same significance for

him as they have for me'. This could be viewed as the intensity of feeling for women in becoming mothers can never be truly articulated by professionals.

Thirdly role models make a goal desirable. This function is not concerned with making something desirable appear possible, but making something new desirable in the first place Gauntlett (2002). Role models need to have in them something mothers want to emulate (Sealy and Singh, 2010). This may be challenging for those women in this study who did not plan on getting pregnant. Although the process for how people choose role models is complex and unique, Morgenroth et al. (2015) cited choice, and subsequent positive outcomes, as a recurring theme in all role modelling theories. Women in this study may have felt pressurised (by self and others) to create maternal role models when they did not feel inspired to do so. Such action moves away from creating a role model, to conforming to the ideology of motherhood. Furthermore, unplanned pregnancy is associated with poor MFA; it creates further challenges for mothers to be inspired by role models associated with being a good mother, either through people they know or by the media's portrayal of motherhood.

Relational care

The findings in this study have highlighted how women's attitudes towards sleep deprivation are strongly influenced by their sense of identity shaped through their relationship with others. The discussion chapter has reflected upon women's belief that the professional has the knowledge to warn mothers about what is coming in terms of sleep deprivation; that the child should know what to do to reduce a mother's experience of sleep deprivation. Women's sense of identity prior to becoming mother is influential in managing sleep deprivation post birth. It would be reasonable to assume that more education for mothers would offer a quick fix solution to the findings in this study. Professionals could be clearer about their role, and they could discuss more about sleep during contacts. Exploring child development from conception to birth during antenatal classes could also help. However, I would propose that this is already happening to some extent. The findings in this study have not found that women who have received education have coped better with sleep deprivation. On the contrary they have felt particularly let down and at times misled by the information they received. This suggests that imparting information is not enough. The data in my study

identified that determining positive outcomes is through the relational care in all of the relationships identified. This can determine whether women see their professional as a stranger or source of support, or whether their child is influential in determining whether they are good or bad mothers.

Relational care is based upon a number of principles: compassion, connection, interdependence and collaboration. It reflects the relationships and significance of those relationships we have with others. Van der Huslt's (1999) study of midwifery care during labour distinguishes relational care from 'care' by moving it to a bio-psychosocial approach rather than relying solely upon theoretical models; the professional attempts to establish a relationship based on trust, in which equality, self-activation and open communication are important elements (Van der Huslt, 1999)

All women in this study emphasised the importance and significance of their relationship with their professional. Relationships are important for nurturing a sense of safety and security, belonging, purpose and meaning (Nolan et al., 2002, 2003; Jordan et al., 2004). However, Van der Huslt's (1999) study describes a moment in time. This study has identified ongoing and complex relationships between professionals and mothers that can change over time. There are stages to the mother/professional relationship in the context of sleep deprivation: before birth, during and afterwards. Therefore, relational care needs to be considered within this context if applied to health visitor practice. Wilson et al.'s (2009) study of relational care for residents in care homes living with dementia identified three types of relationships: 'pragmatic relationships' focused on the generic task elements of care; 'personal and responsive relationships' that met the particular needs of individual residents; and 'reciprocal relationships' that created a sense of community within the home through the interdependencies of residents, staff and family members. Wilson et al.'s (2009) study acknowledges the influential features in relational care, particularly those that are reciprocal. Hasselkus' (1988) study of family relational care suggests that family carers considered that they had expertise and knowledge they wanted to share with professionals. It could be viewed that the reciprocal relationship is more dominant due to the residents having dementia. However, there are parallels with my study as it also highlights the significant influence family members have over mothers.

Acknowledging the significance of relational care, and developing stronger relationships between professionals and mothers would shift the educational aspect from a superficial level (understanding impact of sleep deprivation on our bodies) to meaningful (how does that make us feel about it and why). This introduces and accepts feelings and emotion into our understanding and exploration of the world around us. In doing so, care can be delivered in a tailored way to reflect the diversity in our beliefs and perceptions. In my professional opinion this would have positive outcomes for mothers and their children through constructive affirmation of the challenges motherhood brings. Ultimately, we do not necessarily need to change what we do but the way we do it.

