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Psychological Wellbeing in the
Perinatal Period

Rachel Johnson

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A thesis submitted in partial fulfilment of the
requirements of the degree of Doctor of Clinical
Psychology

Coventry University, School of Health and Social
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Psychology

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Chapter One: Literature Review

The Psychological Impact of Breastfeeding on Mothers: A Review

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First and foremost, I would like to acknowledge the fathers, and their young families, who gave time out of their already busy lives to take part in this research. In sharing their experiences, they expressed hope that the roles and needs of fathers in the delivery room might be better understood and catered for. I hope that they feel the research goes some way to doing justice to that hope.

Recognition must also go to my research team, Helen Liebling-Kalifani, Kirstie McKenzie-McHarg and Erica Bowen for their advice and guidance throughout the research process, and to Rachel Grubb for her persistent efforts to help with recruitment. Without their time, expertise and encouragement, and those of the wider doctoral course team, the journey would have felt much harder.

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Declaration

This thesis has not been submitted for an award at anywhere other than the Universities of Coventry and Warwick, and is entirely the candidate's own work.

This thesis was prepared under the supervision and guidance of Dr Helen Liebling-Kalifani (Academic Supervisor), Dr Kirstie McKenzie-McHarg (Clinical Supervisor) and Dr Erica Bowen (Academic Advisor). The concept and design of the papers contained within this thesis arose through discussion of the candidate's own ideas with the supervisory team.

Chapter One and Two were prepared to comply with the submission criteria of the Journal of Health Psychology (Appendix 1a), and Chapter Three to comply with those of the Psychology of Women Section Review (Appendix 1b). No work contained within this thesis has been previously submitted or accepted for publication.

Ethical approval for the completion of the research reported in Chapter Two was obtained from Coventry University Research committee (Appendix 2a), Staffordshire Research Ethics Committee (Appendix 2b), as well as from the Local Research and Development Teams at the Coventry and Warwickshire Partnership and South Warwickshire Foundation NHS Trusts (Appendix 2c).

Summary

Chapter one systematically reviews the literature on the psychological impact of breastfeeding on mothers. Whilst breastfeeding is indicated as the superior feeding choice for infants, the full impact on mothers is under-reported. Results show that breastfeeding and weaning have a varied psychological impact on maternal wellbeing, identity and perceptions of role. Where incompatibilities between mothers' expectations and lived experiences occur, or where disagreement between self and others is perceived, dissonance, distress and division result. Discussion is made of the implications of these findings for clinical service provision, training and research.

Chapter two presents a grounded theory analysis of fathers' experiences of attending traumatic childbirth. Despite an increasing trend over recent decades for fathers to attend their children's births, relatively little is still known about the potential impact of having been present during a traumatic labour or delivery upon them. In response to this gap in the literature, the current study reports theoretical concepts generated from interviews with fathers. A model of the experiences recounted is also presented, showing that, within the context of their past experiences, antenatal preparation and confidence in the care provided, fathers cycled between seeking control, passive observing, and helplessness. Findings are discussed in relation to the existing literature and the implications of this novel contribution to the subject area for future research and service provision are highlighted.

Chapter three discusses the candidate's personal observations and reflections on the research process. The impact of parenthood and gender upon research into the perinatal period is considered and effects are noted on the researcher, participants and the research itself. Reflections are discussed with reference to previous research into gender and motherhood in qualitative research, and a call is made for researchers to acknowledge their epistemological positions within their subject fields as a matter of routine.

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Abbreviations

LLL	La Leche League
MRA	Maternal Role Attainment
NHS	National Health Service
NICE	National Institute for Clinical Excellence
PTSD	Post Traumatic Stress Disorder
UK	United Kingdom
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organisations

Chapter One

The Psychological Impact of Breastfeeding on Mothers: A Review

Target Journal: The British Journal of Health Psychology

See Appendix 1(a) for Instructions for Authors

Word Count (Excluding abstract, tables, figures and references): 6840

1.1 Abstract

Whilst Breastfeeding is indicated as the superior feeding choice for infants, the psychological impact on mothers is under-reported. Through a systematic review of the literature, mothers' expectations and experiences of breastfeeding are demonstrated to have a varied psychological impact on their wellbeing, identity and perceptions of role. Where incompatibilities between action and expectation, self and others, or self and society arise, dissonance and division result. The uncertainty of physical difficulties and weaning is shown to leave mothers particularly vulnerable. The importance of the findings for clinical services including training is highlighted and further research is recommended.

1.2 Introduction

In the United Kingdom, as across the industrialised world, exclusive breastfeeding is widely promoted as the best feeding choice for infants, with breast milk recommended as remaining part of a child's diet up to and beyond their second birthday (World Health Organisation, 2003). Research suggests that breastfeeding may offer physical and emotional benefits for both mother and child, and health promotion materials have worked hard to highlight these.

Research, although not unequivocal, suggests that breastfed infants have reduced risk of eczema, asthma, allergies, gastrointestinal and respiratory tract infections as well as increased intelligence and academic performance. Health benefits are promoted as extending into adulthood, with breastfeeding reducing the risk of high blood pressure and cholesterol, type-2 diabetes and obesity in later life (Duijts, Ramadhani & Moll, 2009; Horta, Bahl, Martines & Victora, 2007 UNICEF, 2010). The benefits to mothers are suggested to include a reduced risk of ovarian and pre-menopausal breast cancer, and a faster return to pre-pregnancy figure (UNICEF, 2010).

As a consequence of these findings, the National Health Service (NHS) has made a commitment to improving breastfeeding rates, with trusts working with the United Nations International Children's Emergency Fund (UNICEF) UK Baby Friendly Initiative, launched in 1991, to ensure improved facilitation and promotion of breastfeeding across the UK. In order to achieve this, a message of "breast is best" is promoted to mothers from their earliest antenatal contacts with health professionals.

UNICEF reports that implementation of their standards results, on average, in a

10% rise in the number of infants being breastfed on postnatal wards. This is supported by an 8% rise in the numbers of UK mothers initiating breastfeeding between 2000 and 2005 (Department of Health, 2000; Department of Health, 2005). Whilst the 2010 Infant Feeding Survey is unavailable until June 2011, recent additions to legislation, health and public policy (National Institute for Clinical Excellence, 2008; WHO, 2009; Equality Act, 2010) suggest that its publication will show a continued rise in UK breastfeeding rates.

The true research picture behind these high profile and high cost public and health policy initiatives is much more equivocal than might appear. Systematic reviews of the impact of breastfeeding on infants suggest that findings of more neutral or negative impacts on infants are unreported, with suggestions that the true health benefits of breastfeeding may have been overstated within the academic literature (Horta, Bahl, Martines & Victora, 2007).

Whether the under-reporting of these findings is a result of the powerful drive to improve breastfeeding rates, or of publication bias, where smaller studies with negative or neutral results are less likely to be published, is uncertain (Horta, Bahl, Martines & Victora, 2007) however, their absence from the public arena is conspicuous.

A disjoint is also evident in the attention paid to findings of the impact of breastfeeding on mothers compared to that on infants, and the full impact of breastfeeding on mothers has been much less discussed. Recent promotional material produced by the Department of Health and UNICEF (UNICEF, 2010) mentions health, weight loss and financial benefits of breastfeeding to mothers.

Whilst policy has been informed by extensive efforts to clarify and respond to the bio-psycho-social factors influencing mothers' infant feeding decisions (Dennis, 2002; Meedy, Fahy & Kable, 2010; UNICEF, 2010), no mention is made of the psychological impact of breastfeeding on mothers. Although academic research into these effects is limited, with many papers merely alluding to the potential psychological and emotional sequelae of breastfeeding (Susman and Katz, 1988; Thorley, 2005; Wambach, 1998), this remains a glaring omission from the public arena. This is especially striking given that meeting and supporting the emotional needs of mothers has been acknowledged from the outset as critical to the success of interventions aimed at improving breastfeeding rates (WHO, 2003).

In response to this lack of clarity, this paper forms a systematic exploration and critique of the literature regarding the psychological impact of breastfeeding on mothers, and the interventions aimed at supporting them to breastfeed. Through critical review the paper aims to identify the potential psychological consequences of breastfeeding for mothers, as well as facilitating future research, public health and clinical practice to consider and promote a more comprehensive understanding of the impacts of breastfeeding.

1.3 Literature Search Method

In order to locate relevant papers, five primary databases were searched: Academic Search Complete, CINAHL, Medline, ProQuest and PsychInfo. Databases were chosen to reflect as wide a range of professional disciplines as possible. To minimise the impact of incompatible cultural and social norms, searches were restricted to peer-reviewed research conducted in Europe, Australia or North America. Papers unavailable in English language and dissertations were also excluded at this stage. The key search terms used were:

Title:[Breastfeed* OR " Breast Feed*" OR Lactat* OR Breast-feed*] AND
Abstract:[Psych* OR Emotion*]. Initial searches were conducted between
November 2010 and February 2011, and database notifications set to alert the
author to any relevant papers added after this time. A final search of the
databases was conducted in April 2011 to allow the most recent articles to be
incorporated into the review.