CHAPTER 8 – RECOMMENDATIONS AND IMPLICATIONS

Introduction

This final chapter concludes with the recommendations and implications of this thesis for future health visitor (HV) practice, research and education. This is followed by a discussion of its limitations and my reflection regarding my research journey. This study has used interpretative phenomenological analysis (IPA) to explore the attitudes of first-time mothers and sleep deprivation. It has expanded the knowledge and understanding of what meaning each mother attributed to this experience by considering the aim and objectives. The aim of the study was to develop an understanding of the experiences of first-time mothers' attitudes to sleep deprivation in the postnatal period. This was achieved through semi-structured interviews. Using IPA, dominant themes were identified regarding mothers' attitudes to sleep deprivation. In accordance with Smith et al. (2009), the rigour of this research was preserved by continuously revisiting the testimonials throughout the process of analysis. Rigour is defined as the quality of being thorough and accurate (Oxford Dictionary, 2018) However, Thomas and Magilvy (2011) suggest that as qualitative research is a journey of exploration and discovery, it does not lend itself to stiff boundaries. This is explored further in Chapter 4.

Recommendations

HV practice

I feel this study has provided a copious amount of learning for me personally. However, I also feel that the learning can be implemented in practice, benefiting mothers and professionals. My study has found that at one end of this spectrum there is conflict between mothers and HVs. At the other end is relational care, which appears to be hugely beneficial to both mothers and HVs in developing positive attitudes to sleep deprivation and the wider topics associated with motherhood. The recommendations are set within this context. Furthermore, I have drawn upon, reflected and considered every chapter in this thesis to inform the recommendations. This includes the themes identified, power of the professional, relationship with child, transition in redefining self and idealism vs reality. In addition, the subsections within these themes are also considered.

The recommendations are primarily applicable to health visiting practice. The rationale is attributed to my own professional role and the motivation for my study. However, as my findings have included reference to other professionals the principles are readily transferable to those areas.

Promoting a relational model of care in practice

This recommendation requires intervention from the HV in two areas, antenatally and postnatally. The first contact with mothers is at 28 weeks gestation. The second contact is at 10 to 14 days following birth. This reflects national guidance. The rationale to focus upon two particular areas reflects my findings and a key shift in women's attitudes immediately post birth. This requires a shift in professionals' strategies to support.

Table 8 below highlights five stages in promoting a relational model of care between the HV and mother during the antenatal and postnatal period.

Table 9 – Five stages in promoting a relational model of care

	Recommendation	Rationale	Themes and sub themes addressed
1	<p>All mothers to have named HV</p> <p>Professional genogram – Who is who in the team and explanation of HV role</p>	<p>Supports relational care through developing connectedness and positive relationships</p> <p>Understanding roles and responsibilities in HV teams</p>	<p>Power of the professional</p> <p>Professionals viewed as an expert pre and post birth</p> <p>Relational care</p>
2	<p>HV to explore maternal expectations of 'self' through topical areas associated to motherhood, for example sleep deprivation, becoming a mother, feeding.</p> <p>Focus upon self-awareness, self-regulation and self-monitoring (mindfulness)</p>	<p>Creates a baseline of understanding between the HV and mother regarding various topics. Enabler to creating tailored care plans</p>	<p>Power of the professional</p> <p>Relationship with child</p> <p>Transition in redefining self</p> <p>Idealism vs reality.</p>
3	<p>HV to explore mother's expectations of their baby</p> <p>Reflective function</p>	<p>Explored antenatally and postnatally to establish if expectations are the same or have changed. HV to adapt care plans and support to reflect a mother's expectations</p>	<p>Relationship with child</p> <p>Idealism vs reality</p>