The papers identified during initial searches were then examined, and exclusion
criteria applied. The most common reasons for papers being excluded were a
primary focus on the physical or endocrinological effects of breastfeeding
(Susman & Katz 1988, Wambach 1998, Thorley 2005), where mothers were
under 18, or infants ill or pre-term due to the additional psychological demands
on mothers in these groups (Moran, Edwards, Dykes & Downe 2007, Hill, Aldag,
Demirtas, Zinaman & Chatterton 2006). Due to the existence of recent reviews in
the area, papers looking at the effects of breastfeeding on stress (Mezzacappa
2004), depression (Dennis & McQueen, 2009) and sexual function/intimacy
(LaMarre, Paterson & Gorzalka 2003) were also excluded; the importance of
considering these findings in conjunction with the current review is, however,
acknowledged.

Appendix 3 illustrates how the initial search results were narrowed to identify the
final papers included in the review. Searches were deemed complete once no
further references were being identified. In total twenty-four papers were
identified as relevant for inclusion; Appendix 4 provides information of
methodology, participants and major themes of the papers.

1.4 Review of the Literature

Despite a wide range in the type and rigour of methodologies used across the papers, review of their findings reveals many similarities in their contributions to the subject area. A systematic approach was used to identify common themes within the literature. During reading, details of papers' findings were recorded in a separate document to aid comparison between papers. In this way, four recurring themes were identified, with the majority of papers contributing to more than one of the four themes. These themes are used to structure the review, informing a structured understanding of the psychological impact of breastfeeding on mothers.

1.4.1 Early expectations and beliefs

Across the reviewed literature twelve papers highlight the importance of the expectations and beliefs a woman forms about breastfeeding on the impact the experience will have upon her (see Appendix 4).

Whilst content varies, the literature agrees that expectations and beliefs about breastfeeding are formed during and prior to pregnancy. In forming expectations, mothers are shown to draw upon a mixture of their own past experiences of, and exposure to, breastfeeding, the expectations of significant others, and public and professional rhetoric and literature (Hauck & Irurita, 2003, Grassley & Nelms 2008, Crossley, 2009).

These early expectations hold significant potential impact on mothers, with expectations of the breastfeeding experience, its establishment, process and discontinuation, linked to wider expectations of motherhood (e.g. Schmied & Barclay, 1999; Hauck & Irurita, 2002; Hauck & Irurita, 2003). Crossley (2009) described a sense of breastfeeding as a "moral imperative" and of "doing

motherhood the right way". A theme of breastfeeding being synonymous with good, or "right" mothering, was echoed throughout the papers, although the work of Cooke, Schmied & Sheehan (2007) highlights that this is not the case for all mothers, with the role of breastfeeding in maternal identity and role attainment varying between women.

Expectations of breastfeeding as being best for baby, of being "natural" and as promoting a strong mother-infant bond were salient throughout the literature, with almost all papers documenting these beliefs as important for mothers. Dykes (2005), however, disagrees that bonding is central for mothers, with just 1 out of the 106 mothers interviewed referring to bonding and attachment to as part of their reasoning for deciding to initiate breastfeeding.

Dykes' (2005) findings are of particular interest as the study is unique in including analysis of observations of interactions between mothers and health professionals as well as interviews. Observation in this way can be viewed as reducing the social pressures on mothers to give certain responses about their breastfeeding when asked direct questions by health professionals who may be perceived as having specific agendas by participants. Similarly, observations of interactions free research from the need for questions to be asked, often using a pre-prepared semi-structured interview schedule, aimed at accessing the aspects of experiences that a researcher feels are most important. Whilst this allows the research to be truly grounded in participants' spontaneous accounts of their lived experiences, it is important to note a coincident increase in the potential for findings to be influenced by the researcher's own perceptions of the interactions observed. As Morrow (2005) argues, for these studies it is important that researchers acknowledge their subjectivity, and deal with this reflexively

throughout the discussion if the origin of the emerging themes is to be shown to be within the participants. Dykes, like the majority of other researchers in the qualitative papers reviewed, fails to make any such statement.

Linked to beliefs about “breast as best” are those of breastfeeding as being the most “natural” infant feeding choice; six papers raised this as important for mothers. For some mothers, however, the research suggests that this can be translated into expectations of breastfeeding as coming naturally (Scott & Mostyn, 2003) leading to a sense of expectations having been unrealistic and of being unprepared for the physicality of breastfeeding or the extent of the problems experienced.

Schmied & Barclay (1999) quantify that 65% of mothers interviewed felt that their expectations of breastfeeding were contradictory to their experiences, leaving them feeling ambivalent and disappointed. A theme of unrealistic expectations was found within all twelve of the papers, regardless of methodology, current breastfeeding status or duration. This research reports that incompatibility between a mother’s expectations and her lived experiences of breastfeeding was linked with lowered self-esteem, confidence and psychological wellbeing.

Despite this, no paper reported a link between unrealistic expectations and discontinuation of breastfeeding, with both continuing and non-continuing mothers reporting unrealistic expectations (Cooke, Schmied & Sheehan, 2007; Hegney, Fallon & O’Brien, 2008). It is suggested that this may be due to moderation of the potential negative impact by the development of more realistic expectations (Hegney, Fallon & O’Brien, 2008; Schmied & Barclay, 1999). Increased realism of mothers’ expectations was found to result from prior

experience of and exposure to breastfeeding, either in person, or through literature (Crossley, 2009; Scott & Mostyn, 2003).

1.4.2 Maternal identity and the internal world

The research indicates that the experience of breastfeeding impacts on mothers' internal worlds. Eighteen of the twenty-three included papers are relevant to developing our understanding of this theme (see Appendix 4).

Of primary significance within the reviewed literature is a discourse of the impact of breastfeeding on mothers' identity and self-concept, with participants describing both positive and negative aspects of their experiences.

Positive effects of changes in role and self-concept were reported by twelve papers. For these mothers, breastfeeding is viewed in terms of gaining a new role of "breastfeeding mother". Within this role, mothers described increasing maternal attentiveness and sensitivity towards their child, increasing a sense of being important and needed, strengthening the mother-child bond and growing confidence in their wider maternal role. Mezzacappa (1997) and Mezzacappa, Guethlein & Katkin (2002) suggest that developing a successful breastfeeding relationship results in reduced physician visits for psychological symptoms, better mood and stress levels for breastfeeding mothers compared to mothers who had never, or who were not currently breastfeeding. In other words, mothers with an active "breastfeeding mother" role were less likely to be distressed than those for whom this role had either lapsed or never been developed.

These positive responses to identity and role change, however, were not universal. Leff, Gagne and Jefferis (1994) describe that whilst some mothers

experienced breastfeeding, despite its difficulties, as natural, harmonious and deeply satisfying, others spoke of breastfeeding as a burden, incompatible with their desired lifestyle, and draining.

Whilst the negative impact of breastfeeding is described by some mothers as “a small price to pay” for the positive, the less favourable impacts of breastfeeding were nonetheless significant for mothers in thirteen papers. Across these papers, mothers reported finding changes to their roles, bodies and sense of physical and emotional independence and autonomy difficult to accept (Dykes, 2005; Hewat & Ellis, 1986; Leff, Gagne & Jefferis, 1994; Schmied & Barclay, 1999). Schmied and Barclay (1999) quantify this, reporting that 25% of participating mothers found breastfeeding disappointing, demanding and disruptive of body and self. Furthermore, 32% of these mothers experienced significant pain during feeding, leading to feelings of breastfeeding as distorting of body and self, and leaving mothers with a sense of being separate and opposing their infants (Schmied & Barclay, 1999).

There is some suggestion that the age of child being breastfed affects the impact of breastfeeding upon its mother, however there is disagreement in the papers as to what this impact might be. Whilst Reamer and Sugarman (1987) found that mothers of older children felt less restricted by breastfeeding, Kendall-Tackett & Sugarman (1995) report the opposite effect that maternal perceptions of restriction due to breastfeeding increased with the age of the child.

The reason behind this discrepancy is unclear; however it is likely to result from the design of the two studies, with Reamer and Sugarman’s (1987) open questioning of mothers leading to a lower incidence of increasing age as

restrictive compared to Kendall-Tackett and Sugarman's (1995) request for mothers to rate a series of specific positive and negative statements about breastfeeding for their applicability to their own experiences. In the latter study, mothers are therefore, clearly prompted to consider whether or not breastfeeding feels restrictive, increasing the risk of leading mothers to give responses they might not have done spontaneously, giving rise to inflated prevalence data.

However they arise, it is nonetheless important to note that negative reactions to breastfeeding do not necessarily result in its discontinuation, and that mothers often choose to continue despite significant physical, emotional and personal costs (Cooke, Schmied & Sheehan, 2007). When discussing their decision to continue, these mothers described a need to balance what is "best" and "right" for both mother and child, viewing breastfeeding as "an identity project to be persevered with" (Dykes, 2005; Schmied and Barclay, 1999) Perseverance, determination, courage and commitment to breastfeed despite the uncertainty and emotional or physical trials were raised by mothers in seven of the reviewed papers. Persisting through and triumphing over these difficulties gave mothers a sense of achievement, and pride, and led mothers to define themselves by their continued breastfeeding (Bottorff, 1990; Manhire, Hagan & Floyd, 2007).