	MFA		Baby viewed as a helpless infant, has instincts or is a decision maker
4	<p>HV exploration of maternal sphere of influence from a social perspective:</p> <p>Who is important to you?</p> <p>What was your previous role?</p> <p>Affiliation to groups</p>	<p>The purpose is to help HV understand the social and societal influence upon mothers. Will help HV understand how mothers are making sense of their world and who and what is important to them</p>	<p>In/out group</p> <p>Attitudes and norms</p> <p>Role models</p>
5	<p>HV information sharing based upon recommendations above in 1-4</p> <p>For example discussing the physical, behavioural, performance and mental health impacts of sleep deprivation</p> <p>Planning and routines in caregiving</p> <p>Evidence of tailored discussions in care records.</p>	<p>Findings suggest that women are receptive to being guided or directed by professionals in antenatal period. This should be done within the context of understanding developed during stages 1-4</p> <p>HV change their strategy postnatally by revisiting stages 1-4 and empowering mothers to take the lead (in caring for their baby) wherever possible. HV to remain mindful of how women attempt to raise issues they are concerned about, for example stages to disclosure of sleep deprivation to help guide this discussion with mothers</p>	<p>Professionals viewed as pre-birth expert</p> <p>Power of the professional</p> <p>Idealism vs reality</p> <p>Stages to disclosure of sleep deprivation</p>

Policy

This study has highlighted a gap in professionals' knowledge regarding discussing the effects of sleep deprivation with mothers. Current HV policy does not explicitly reference sleep deprivation as a topic for discussion, although there is reference to 'sleep hygiene' which provides advice such as sleep when baby sleeps (Department of Health, 2009). I do believe there should be more reference to sleep deprivation in policy including strategies to manage, and references to the detrimental effects. However, this alone would not address the findings and subsequent recommendations in my study.

Policy needs to provide more guidance around developing opportunities for professionals to explore their own practice including how they see themselves and how they perceive others see them. Reflective supervision and mindfulness would provide such opportunities. Being present is a common and significant feature in mindfulness (Marlatt and Kristeller, 1999). Mindfulness encourages us to notice how our thoughts are driving our emotions and behaviour (NHS Choices, 2018). There is a focus upon self-awareness, self-regulation and self-monitoring (Baer, 2003; Biegel, 2009). Such a model would be sensitive to the findings in this study as it requires you to pay more attention to the world around you. This could be achieved through one-to-one or peer supervision and investment in meaningful training that draws out and explores professionals' values and beliefs. A national maternity review (National Maternity Review, 2016) stated that women have made it clear that they want to be in control of their care, in partnership with their healthcare professionals. Such investment in mindfulness and supervision would prepare professionals to support and empower mothers.

I believe this move to developing inclusive policy development (professionals and mothers) would ensure practical advice and support for mothers and professionals is referenced regarding sleep deprivation. It would also support development of relational care, improving self-awareness, emotional intelligence and reflection. It moves away from some professionals delivering care under a model of 'knowing best' rather than connectedness. However, policy could go further by reviewing all activities considered and defined as 'normal' during motherhood, moving away from the notion that challenges in transitioning to motherhood are easy and self-limiting.

Research

The findings of this study concur with what is already known about the effects of sleep deprivation. However, it adds to what we understand about motherhood in terms of the associated complexities of living up to expectations of oneself and others. It also adds to what we know about maternal identity, specifically how maternal identity is shaped through relationships with others. The findings highlight that both education and relational care are intrinsically linked to influencing attitudes towards sleep deprivation. Further research in this area is needed. I have referenced 'mindfulness' as a concept aligned to supporting the promotion of relational care. Further research in this area would be beneficial if exploring professional/client roles in any discipline.

The findings in this study also contribute to wider research in a number of areas which may benefit from further exploration.