Throughout the papers there is an acknowledgment of variation in the responses mothers had to their experiences of breastfeeding, although few papers attempt to explain why these differences exist. There is very little demographic variability within the included papers; participants across all included studies are reported to be white Caucasian women, almost exclusively primiparous with above average education, and slightly older than the average age of mothers within their countries. Whilst this raises concerns about the external validity of the studies, it

also allows a demographic explanation of breastfeeding's variable impact, to be ruled out; the subjective experiences of these mothers cannot be explained by race, age, parity, education or culture.

Neither can this variability be attributed to the age of the breastfed child, or the duration of the breastfeeding relationship. Whilst mothers who breastfeed for longer durations reported a higher incidence of positive experiences, negative aspects of breastfeeding were reported regardless of feeding duration (Hewat & Ellis, 1986).

The only true attempt to explain the between-participant variability of the findings is the consideration of the concept of breastfeeding Maternal Role Attainment (MRA). This is raised by just three of the papers, and relates the strength of a mother's association of breastfeeding with her wider beliefs about what makes a "good mother" (Cooke, Schmied & Sheehan, 2007; Cooke, Sheehan & Schmied, 2003; Leff, Gagne & Jefferis, 1994). These papers report that mothers with high MRA breastfed for longer overall, regardless of the problems they encountered. In contrast women with low MRA, those for whom breastfeeding was not a central part of mothering, were not only more likely to give up, but were also more likely to be distressed. This links to the earlier themes of maternal expectations of breastfeeding, suggesting that compatibility between a mother's pre-existing beliefs and her lived experiences is central to understanding the impact breastfeeding will have upon her.

1.4.3 Division and breastfeeding

The impact that breastfeeding has on a mother is further moderated by the wider social world in which she lives. Seventeen of the reviewed papers discuss the

effect that the external world has upon breastfeeding mothers, with the expectations and actions of others having a considerable impact on the mothers' own experiences and perceptions of breastfeeding (see Appendix 4).

The earliest impact of others on mothers is the extent to which she has observed breastfeeding prior to the birth of her own child. Mothers within three papers discussed the effects of their prior exposure to breastfeeding, with mothers who were the first among their peers to breastfeed, feeling their decision to breastfeed made them "different" within their social circles.

Regardless of their prior experience of breastfeeding, all mothers described needing advice, support and encouragement from others. Identifying specific sources of support with whom experiences could be shared was seen as increasing mothers' confidence in their own breastfeeding ability, and mothers able to rely upon professional, partner and peer support were shown to be more likely to continue with breastfeeding despite physical difficulties (Hegney, Fallon & O'Brien, 2008).

The level, consistency and appropriateness of the support received however varied greatly across studies even from trained health professionals. Eight papers describe perceptions of professional support as mixed, with many mothers describing episodes of physically invasive and inappropriate, insensitive and inconsistent nursing care that failed to meet their needs, causing them to lose confidence in themselves, breastfeeding and professionals alike (Grassley & Nelms, 2008; Kelleher, 2006; Manhire, Hagan & Floyd, 2007; Mazingo, Davis, Droppelman & Merideth, 2000).

Others do not only impact upon mothers through their support, however, but also through the expectations and beliefs they hold about breastfeeding, a finding discussed by nine papers, making facing the expectations of others the most commonly discussed social impact of breastfeeding. The research reviewed shows that mothers use the expectations of family and friends to judge their success in a mothering role, and where it is felt that they were not meeting others' expectations, mothers describe pressure to conform. Throughout the reviewed papers pressure from family and peers is described as both covert and overt attempts to either coerce mothers to initiate breastfeeding, or to cease breastfeeding when others felt that it was time, often around 6 months of age (Hewat & Ellis, 1986; Kendall-Tackett & Sugarman, 1995).

Mothers across the papers also discuss a sense of social stigma around breastfeeding, with seven papers discussing difficulties around the intersection of breastfeeding and the wider social and cultural world. Social stigma towards breastfeeding increased with the age of the child, with papers reporting between 24-29% of mothers perceiving social hostility towards their breastfeeding a six month old, rising to 42-44% at feeding a child above 12 months of age. By the time of the child's second birthday, this figure had risen to 61% (Kendall-Tackett & Sugarman, 1995; Reamer & Sugarman, 1987).

Whilst this trend is explained in relation to social taboos around breastfeeding older children, with mothers choosing to do so describing facing the judgment and disgust of others, this is not the only explanation. As children get older, mothers in three papers described the importance of discretion during public feeds, with mothers describing being aware of other people's feelings about public nursing (Kendall-Tackett & Sugarman, 1995; Reamer & Sugarman, 1987;

Scott & Mostyn, 2003). Although it was considered to be other people's "issue if they were offended", mothers nonetheless preferred not to discuss their continued breastfeeding, describing "hidden feeds" for older children to avoid negativity and disapproval (Scott & Mostyn, 2003).

Reamer & Sugarman (1987) report that mothers find discretion harder when feeding older, more mobile and verbal toddlers, with 10% of mothers struggling to be discrete at 12 months, compared to just 2.2% at 6 months. It is likely that this decrease in the ability to be discrete is at least partially responsible for the increasing social hostility towards mothers feeding older children.

What is clear, however, is that perceptions of widespread opposition from both family, friends and society as a whole leads mothers to develop a sense of being both divided from, and dividing, others. Mothers spoke of perceiving others as either supportive of breastfeeding, or as an opposing force, to whom breastfeeding must be defended; throughout the papers, dialogues of "them and us" or "finding a tribe" where one can feel "normal" and accepted are raised.

This dialogue of division is particularly strong in the accounts of mothers feeding beyond six months, however, it is important to consider the effect that the sampling method used within the papers dealing with their experiences. Of the four papers dealing specifically with long-term breastfeeding mothers, two accessed participants through La Leche League (LLL) groups or conferences (Faircloth, 2010; Kendall-Tackett & Sugarman, 1995). LLL works to promote breastfeeding by the provision of support, information and education, and mothers attending LLL support groups have noted a form of social control in LLL groups, where group polarisation leads to bias towards extended breastfeeding in

the group leading to accounts of “militancy” and pressure on mothers to feed longer than they initially intended (Faircloth, 2010; Hewstone & Stroebe, 2001).

Finally, although Kendall- Tackett & Sugarman (1995) suggest that the coercive and often negative reactions of others are more likely to have an emotional impact on a mother than to bring about a change in her behaviour, only two papers, both by the same authors, explicitly discuss the nature of this emotional impact (Hauck & Irurita, 2002; Hauck & Irurita, 2003). These papers report that for the mothers interviewed, incompatibility resulted in dissonance, confusion, doubt in one’s own abilities and guilt, reducing maternal self-concept and self-esteem. Hauck and Irurita (2002) go on to propose that mothers resolve this dissonance by a process of selective focussing. Mothers weighed expectations’ content, impact and source, before choosing which to embrace whilst simultaneously distancing themselves from sources perceived as incompatible, incredible or coming from others not perceived as reliable or not within the mother’s immediate social circle.

It is important to note, however, that not only do these two papers share their authors, but also report the experience of the same sample of thirty-three mothers. Participants were selected using purposeful sampling from a larger study to represent as wide a range of breastfeeding and weaning experiences as possible and transcripts were analysed using Grounded Theory. Selecting all participants beforehand, in order to meet preconceived criteria, however, violates a central tenet of Grounded Theory. The method demands theoretical sampling, where, following the first interviews, subsequent participants are selected to further explore the emerging themes in the data (Coyne, 1997). Morse (1991) warns that blurring the boundaries of qualitative methodology in this way reduces

both methodological rigour and the ability for true saturation to be achieved (Charmaz, 2006).

1.4.4 Facing problems, uncertainty and change

Throughout the reviewed papers, mothers describe being particularly vulnerable during both breastfeeding difficulties and periods of change. Fifteen papers raise these periods as posing psychological risk for mothers (see Appendix 4).

Mothers in three papers described change as a fundamental aspect of breastfeeding. Mothers felt breastfeeding required them to accept inherent uncertainties about ability and supply, to continually readjust and persevere despite distress at physical changes and the lack of rhythm and predictability (Bottorff, 1990; Dykes, 2005; Schmied & Barclay). Dykes (2005) paper goes further to describe decisions to express milk or introduce formula as mechanisms for helping mothers cope with uncertainty and regain control over their breastfeeding, role and return to a “normal” life.

One of the most uncertain phases of breastfeeding is raised by four papers to be the experiences of breastfeeding problems. Between 32 and 66% of mothers described breastfeeding problems, pain and discomfort during the early weeks of breastfeeding, and whilst the prevalence of problems fell as breastfeeding duration increased, 28% of mothers continued to experience problems at 3 months (Cooke, Sheehan & Schmied, 2003; Schmied & Barclay 1999).

Breastfeeding problems and nipple pain are linked to higher levels of depression, tension, fatigue and confusion, and reduced mothers’ satisfaction with their maternal identities and lifestyles, as well as their perceptions of their infants’

enjoyment of breastfeeding (Amir, Dennerstein, Garland, Fisher & Farish, 1996; Cooke, Sheehan & Schmied, 2003). When problems clashed with mother's early expectations of breastfeeding, and were combined with perceptions of inadequate assistance, mothers described increasing disillusionment with breastfeeding and emotional and physical exhaustion leading to a "breaking point" where a decision had to be made about whether or not to continue (Amir et al, 1996; Hegney, Fallon O'Brien, 2008). Mothers weighed the perceived impacts of potential decisions about weaning for themselves and their role as mothers, their child and families as a whole, and wider social expectations and beliefs (Hauck & Irurita, 2003).

Similarly, the reasoning behind a decision to wean is also important. Whilst the minority of mothers within the research who felt they had reached a natural ending point still reported sadness and loss of their child's "babyhood" and the unique relationship of breastfeeding, they were also able to express satisfaction and relief at being able to move on to the next stage. For others, for whom this mutual readiness was not reached, mothers described feeling "pushed" to wean, by their child, their families, their return to work, physical difficulties, medication or illness (Hauck & Irurita, 2003). For these mothers, although some expressed initial relief at cessation, discourses of guilt, failure, inadequacy, regret and disappointment inevitably prevailed. (Bottorff, 1990; Lamontagne, Hamelin & St-Pierra, 2008; Hegney, Fallon & O'Brien, 2008; Mazingo et al, 2000). Shame at having discontinued was also important for these mothers, with mothers feeling unable to admit their decisions to either peers or professionals (Crossley, 2009).

Mothers for whom breastfeeding was most closely linked to maternal role were between two and seven times more likely to be distressed by weaning, especially

where their own physical limitations and needs were central in the decision to wean (Cooke, Schmied & Sheehan, 2007; Crossley, 2009; Kelleher, 2006).

Mothers who discontinued breastfeeding were shown not only to have higher levels of psychological symptoms, worse mood and higher stress levels than mothers who continue breastfeeding, with the gap widening as time since the last breastfeed increased, but also fared worse emotionally than those who never breastfed at all (Mezzacappa, 1997; Mezzacappa, Guethlein & Katkin, 2002).

These findings are of particular importance in understanding the psychological impact that weaning has upon mothers (Mezzacappa, 1997; Mezzacappa, Guethlein & Katkin, 2002). This is because they alone discriminate between mothers who are currently breastfeeding, those who have previously breastfed and exclusively bottle-feeding or non-breastfeeding mothers. The findings of these two papers show that failure to discriminate between non- and previously-breastfeeding mothers may mask the full impact of discontinuation.

Reports of higher incidences of psychological problems, mood disturbance and stress in non breast-feeding mothers in policy and research must, therefore, be explored to identify whether the effects observed are, as proposed, truly a result of bottle-feeding, or whether the impact of breastfeeding cessation might underlie the results.

Even so, in discussing the impact of discontinuing breastfeeding, the reviewed papers illustrate that the psychological effects of breastfeeding can continue long after mothers have weaned their children. In Mozingo et al's (2000) study nearly

all mothers spoke of doubts about the decision to discontinue, lasting for months or even years before resolution occurs.

Interestingly, given its implications for therapeutic and clinical practice, only four papers discuss the mechanisms by which mothers reduce dissonance and reach resolution following weaning. Hauck & Irurita (2002) describe a process of reflecting back over their experiences, rationalising decisions by weighing the positive outcomes for mother, child and extended family, and acknowledging the mixed feelings that weaning brings. This process is confirmed by other papers, where mothers described weighing their child's needs against personal, practical and family needs, and acknowledged the extent to which personal and social expectations and pressure to continue affected their decisions (Bottorff, 1990; Hauck & Irurita, 2003; Hegney, Fallon & O'Brien, 2008). This process of resolution is described by mothers as leading to the realisation of the inevitable need to move on. Reassured that they were "good enough" and with a sense of satisfaction at having "hung in there" for a time, mothers were able, finally, to move on from breastfeeding to the next stage of motherhood (Bottorff, 1990; Hauck & Irurita, 2002).

1.5 Methodological limitations

1.5.1 Methodology and study design

The dominance of qualitative methodologies in the reviewed papers (seventeen out of twenty-three papers) has produced strong correspondence between the findings of the impact of breastfeeding on mothers' psychological wellbeing.

Given the subject matter, qualitative and "feminist" research methods are invaluable (Crossley, 2009) and the recurrence of all four major themes across

the reviewed papers suggest strong support for these, however, several factors call this suggestion into question.

The previously mentioned concerns about authors' choices of sampling methods which may affect the rigour of the qualitative methodologies used, and the effects of such homogeneous participants across the reviewed literature, is further affected by the omission of key methodological concepts from the papers themselves.

Whilst qualitative studies are exempt from the effect size demands of quantitative methodologies, and small samples sizes are not automatically problematic (Charmaz, 2006), there is, nonetheless, a requirement to have thoroughly explored the experiences in question. This is often considered in terms of having reached "saturation" – the point at which a researcher is no longer drawing out new themes from the data, not just through gaining more participants, but also by allowing the emerging theory to guide recruitment to allow a full exploration of the experiences raised by earlier participants.

Not one of the seventeen qualitative papers includes a statement as to whether saturation was reached, or indeed whether any efforts were made to attempt to achieve this, raising doubts as to whether experiences have been indeed been fully explored (Charmaz, 2006; Coyne, 1997).

1.5.2 Researcher subjectivity and bias

Only one author out of the seventeen qualitative papers reviewed makes an explicit statement about their own position within the research (Crossley, 2009). Failure to acknowledge the researchers' subjectivity and discuss its potential

influence on the research is a significant methodological error. Morrow (2005) argues that in failing to acknowledge their own perspectives in research, qualitative researchers leave themselves open to questions regarding whose perceptions are really being described in the findings. Indeed, there is clear evidence to suggest that many of the authors failing to declare their position within the research may hold certain stances towards breastfeeding, with many holding clinical positions in the health organisations serving the mothers accessed for the research (Grassley & Nelms, 2008; Mozingo et al, 2000). Given that the researchers did not discuss the influence of researcher position and subjectivity in the research process it is hard to estimate how this may have influenced their findings. Although the high level of agreement across all reviewed papers, regardless of methodologies, suggests it would be reasonable to assume only minimal influence, this lack of clarity does call the true accuracy of the findings into question.

Researcher subjectivity can also be observed in the review papers as affecting the manner in which their findings are discussed. Pro-breastfeeding biases are observable just below the surface in several papers, with authors' own preconceptions and biases being transmitted, no doubt unintentionally, through the terminology used to discuss their findings; for example, in their paper in to the differences between mothers who continue and discontinue breastfeeding in the face of extraordinary breastfeeding problems, Hegney, Fallon and O'Brien (2008) articulate continuing mothers' accounts of action as "demonstrating" determination or flexibility. However, in the same paper, discontinuing mothers' accounts of actions, rather than being similarly described as "demonstrating" their perspectives, they are depicted as "justifying their behaviour". The research suggests that these pro-breastfeeding biases are reflected across policy and

clinical practice, and raises the question of how open a mother may feel to discuss the negative impact breastfeeding has had upon her to health professionals on whom she relies upon for care and views as having a vested interest in a particular viewpoint.

1.6 Conclusions

1.6.1 Discussion of the findings

The review aimed to explore current understanding of the psychological impact of breastfeeding on mothers through highlighting salient themes within the reviewed literature. Four recurring themes were identified within the literature as important.

The research suggests that common antenatal expectations of breastfeeding as “natural”, “best” and “right” lay the paving stones for the impact breastfeeding will have upon mothers. Where contradictions exist between mothers’ expectations and experiences, dissonance arises, leading to lowered self-esteem, confidence and psychological wellbeing.

Post-natally, the breastfeeding experience itself brings about changes in mothers’ roles and internal world. Research into the impacts of these changes suggests variable effects. Whilst many mothers describe a successful, harmonious breastfeeding relationship which is seen as protecting a mother from psychological difficulties, others describe breastfeeding as distressing, disruptive and restrictive. Regardless of their perceptions, all mothers felt that the identity work of breastfeeding required persistence, courage and determination to complete, with the extent to which a mother links breastfeeding with wider success as a mother mediating the impact that breastfeeding success, or failure, will have on her.

With regard to the social world, mothers desired an ideal of sensitive, consistent and appropriate support from family, peers and professionals; however this was rarely achieved within the reviewed papers. Instead, incompatibility of the attitudes and expectations of others and society were noted, with mothers describing direct and indirect attempts to influence their behaviour, and a dialogue of social stigma and hostility was raised, leading mothers, especially those feeding for extended durations, to a sense of “them and us” reflecting a group stand in face of perceived and actual societal opposition.

Finally, mothers discuss the impact of change and uncertainty within their breastfeeding, which requires them to persist through feelings of lack of control and predictability. Periods of breastfeeding problems and eventual discontinuation are discussed as particularly vulnerable times of uncertainty, with mothers, especially those for whom family and peer support was limited, once again expressing disappointment in the professional support available to them. A long and difficult journey through guilt, regret, inadequacy and shame was described before mothers felt they reached a point of final resolution and progression from breastfeeding and its emotional impacts.

Although the reviewed papers provide us with information about the varied impacts that breastfeeding is most likely to have on mothers, very few papers discuss the mechanisms by which these effects occur. This is a significant gap in the current answer to the review question, and further work to explore this is needed.