Attachment and Resilience

Attachment theory is defined as the emotional and physical attachment of a primary caregiver and how they can influence a child's social, emotional and cognitive development (Bowlby, 1969). Ainsworth's (1979) study of maternal attachment found that there were three patterns of attachment: secure, ambivalent and avoidant. Each influenced a mother's ability to tune into their infant and respond appropriately to their needs. Strong attachment relationships are considered important in the promotion of resilience (Yates and Masten, 2004). Resilience is the capacity to bounce back from adversity (Public Health England, 2018). Researchers are intrigued why some children are resilient and others not, despite having similar experiences. Resilience in children in care (foster care) is of particular interest to researchers (Rees, 2013; Jackson and Martin, 1998; Schofield and Beek, 2005). This is primarily attributed to children in care frequently over represented in many poor health areas (mental and physical). Based upon my professional experience there is a general consensus (amongst professionals) that more must be done to improve health outcomes for this cohort of children and young people. Atwool (2006) cites Ainsworth's (1979) findings as significant in resilience, however also references individual characteristics such as temperament, competence, self-efficacy and self-esteem as areas for resilience to be explored. My study found that women view their relationship with

their baby in three ways (helpless, instinctive or a decision maker). These perceptions influence positive and negative attitudes to sleep deprivation that may affect attachment. I feel my findings add a further dimension to our understanding of attachment and resilience. I would be interested to know if the three ways mothers view their babies can be linked to secure, ambivalent and avoidant and whether this influences those characteristics that effect resilience in children.

Breastfeeding

A study by Rudnik and Ball (2016) who explored maternal perceptions of infant sleep and feeding found that breastfeeding mother's favoured cue based care and formula feeding mothers favoured routine based care. This study supports my own study's findings if viewed within the context of different approaches to care giving. However, Rudnik and Ball (2016) also found that breastfeeding mothers perceived their waking episodes as driven by a biological perspective and non-breastfeeding by social norms. Essentially, cue based care is biological and routine based care is social.

Albeit, Rudnik and Ball's (2016) study is regarding breastfeeding, sleep deprivation, like breastfeeding is something considered 'natural' and expected following birth. The biological vs social perspective may offer further insight into why women in my study felt quite strongly that their body would physically prepare them for motherhood.

Women in my study also frequently cited their disappointment in midwives and health visitors not preparing them for the physical impact that sleep deprivation could have on them. Although my study did not establish whether women continued to breastfeed postnatally it would be interesting to explore in further detail if the biological / social perspective affects attitudes to sleep deprivation. Perhaps the three ways mothers view their babies is actually is also true of how they view themselves, helpless (a biological response will occur), instinctive (biological response) or a decision maker (social response).

Fathers

The findings in my study identified a shift in attitude in mothers immediately following delivery. Although my study explored this within the context of the professional role based upon mother's interviews, it would be interesting to know if the presence of the father could be influential in this sudden change in attitude. Fathers are inclined to take a back seat and hide their fears from their partners during birth, feeling helpless and fearful (Chandler and Field, 1997; Johansson, et al. 2015). This may force mothers to be more assertive and take control during this period. A study by Lindgren and Erlandsson (2011) found that fathers were compliant to the woman's decision during birth; describing it as a deliberate choice to give mothers control. My study did not set out to explore father's influence; however none of the mothers in my study made reference to the influence of fathers, despite the opportunity to talk about support. Mothers referenced professionals, friends and grandmothers. This may support Lingren and Erlandsson (2011) findings that fathers blend into the background. This is concerning as there is an increase in research showing that fathers can be negatively affected by a birth experience as much as mothers (Oxford University , 2016; Etheridge and Slade, 2017). Whereas women may be able to recover and be supported through such trauma if they feel in control (Thompson and Garrett, 2019; Simpson and Catling 2016) fathers may continue feeling traumatized and isolated.

Implications

Safeguarding

The research question was generated from a tragic safeguarding incident. Upon reflection, at the start of my research journey I had perhaps been motivated to find out if I could avoid being in a similar scenario again. Sleep deprivation is such a common problem. I had naively assumed that there was a discovery to be made that would lead to identifying a trigger point so that professionals could intervene to prevent children being harmed. I have concluded that there is not. Instead, I have discovered that human beings are very complex, with motherhood and sleep deprivation only adding to that complexity.

I am concerned that we do label mothers as 'bad mothers' because of certain behaviours that could be related to being sleep deprived. Despite the plethora of learning from serious case reviews (Laming, 2009; Munro, 2011) we still appear

to be in a perpetual cycle of *deja vu*. Therefore, on that basis alone, any research that raises further questions about the topic or asks us to reconsider our perspectives in how we review safeguarding is worthy of further examination. I will be sharing my findings with the local safeguarding board (LSCB) and hope to facilitate a multi-agency focus group to explore further the issues they raise. Interestingly, as a member of the LSCB I have recently been heavily involved in a safe sleep campaign for babies. It seems glaringly obvious now that we should have also looked at mothers' sleep issues as the findings from this study emphasise the significance of the relationships between babies and their mothers.

Health visitors

This study has found that the relationship between the health professional and the mother is significant in determining whether women have positive or negative experiences in managing sleep deprivation. My personal view, and the findings in this study concur, that professionals are not aware of this. Therefore, I believe a focus group will provide an opportunity to explore this further. In the very early stages of developing my study, I had considered exploring both mother and HVs' attitudes to sleep deprivation. However, I did not pursue the HV element for a number of reasons. After reading around IPA, I felt it important to give a voice to women in their entirety. Within the widest context, the findings highlight that women generalise their views of health professionals. For example, if one professional is not supportive then all professionals lack this skill. I would not have discovered this if I had restricted my study to HVs. However, I do feel that I have one half of a story and I am really interested in what HVs will think about the findings, particularly the significance of relational care.

It will be interesting to see how HVs make sense of the mothers' experiences. I think it will generate an intense discussion and a potential conflict of views. In my experience many HVs believe caring is a 'given', something that is natural to them. I believe this is primarily attributed to a common belief that you must be 'caring' if you are a nurse. However, relational care is quite different, as this thesis has highlighted. I suspect therefore that HVs will be surprised in terms of how mothers view them. Kitzinger (1994) reports that focus groups are not only about consensus. The diversity of views is equally important.

I hope that the findings from the focus group can be translated into a learning event for HVs (along with the study's general findings and the 5-point plan for contact visits as set out in the recommendations), which will encourage personal reflection to improve practice.

Implications for practice for other professionals

Although this study has predominately focused upon professionals within the context of midwives and health visitors, the new knowledge gained from this study would benefit other health and social care professionals.

It would be helpful for professionals to understand that a mother views her child in one of three ways, helpless, instinctive or a decision maker. This would support professionals in assessments and care planning to promote and strengthen bonding and attachment. For example, a mother who views her child as helpless may welcome support in developing routines, or a mother who thinks that her child doesn't like her because she believes her child is a decision maker may benefit from understanding how babies develop.

Mothers 'test the waters' in disclosing their struggles with sleep deprivation. This knowledge may encourage professionals to initiate a conversation regarding the subject, potentially avoiding misdiagnosis of depression.

My study has found there is a shift in attitude by mothers towards professionals immediately following birth, therefore professionals would benefit from reviewing care plans and postnatal interventions during this period to ensure they are aligned to a mother's wishes.

Wider learning from this study for professionals would ensure that women receive tailored care and support. Such an investment would improve a mother's self-esteem and confidence. This study has shown that a mother's perception of herself is influential in positive outcomes for them and their babies.

Limitations of the study

I have stayed close to the principles of IPA as set out by Smith et al. (2009). Upon reflection, this was attributed to a lack of confidence in branching out or adapting the model a little. I do feel confident that I have not compromised my research to

fit into Smith et al.'s methodology. However, this was probably more luck than anything I had planned. I would feel more confident now to push IPA a little further, for example cross-referencing interview scripts from the outset rather than a rigid review of each individually. Towards the end of the analysis I thoroughly enjoyed developing the master themes, and when going back to the interviews discovering a new theme that had not been there before.