Whilst there exists in the wider literature papers exploring the applicability of theories such as Azjen's (1991) Theory of Planned Behaviour (Stockdale, 2001) and Bandura's social cognitive theory (Pollard, 2011) these lack adequate consideration of the emotional factors so prominent within mothers' breastfeeding experiences, and, as yet, have been applied only to the task of furthering understanding and influence levels of breastfeeding initiation and durations.

In order to better understand mothers as psychological beings, rather than simply statistics on public policy documents, future research should consider further investigation of how more complex psychological models might be applied to the field. For example, the contributions that theories such as the Health Belief model (Rosenstock, Strecher & Becker, 1988) or Self Determination Theory, with its recent links to Motivational Interviewing (Markland, Ryan, Tobin & Rollnick, 2005) might make to our understanding of the maternal impact of breastfeeding should be explored to provide guidance on how mothers might be supported through periods of psychological vulnerability.

1.6.2 Recommendations for future research

Currently, there is significantly more qualitative than quantitative research within the literature on the psychological impact of breastfeeding on mothers. These phenomenological methods are essential to understanding the lived experiences of participants, and are useful as exploratory methods, helping to generate new models of theory and understanding of lived experiences, on which further quantitative work can be based. It is now, therefore, important for further quantitative research in the area to be conducted, with a view to testing the validity and prevalence of the themes described. Given the issues with sampling

methods raised within the qualitative research, the use of randomised controlled trials would be valuable.

The current review of the literature has highlighted a gap in the research carried out into the impact of discontinuing, or failing to fully establish, breastfeeding on mothers' psychological wellbeing. Whilst the impact of discontinuing breastfeeding was discussed by eleven papers, only three made quantitative consideration of the impact of discontinuation (Cooke, Schmied & Sheehan, 2007; Mezzacappa, 1997; Mezzacappa, Guethlein & Katkin, 2002). Further research into the area could consider the prevalence and exact nature of mothers' reactions to weaning across a wider section of the population. This research would assist the development of academic and clinical understanding which will further guide service provision for new mothers.

1.6.3 Clinical implications of the review

Review of the literature has revealed that breastfeeding has a significant and varied psychological effect on mothers, beginning with the formation of her perinatal expectations of her breastfeeding experiences, and ending some time after the last time she feeds her infant. The precise impact a mother's experience will have upon her has been shown to be mediated by appropriate, timely and sensitive professional and social support. Mothers report that current service provision is inconsistent and perceive that their needs around breastfeeding problems and weaning go unmet. This results not only in distress, but also the loss of confidence in themselves, breastfeeding and professionals.

To maximise the impact on public health and wellbeing, it is crucial that research and clinical practice inform policy, bringing it in to line with service user

consultation and good practice standards, rather than taking a policy-first stance, where meeting targets, such as a set level of breastfeeding initiation, takes precedence over the true needs of clinical populations.

Where policy leads practice, obvious avenues for intervention may be ignored or overlooked. For example; in pursuit of increasing breastfeeding rates, the UNICEF Baby Friendly Initiative (1991) estimates the saving to the NHS if all babies were breastfed would be over £35million in England and Wales, treating gastro-enteritis alone. In response, health service trusts signed up to the initiative have worked hard to promote breastfeeding. However, given the link between gastro-enteritis and bottle-feeding practices, the question arises as to whether a similar saving might also be accrued by improving antenatal education around bottle-feeding, or working to reduce women's shame and guilt regarding breastfeeding discontinuation, in turn increasing maternal uptake of support for ideal bottle-feeding practice.

The role of both society and the health professionals working with families has also been highlighted as important by the review. The strong reactions to the varied support which mothers received during breastfeeding highlight the need for increased clinical awareness of the emotional and psychological impact of mothers. Maternal distress could be significantly reduced by additional support aimed at periods of particular emotional vulnerability for mothers; it appears that mothers who consider weaning their infants from the breast may require additional, sensitive support, recognising the complex social and psychological implications of cessation.

Clinical psychology services could helpfully consider their role in service provision in relation to breastfeeding mothers. A dual approach of either direct support for women experiencing distress around breastfeeding, or adding value to the input of other frontline staff would seem appropriate. Through the provision of client work and staff training, consultation and supervision significant improvements to current service provision for this vulnerable period for mothers could be made (Labbok, 2008).

The provision of psychological supervision is especially important if, as Eccleson (2005) suggests, staff themselves find distress around breastfeeding cessation difficult to manage and tolerate. If further research indicates this to be the case, there is also a role for psychologists here. By offering support to colleagues working with mothers, often one-to-one, in the community, both patient and professional distress could be managed adequately before, during and after the breastfeeding experience.

1.6.4 Conclusions

Through a systematic review of the current literature recurrent themes have been revealed within mothers' lived experiences of breastfeeding. It is clear that the choice to breastfed has significant implications for mothers as well as their infants. In conclusion, the author calls for open acknowledgement of the wider psychological consequences of breastfeeding, with a view to developing current service provision and health policy to incorporate the diverse needs of mothers throughout breastfeeding and weaning.

1.7 References

(* denotes papers included in the review)

*Amir LH, Dennerstein L, Garland SM, Fisher J & Farish SJ (1996) Psychological aspects of nipple pain in lactating women. *Journal of Psychosomatic Obstetric Gynecology*, 17: 53-58.

Azjen I (1991) The theory of planned behaviour. *Organizational behaviour and human decision processes* 50: 179–211.

Boiling K, Grant C, Hamlyn B. & Thornton A. (2005) *Infant Feeding Survey 2005*. UK: NHS.

*Bottorff J L (1990) Persistence in breastfeeding: a phenomenological investigation. *Journal of Advanced Nursing*, 15: 201-209.

Charmaz K (2006) *Constructing Grounded Theory: A practical guide through qualitative analysis*. London: Sage Publications.

*Cooke M, Schmied V & Sheehan A (2007) An exploration of the relationship between postnatal distress and maternal role attainment, breast feeding problems and breast feeding cessation in Australia. *Midwifery* , 23: 66-76.

*Cooke M, Sheehan A & Schmied V (2003) A description of the relationship between breastfeeding experiences, breastfeeding satisfaction and weaning in the first 3 months after birth. *Journal of Human Lactation*, 19(2): 145-156.

Coyne IT (1997) Sampling in qualitative research - Purposeful and theoretical sampling; merging or clear boundaries. *Journal of Advanced Nursing*, 26: 623-630.

*Crossley ML (2009) Breastfeeding as a moral imperative: An autoethnographic study. *Feminism and Psychology*, 19: 71-87.

- Dennis C (2002) Breastfeeding initiation and duration: a 1990-2000 literature review. *Journal of Obstetric, Gynecologic & Neonatal Nursing* , 31(1): 12-32.
- Dennis C & McQueen K (2009) The relationship between infant-feeding outcomes and postpartum depression: a qualitative systematic review. *Pediatrics*, 124(4): 736-751.
- Department of Health (2000) *Infant feeding survey 2000*. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4079223.
- Department of Health (2005) *Infant feeding survey 2005*. Available at: www.ic.nhs.uk/pubs/ifs2005.
- Duijts L, Ramadhani M & Moll H (2009) Breastfeeding protects against infectious diseases during infancy in industrialized countries: A systematic review. *Maternal and Child Nutrition*, 5: 199-210.
- *Dykes F(2005) 'Supply' and 'demand': breastfeeding as labour. *Social Science and Medicine*, 60: 2283-2293.
- Eccleson M (2005) Ending breastfeeding: How does psychodynamic thinking inform breastfeeding services in helping women wean their babies from the breast? *Infant Observation*, 8(2): 139 - 155.
- Equality Act, c15. U.K. (2010).
- *Faircloth CR (2010) "If they want to risk the health and wellbeing of their child, that's up to them": long term breastfeeding, risk and maternal identity. *Health, Risk and Society*, 12(4): 357-367.
- *Grassley JS & Nelms TP (2008) Understanding maternal breastfeeding confidence: A gadamerian hermeneutic analysis of women's stories. *Health Care for Women International*, 29: 841-862.

- *Hauck Y L & Irurita VF (2002) Constructing Compatibility: Managing Breast-Feeding and Weaning From the Mother's Perspective. *Qualitative Health Research* , 12 (7): 897-914.
- *Hauck YL & Irurita VF (2003) Incompatible Expectations:The Dilemma of Breastfeeding Mothers. *Health Care for Women International*, 24: 62-78.
- *Hegney D, Fallon T & O'Brien ML (2008) Against all odds: a retrospective case-controlled study of women who experienced extraordinary breastfeeding problems. *Journal of Clinical Nursing* , 17: 1182-1192.
- Hek G, Langton H, & Blunden G (2000) Systematically searching and reviewing literature. *Nurse Researcher* , 7(3): 40-57.
- *Hewat RJ & Ellis DJ (1986) Similarities and difference between women who breastfeed for short and long duration. *Midwifery*, 2: 37-43.
- Hewstone M & Stroebe W (2001) *Introduction to Social Psychology* (3rd ed.). Oxford: Blackwell Publishers Ltd.
- Hill PD, Aldag JC, Demirtas H, Zinaman M & Chatterton RT (2006) Mood states and milk output in lactating mothers of preterm and term infants. *Journal of Human Lactation*, 22: 305-314.
- *Hills-Bonczyk SG, Tromiczak KR, Avery MD, Potter S, Savik K & Duckett LJ (1994) Women's experience with breastfeeding longer than 12 months. *Birth*, 21(4): 206-212.
- Horta BL, Bahl R, Martines JC & Victora CG (2007) *Evidence on the long-term effects of breastfeeding: Systematic reviews and meta-analyses*. Geneva: World Health Organization.
- *Kelleher CM (2006) The physical challenges of early breastfeeding. *Social Science and Medicine*, 63: 2727-2738.
- *Kendall-Tackett KA & Sugarman M (1995) The social consequences of long-term breastfeeding. *Journal of Human Lactation*, 11(3): 179-183.

- Kramer MS & Kakuma R (2004) The optimal duration of exclusive breastfeeding: a systematic review. *Advances in Experimental Medicine and Biology*, 554: 63-77.
- Labbok M (2008) Exploration of Guilt Among Mothers Who Do Not Breastfeed: The Physician's Role. *Journal of Human Lactation*, 24: 80-84.
- LaMarre AK, Paterson LO & Gorzalka BB (2003) Breastfeeding and postpartum sexual functioning: A review. *The Canadian Journal of Human Sexuality*, 12(3-4): 151-168.
- *Lamontagne C, Hamelin A & St-Pierre M (2008) The breastfeeding experience of women with major difficulties who use the services of a breastfeeding clinic: a descriptive study. *International Breastfeeding Journal*, 3: 17-30.
- *Leff EW, Gagne MP & Jefferis SC (1994) Maternal perceptions of successful breastfeeding. *Journal of Human Lactation*, 10(2): 99-104.
- *Manhire KM, Hagan AE & Floyd SA (2007) A descriptive account of New Zealand mothers' responses to open-ended questions on their breastfeeding experiences. *Midwifery*, 23: 372-381.
- Markland D, Ryan RM, Tobin V & Rollnick S (2005). Motivational interviewing and self-determination theory. *Journal of Social and Clinical Psychology*, 24: 811–831.
- Meedya S, Fahy K & Kable A (2009) Factors that positively influence breastfeeding duration to 6 months: A literature review. *Women & Birth*, 23(4): 135-145.
- *Mezzacappa ES (1997) A Preliminary Study of the Effects of Breast-Feeding on Maternal Health. *International Journal of Behavioural Medicine* , 4 (3): 230-241.
- Mezzacappa ES (2004) Breastfeeding and Maternal Stress Response and Health. *Nutrition Reviews*, 62: 261–268.

- *Mezzacappa ES, Guethlein W & Katkin ES (2002) Breast-feeding and maternal health in online mothers. *Annals of Behavioral Medicine*, 24(4): 299-309.
- Moran VH, Edwards J, Dykes F & Downe S (2007) A systematic review of the nature of support for breastfeeding adolescent mothers. *Midwifery*, 23(2): 157-171.
- Morrow S (2005) Quality and trustworthiness in qualitative research in counselling psychology. *Journal of Counselling Psychology*, 52(2): 250-260.
- *Mozingo J N, Davis M W, Droppleman PG & Merideth A (2000) "It Wasn't Working": Women's Experiences with Short-Term Breastfeeding . *American Journal of Maternal Child Nursing* , 25(3): 120-126.
- National Institute for Health and Clinical Excellence (2008) *Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households*. Available at: www.nice.org.uk/nicemedia/live/11943/40092/40092.pdf.
- Pollard D (2011) Impact of a Feeding Log on Breastfeeding Duration and Exclusivity. *Maternal & Child Health Journal* 15(3): 395-400.
- *Reamer SB & Sugarman MD (1987) Breastfeeding beyond six months: Mothers' perceptions of the positive and negative consequences. *Journal of Tropical Pediatrics*, 33: 93-97.
- Rosenstock IM, Strecher VJ & Becker MH (1988) Social learning theory and the health belief model. *Health Education Quarterly*, 15(2): 175-83.
- *Schmied V & Barclay L (1999) Connection and pleasure, disruption and distress: Women's experience of breastfeeding. *Journal of Human Lactation*, 15(4): 325-334.
- *Scott JA & Mostyn T (2003) Women's experiences of breastfeeding in a bottle-feeding culture. *Journal of Human Lactation*, 19(3): 270-277.

- Stockdale J (2001) A measure of intention: the theory of planned behaviour applied to breastfeeding. *RCM Midwives Journal*, 4(10): 330-333.
- Susman VL & Katz JL (1988) Breastfeeding and depression: another postpartum complication. *American Journal of Psychiatry*, 145(4): 498-501.
- Taylor SE (2003) *Health Psychology* (5th ed.). New York: McGraw -Hill
- Thorley V (2005) Latch and the fear response: Overcoming an obstacle to successful breastfeeding. *Breastfeeding Review*, 13(1): 10-11.
- UNICEF (1991) *The UNICEF UK Baby Friendly Initiative*. Available at: www.babyfriendly.org.uk/pdfs/infosheets/introduction_infosheet.pdf.
- Wambach K (1998) Fatigue in breastfeeding primiparae during the first nine weeks postpartum. *Journal of Human Lactation*, 14: 219-229.
- Weaver J & Ussher J (1997) How motherhood changes life - a discourse analytic study with mothers of young children. *Journal of Reproductive and Infant Psychology*, 15(1): 51-68.
- World Health Organization (2003). *Global Strategy for Infant and Young Child Feeding, The Optimal Duration of Exclusive Breastfeeding*. Available at: www.who.int/child_adolescent_health/documents/9241562218/en/index.html.
- World Health Organization (2010) *Infant and young child nutrition: Report by the Secretariat*. Available at: http://apps.who.int/gb/ebwha/pdf.files/WHA63/A63_9_en.pdf.

Chapter Two

Exploring Paternal Experiences of Traumatic Childbirth

Target Journal: The Journal of Health Psychology

See Appendix 1(a) for Instructions for Authors

Word Count (Excluding abstract, tables, figures and references): 6438

2.1. Abstract

Research indicates that most fathers attend their children's births, and that this may have a significant impact upon them. Relatively little is known, however, of the impact of attendance at traumatic childbirth. Addressing this gap in the literature, the current study generated theoretical concepts from a grounded theory analysis of six interviews with fathers and a model of their experiences is presented. Within the context of their past experience and confidence in the care provided, fathers cycled between seeking control, passive observing, and helplessness. Fathers' views on their own futures, as well as future research and service provision are discussed.

2.2. Introduction

In most western countries there is a well-established trend for fathers to attend the births of their children. Whilst in the 1960s it was almost unheard of for a father to be present during delivery, twenty years later figures had risen to 80% of American fathers (Palkowitz, 1987). Recent studies suggest that this figure has continued to rise, with 93 to 98 % of British fathers who live with their partners during pregnancy attending the birth of their child (Kiernan & Smith, 2003; National Health Service, 2005). Whilst variation was found in these rates when considering geographic area, social class, and ethnicity, it is clear that attending childbirth is a significant event in the lives of many men in the post-industrialised world (Burgess, 2008).

As a result, research into fathers' experiences of birth attendance has also increased in prominence within the literature, and reflects a significant shift in the professional tolerance of fathers' presence within the delivery room over recent decades (Draper, 1997). In their investigation into fathers' feelings after accompanying their partners in labour and delivery, Chan and Paterson-Brown (2002) found that most fathers were eager to attend the birth, and although the lack of a defined purpose within the delivery room meant that their role was often unclear, the vast majority of men found it to be a positive experience (Chan & Paterson-Brown, 2002; Longworth, 2006).

The evidence also suggests that labouring mothers benefit from fathers' presence in the delivery room. A Cochrane Review of the impact of a continuous supportive birth partner for mothers during labour found that such support reduces the need for intra-partum analgesia, assisted or caesarean deliveries, and is correlated with shorter labours. Mothers who received continuous support

from a chosen member of their social or family networks, such as a partner, were also more likely to be satisfied with their birth experiences (Hodnett, Gates, Hofmeyr, Sakala & Weston, 2011).

Fathers themselves, however, were likely to underestimate the value of the support they provided during labour, with mothers finding them more helpful than the fathers themselves felt they had been (Chan & Paterson-Brown, 2002). This is particularly marked during instrumental or caesarean births, where fathers reported feeling less able to offer useful support, and finding the experience more traumatic than fathers in attendance at normal vaginal deliveries (Chan & Paterson-Brown, 2002).

For mothers, the potential traumatic impact of birth, particularly where emergency medical interventions are required, has been increasingly studied. Research estimates the maternal prevalence of meeting the full diagnostic criteria for Post Traumatic Stress Disorder (PTSD) following childbirth is estimated to be between 1 and 6% of all new mothers, with significantly more experiencing partial symptomatology (Ayers & Pickering, 2001; Creedy, Shochet & Horsfall; 2000; Parfitt & Ayers, 2009; White, Matthey, Boyd & Barnett, 2006; Zaers, Waschke & Ehlert, 2008).