IPA requires a small sample, which could perhaps be considered a weakness of the study. I would agree if I wanted to generalise the findings. However, this is not the purpose of IPA. I would also agree if interpretation was not a crucial part of the process. Interpretation adds a wealth of rich information. I was worried that my transcripts did not have enough to analyse. I was wrong. I now feel that even one transcript can yield a copious amount of rich data.

Reflection

I started out on this journey believing that I was studying sleep deprivation. I had probably believed that I would find an answer to why women harm their children. Perhaps motivated to alleviate some of the guilt I had felt when Evie died. Upon reflection, this is not what the study was about. It was actually about how a mother's identity and subsequent attitude to sleep is shaped through her relationships with others, including her child. Although preconceived ideas may have motivated exploration, I am pleased that I allowed the research to take me on a journey of discovery. I do think exploration of sleep deprivation was important as it is something expected following birth. However, if I repeated the study I would simply use the term sleep as this would allow women to consider the subject in a wider context. By using the word deprivation I had potentially added a definition to their experience and perhaps implied connotations of difficulties. It may have widened the scope of definition for women from childhood experiences to discussing what sleep is in the widest context; I feel now that I would have more confidence to explore wherever the feedback took me. The pre-interview pilot was very helpful as previously referenced in Chapter 4; however, upon reflection it had not given enough focus to the sequencing of the questions. I would have asked question three before two. My opening question was too broad and I found it challenging to bring it back to the focus of sleep deprivation. Although it did appear to put women at ease, as they were given an opportunity to describe their birthing experience.

I am thankful that I was given an opportunity to explore a research area that has held my interest for many years. I hope it will improve practice and generate further research. I also hope it motivates other nurses to pursue research.

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APPENDICES

Appendix 1 – MMU ethics committee approval letter


Health Research Authority
National Research Ethics Service
NRES Committee North West - Greater Manchester West
HRA NRES Centre Manchester
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Mrs Joanne Chwalko
Health Visitor Team Leader
Wirral Community Trust
Old Market House
Birkenhead
CH41 5AL

20 August 2013

Dear Mrs Chwalko

Study title: A phenomenological study exploring the attitudes of first time mothers and Health Visitors toward sleep disturbance in the postpartum period
REC reference: 13/NW/0539
IRAS project ID: 113352

Thank you for your email dated 19 August 2013. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 15 August 2013

Documents received

The documents received were as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter	Email	19 August 2013
Participant Consent Form: Mothers	2	19 August 2013
Participant Consent Form: Health Visitors	2	19 August 2013
Participant Information Sheet: Mothers	2	19 August 2013

Appendix 2 – Participant consent form

Standard Consent form (for competent adults)

(Form to be on letter headed paper)

Centre Number:
Study Number:
Patient Number for this study:

CONSENT FORM Version 2

Study title: Attitudes of first time mothers towards sleep disturbance

Name of Researcher: Joanne Chwalko

Please initial box if you agree

1. I confirm that I have read and understand the information sheet dated
(Version.) for the above study. I have had the opportunity to consider the
information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time,
without giving any reason, without my medical care or legal rights being affected.
3. I understand that relevant sections of any of my medical notes and data collected during
the study, may be looked at by responsible individuals from Manchester Metropolitan
University and Wirral Community Trust, where it is relevant to my taking
part in this research. I give permission for these individuals to have access to my records.
4. I agree for the interview/focus group to be audio/video taped and transcribed
5. I agree to information being shared between the researcher, and Health Visitor if
during the study it is identified (in partnership with me) that I would benefit from additional
support
6. I understand that quotations from the study can be used in the final report and in
other publications however all information I give will be confidential and it will not be possible
to identify any of the respondents in the study report

_____ Name of Patient	_____ Date	_____ Signature
_____ Name of Person taking consent	_____ Date	_____ Signature
_____ Researcher	_____ Date	_____ Signature

When completed: 1 for patient; 1 for researcher site file; 1 (original) to be kept in medical notes

Version 2 19/08/2013 13/NW/0539

Consent form Version xx Date DD/MM/YYYY

Appendix 3 – Participant information sheet



Participant Information sheet

Study Title: Attitudes of First time mothers and Health Visitors toward sleep disturbance in the postnatal period

Please read the following before completing the consent form.