It would appear that fathers may also be affected psychologically by traumatic birth. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders IV Text Revision (DSM IV TR, 2000) definition for Post Traumatic Stress Disorder (PTSD) states that an event may be viewed as traumatic not only where an individual has either experienced an event involving actual or threatened death or serious injury to themselves, but also where they

have witnessed this threat to another. With respect to these criteria, it is clear that childbirth holds the potential to be a traumatic experience, not only for labouring mothers, but also for fathers present as traumatic birth occurs.

As might be expected given the DSM IV TR (2000) definition, Ayers, Wright and Wells (2007) found comparable levels of Post traumatic Stress Disorder (PTSD) symptoms in mothers and fathers. In a quantitative study of fathers' reactions to birth, Bradley, Slade and Leviston (2008) report that although no father described clinically significant symptoms across all three dimensions of intrusion, avoidance and hyper-arousal required to make a diagnosis of PTSD, 12% of participants reported clinically significant symptoms on at least one dimension. Attendance at the actual delivery, feeling distressed during childbirth and feeling less prepared were all identified as key predictors of symptoms (Bradley, Slade & Leviston, 2008).

Failing to obtain adequate support from staff during and immediately after birth has also been shown to increase the risk of perinatal distress for both parents (Allen, 1998). It is feasible, however, that fathers may be at greater risk of being affected by inadequate support given the focus of the delivery room team on mother and child. Whilst this must necessarily remain the case, it would appear undeniable that there is a responsibility for services to recognise and support fathers' needs and roles during childbirth (Draper, 1997; Longworth, 2006).

Despite this, there remains a strong maternal focus within qualitative research of traumatic birth experiences, and as such, very little is known about fathers' perceptions of, and reactions to, traumatic childbirth, and consequently little provision is currently available for providing adequate support for their needs.

This paper, therefore, aims to widen current understanding by accessing fathers' accounts of their children's births. The research aims to explore the central themes of their experiences and reactions to them, by seeking to answer the following research questions:

- i. What are fathers' experiences of traumatic labour and delivery?
- ii. What are fathers' views on current and future service provision?

In answering these questions, the accounts provided by fathers will be considered in context of the existing literature, and the implications for research and clinical service provision will be raised.

2.3. Method

Given the lack of prior research into the area, it was felt that an explorative qualitative methodology would be most appropriate to address the research aims. Qualitative methods allow in-depth, participant-led exploration of lived experience, free from the influence of preconceived theory or hypotheses about what will emerge from the research. Of the qualitative methodologies, Grounded Theory was selected as the most suitable as it not only explores participants' experiences but also allows theory to be generated from the data (Glaser & Strauss, 1967). The latter was considered particularly useful given the lack of existing knowledge in the subject area.

2.3.1. Ethical Approval

In accordance with professional and academic guidelines, ethical approval was sought from both the Coventry University Ethics Committee (see Appendix 2a), and local NHS Regional Ethics Committee (see Appendix 2b) and relevant local Research and Development NHS Trust departments (see Appendix 2c). Approval

to proceed with an amendment to the original recruitment procedure was later obtained from representatives on the Coventry University and Regional Ethics Committee panels.

The research was conducted in line with the British Psychological Society's codes of ethical conduct and confidentiality (British Psychological Society, 2009); informed consent was obtained from all participants prior to interview (see Appendix 7), and details of how to withdraw from the research was provided and reiterated throughout the research process. Given the sensitive nature of the topics under discussed, participants were also provided with a list of local and national services able to provide guidance and support should they become distressed during or after their involvement in the research.

2.3.2. Participants

Participants were initially recruited through a hospital postnatal group, run by the Physiotherapy Department, and facilitated by Clinical Psychology, in the West Midlands region of the United Kingdom. This group is offered to all mothers who have experienced a difficult labour or delivery at the hospital; primarily defined by assessment of the physical impact on the mother (see Appendix 5), although emotional and psychological complications due to birth may also prompt a referral.

Mothers attending the groups between November 2010 and April 2011 were asked to take introductory details of the study home to their partners, inviting them to contact the researcher for further information. Fathers who responded were then sent an information pack on the aims of the study, a screening questionnaire gathering data about the family and birth, and a consent form.

Details of recommended sources of support services were also sent out (see Appendix 7).

Four fathers from the hospital postnatal group responded with final consent to participate. In line with Charmaz's (2006) method of Grounded Theory, once interviewing had commenced and themes began to emerge from the data, a further two fathers were recruited using theoretical sampling from responses to an advert placed on the Oxford Perinatal Mental Health Research Group website. Six fathers had been interviewed; although recruitment remained active, no further participants were identified prior to the close of the study. Although a good level of consistency was observed between the themes emerging across fathers' accounts, true saturation of data for the study cannot be stated due to low participant numbers (Coyne, 1997).

Participants ranged in age from 28 to 46 years old, with a mean age of 34 years. All participants were discussing the birth of their first child, and ranged from 7 to 56 months after the birth. Two participants had had a second child since the birth under discussion; the second birth was not reported as traumatic by either father. All participants were married to their child's mother, were in continuous employment and were native English speakers, living in the Midlands region of the United Kingdom.

All participants were offered, and accepted, a written summary of the results upon completion of the research. Results were also presented for dissemination to the mental and physical health teams involved in recruitment.

2.3.3. Interview Schedule

For the purposes of the interviews, a semi-structured schedule was developed. In line with the research aims, this sought to access fathers' experiences of labour and delivery, the support offered during and afterwards, and their perceptions of the implications of their experiences (see Appendix 6).

Although the basic format of the interview remained similar for all participants, in line with Grounded Theory methodology, the process remained flexible, open and non-directive, allowing participants to guide the interview to ensure their experiences were explored fully (Chiovitti & Piran, 2003).

2.3.4. Procedure and Analysis

Following receipt of full ethical approval, interviews with fathers were digitally recorded and transcribed verbatim. Transcripts were then analysed using Grounded Theory methodology, as specified by Charmaz (2006), and coding was aided by the use of Atlas Ti, a qualitative data management computer programme, which assists with the organisation and coding of interview data (Atlas.ti.1999).

In accordance with Charmaz's (2006) protocol, analysis of the data gathered was conducted in three discrete stages:

- i. Initial coding of transcripts, in turn, describing the content of each section of the interview, line-by-line. Initial codes were action-oriented, and used participants' own terminology and expression whenever possible.
- ii. Focused and Axial coding; separating, sorting and synthesising the line-by-line codes into discrete categories and subcategories in order to reflect themes in the data and specify relationships between subcategories.

- iii. Axial codes were then further organised into theoretical codes, for which relationships were determined, allowing the construction of a model illustrating the emergent themes of participants' original accounts.

Progression through these stages is not linear. After the initial interviews, Charmaz (2006) highlights the importance of further clarifying emerging themes and categories by the elicitation of further accounts using theoretical sampling to select participants potentially able to elaborate upon them. Theorising is deemed complete only once new categories, or properties of categories, cease to emerge during data collection (Charmaz, 2006). During this study, a high level of consistency was present in participants' accounts, with later interviews adding clarification rather than elaboration of emergent themes, although it is acknowledged that additional participants would have been required to reach true saturation.

2.3.5. Reliability and Validity

Whilst reliability and validity, due to their roots in the positivist perspective, are most frequently concepts associated with quantitative research, they also have importance for qualitative research, although reconsideration of their meanings may be necessary. Golafshani (2003) suggests that, for constructivist qualitative methodologies such as grounded theory, reliability and validity should be conceptualised as trustworthiness, rigour and quality.

Chiovitti and Piran (2003) argue that in order to maximise rigour in grounded theory, the inquiry process must be guided by participants and the theoretical constructs generated must remain as close to participants' accounts as possible, and be cross-checked against participants' original meanings and experiences. In line with Charmaz's (2006) method, therefore, codes remained action oriented,

and participants' own terminology and expressions were preserved at all levels of construction (see Appendix 8). Excerpts of the primary researcher's initial coding were cross checked against those of other qualitative researchers to further ensure fit of the codes to the original transcripts and confirm adherence to the selected method (Charmaz, 2006).

Finally, it is necessary for constructivist research to articulate the researcher's subjective position, noting their own personal views and insights about the phenomenon explored; a statement of the primary researcher's position follows (Chiovitti & Piran, 2003).

2.3.6. Researcher's Position

At the time of conducting research, the researcher was a final year trainee clinical psychologist with an interest in, and experience of, traumatic birth. The researcher's dual role of researcher and mother appeared to help participants discuss their experiences openly, however the potential for participants' interviews to have been influenced by the assumption of shared knowledge and perspectives by both parties is also acknowledged.

2.4. Results

Following analysis of interview transcripts by line-by-line coding, twenty-three focused codes were identified. These were then grouped in to seven theoretical codes, each representing a conceptual category within the lived experiences of the interviewed fathers. Figure 1 illustrates how the focused codes were combined to create the emerging theoretical codes. Frequencies of the initial line-by-line codes generating each focussed code are also presented.

After checking back against transcripts to ensure a high degree of fit had been obtained between the theoretical codes and participants' original meanings, the theoretical codes were combined to construct a theory which provides a framework for the emergent concepts. Figure 2 is a visual representation of this theory, illustrating not only the theoretical codes identified as important for the interviewed fathers, but also the interrelation of these themes. The model is presented for the purpose of increasing comprehension and accessibility of the research findings.