We would like to invite you to take part in a research study. Before you decide, we would like you to understand why the research is being done and what it would involve for you.

Your Health Visitor will give you an information pack during your routine 4-8 week contact but the researcher would be happy to go through the information sheet in more detail with you and answer any questions you have.

What is the Purpose of the Study?

The purpose of this study is to help us understand more about new mothers' experiences of sleep disturbance during the postnatal period. We know that having a baby is a significant life event and sleep disturbance is part of that; however we want to have a better understanding of why this impacts upon some women more than others. If we have a better understanding then we can ensure those mothers who need additional support can access it more readily.

Your role in the study

Your role in this study will involve you describing your experiences of sleep disturbance after you have had your baby. The researcher will want to talk to you about what it has been like for you and will be interested in your experiences. The researcher will be interested your views.

Why you have been invited

The researcher is interested to hear about your experiences as a new mother

13/NW/0539 Version 2

Do you have to take part?

It is up to you to decide. You will need time to consider if you would like to join the study so if you are interested in taking part we have provided a consent form that you will need to sign. This will be collected from you by a member of the research team if you opt into the study. You are also free to withdraw at any time throughout the study without giving a reason and this will not affect the Health Visiting care you receive

Procedure and time requirement

You will be invited to participate in a semi-structured interview (a one to one talk with the researcher based on a set of prompts relating to the subject matter). The researcher will have a set of topic areas to guide the discussion but you will be free to discuss areas related to the subject which you may feel are important.

The interview can take place in your home or in one of Wirral Community Trusts bases at a mutually convenient time so that disruption to your schedule will be minimal. To allow you to focus upon expressing your thoughts we can arrange for a nursery nurse to be present at the interviews in the home to help with childcare if you do not have anyone else who can support you. The interview will last about an hour and will only involve yourself and the researcher.

The discussion will be voice-recorded so that the researcher can listen and reflect on your thoughts later.

Expenses and Payments

There will be no monetary payment for expenses or participation in this study

Benefits, Risks and Discomforts

It may be that discussing your feelings is a positive experience, however due to the nature of the subject matter thinking about an experience can make some women anxious or upset. Please be assured that no pressure will be placed on you to carry on with a discussion of any subject about which you are uncomfortable, or that you find distressing. You can withdraw from the study at any time, without giving a reason. If however you disclose anything to the researcher that you both feel would benefit from additional support from your Health Visitor or G.P then this has and will be made available for you.

The researcher cannot promise that this study will help you personally, but your valuable thoughts and experiences could be used to support other mothers in the future.

Confidentiality

Confidentiality will be maintained at all times and you will not be identifiable from conversations which take place during the interviews. For example, the context of the conversation can be changed in the written report so that a future reader of the work will not be able to recognise you in any way.

How will my data be kept confidential?

All written summaries of the information the researcher receives from you will be password protected on a Community Trust computer to which others have no access. All recordings and written field notes will be kept in a locked drawer at the Community Trust's researcher's office. The data collected will be kept for ten years. When it is destroyed it will be disposed of securely via confidential waste. The audio tapes will be destroyed on completion of the study.

What will happen to the results?

The results of the research are being used to inform the development of Health Visiting Practice. Results may be published in peer reviewed journals and a copy of the thesis which summarises the research will be available in the University library.

A transcript of your interview will be sent to you so that you can check it for accuracy. You will not be identifiable in any publication unless you have given your explicit consent.

Who is organising and funding the research?

The research is part of a Professional Doctorate programme being undertaken by the researcher. The educational programme is being funded by the researcher, the Royal College of Nursing Research Institute, and supported by the Community Trust and Manchester Metropolitan University

Who has reviewed the study?

The research proposal has been looked at by the Research Ethics Committee to protect your safety, rights, well being and dignity. This study has been reviewed and given favourable opinion by the university's Faculty Research Ethics Committee.

Complaints

If you have a concern about any aspect of this study you should speak to the researcher who will do her best to answer your question. She can be contacted on 0151 604 7320. If you remain

unhappy and wish to complain formally you can do this by contacting my Director of Studies, Dr Carol Taylor on 0161 247 2970.

Further Information and contact details

Further information can be obtained by contacting

Jo Chwalko 0151 604 7320

Joanne.chwalko@wirralct.nhs.uk

13/NW/0539 Version 2

Appendix 4 – Interview excerpt, interview 4 – Georgia

Support seeking behaviours

I am really interested in finding out about your experiences of seeking or being given support for sleep deprivation or other parenting issues since having your baby

P = Participant R= Researcher

Transcription

Researcher Notes

<p>P It was goin quite well an she really was sort of attaching.. erm and then the home start women came in on the Friday morning when i was bein discharged that afternoon ,feelin so tired, no sleep me and she basically just said oh no no you don't wanna use nipple shields blah blah blah</p>	<p>Looks teary, upset (baby noise)</p>
<p>R How did that make you feel ?</p>	
<p>P at that stage I was really upset..ermm. I knew in my heart of hearts cos I'm not a silly person I knew.. that I thought right I'm not .. this isn't gonna be for me... so homestart is not gonna be a process I'm gonna go through. Cos I'm not so pro breastfeeding that I'll go through that kind of, anything that can help me sleep or to do this so that we can go home, I'm gonna use erm .. but she started pushin me sayin come on lets try without the nipple shields blah blah blah</p> <p>so we did and we sat there .. and she was absolutely red in the face screaming an cryin , an couldn't attach. An I was crying</p>	<p>Looks annoyed, fist clenched</p> <p>Sharp intake of breath</p>
<p>R right</p>	

P it was just horrendous and I just in the end .. I think it was that .. inate motherly instinct that I'd never had before	
R yeah	
P just kicked in an I just said I'm really sorry I'm gonna have to leave. I can't do this.	(baby noise)
R so... thinking about what she said was..do you feel like maybe the way it was said or is it, d'you think it was the way it was said or do you think it was what was said or.....	
P no I think it's their, I think it's.. I think it's their process is to breastfeed naturally .. whatever it takes..... and nipple shields are ... something that intervenes with that.. natural process. But for her it was the only way he could attach	Long pause
P at that stage ... and I kept sayin, what what I knew in my mind and I'd spoke with the midwives about was ... I'll use a nipple shield to start her off ..	
R yeah	
P .. but if we get to a point were he ermm... I'll keep trying her naturally ... (baby noise) and hopefully she'll take naturally and that'll be my plan erm .. er, to me it was just the wrong person at the wrong time .. with the wrong approach	
R Ok	

<p>P and she wasn't in a position where she was gonna change her views .. and I was just like ... I just, I knew I had the support of all the other people in the hospital there behind me, and I felt like This is a form of brainwash to an extent that if, I was a young vulnerable person .. with no support and struggling.. I could possibly, stop what I'm doing conform to what you're asking me to do, and will end up going 2 steps backward and ..he may not attach and it.... What do I keep doing?</p>	<p>Direct eye contact with me</p> <p>Holds my gaze. feeling awkward (me)</p> <p>Re-enacting event , stands up sits down sets the scene shows were practitioner was sitting</p> <p>Not sure what to say next –decide to keep response simple .Wants to tell her story</p> <p>Appears to be therapeutic for mumbecomes calmer</p>
<p>R yeah</p>	
<p>P Do .. do I keep feeding her out the donor cup that the midwives kept giving him, (baby noise) ..so I just asked her to leave and ... for me it was ... sigh, it was absolutely a process, that the midwives once she'd left were.. furious as well, they were really upset because they'd said.. you know we're trying to work with you to help you, we advise nipple shield cos it works for some people. It helps the baby to attach and blah blah blah extra.</p>	