Figure 2 depicts a central cycle where fathers move between seeking to take control of events and emotions, having to take on an observer role, and feeling helpless and passive in the face of the developing trauma. This cycle occurs within the context of a father's confidence in the team and system providing care, and is affected by the experience and knowledge he possesses prior to arrival in the delivery room. Finally, postnatally, fathers reach a phase of adjustment - to the traumatic events and their new role as parents, and, after time, begin to look to the future for the implications of their experiences on their own future and visions of how things might need to change.

Figure 1. *Theoretical Codes showing constituent Initial and Focused codes*

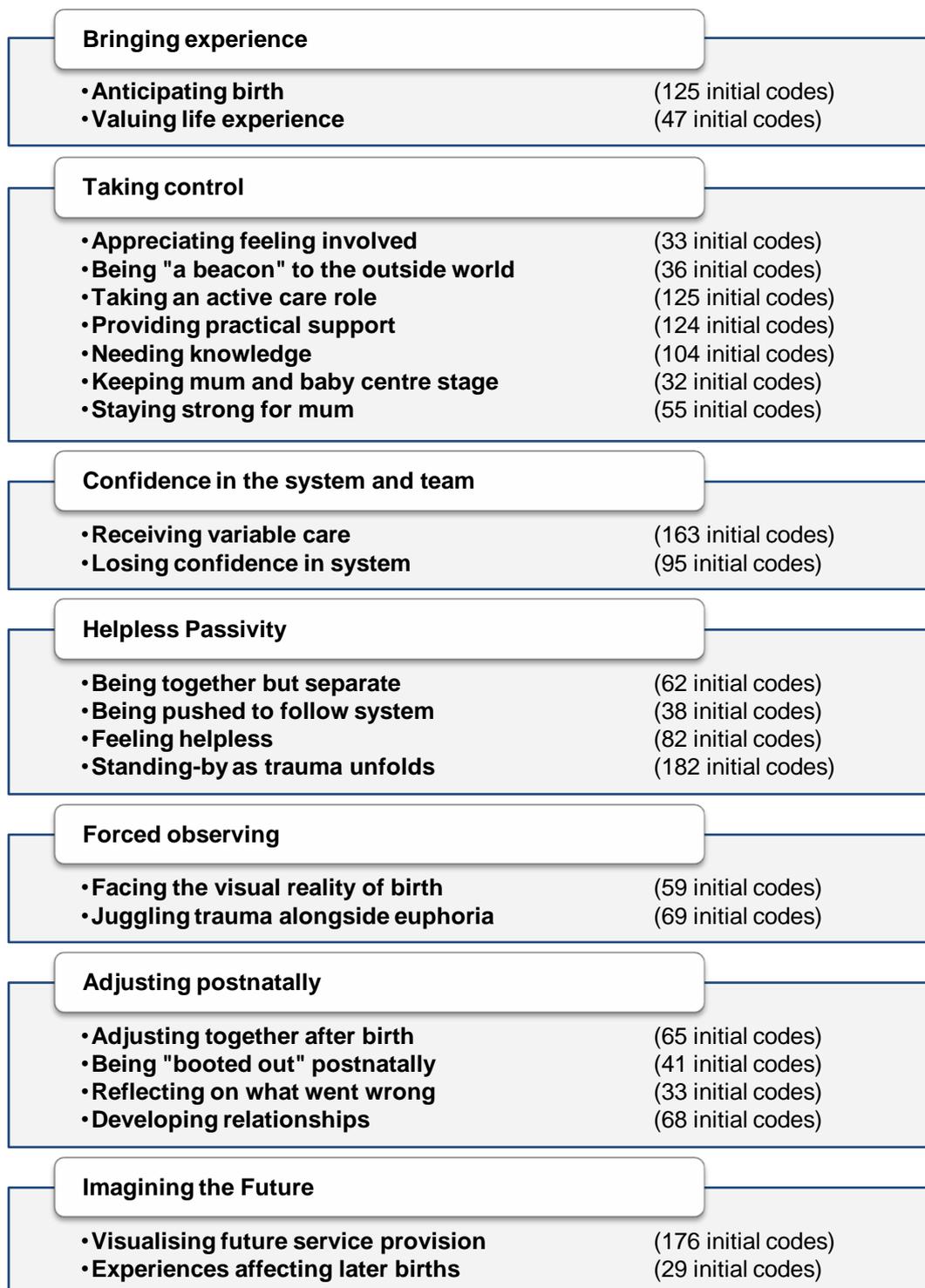
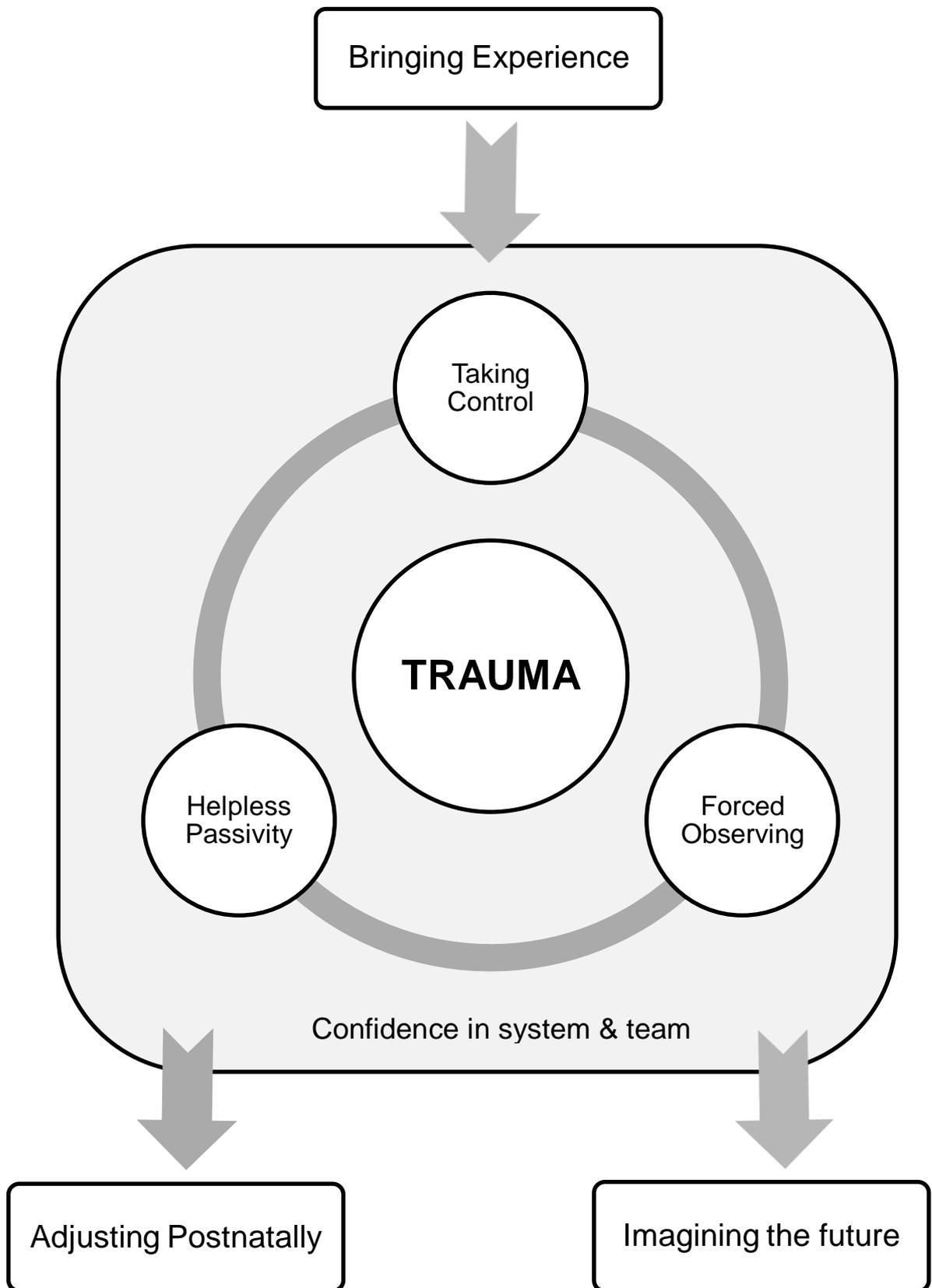


Figure 2. *Constructing theory: Theoretical categories within fathers' experiences of labour and delivery*



The theoretical categories illustrated within figure 2 are elaborated below and verbatim quotations from the interviews are used to illustrate the discussion. In order to protect participants' anonymity pseudonyms have been used.

2.4.1. Bringing Experience

All the fathers described the importance of the previous experiences they brought to the delivery room. These were differentiated into two subcategories; the knowledge and preparation that fathers had gathered during pregnancy, as they anticipate their role during delivery, and the wider life experiences they felt impacted upon their experiences.

In anticipation of birth, fathers spoke of having prepared for this, both alone and together with their partners during pregnancy. Most couples had attended antenatal classes together and had prepared a verbal or written birth plan, which fathers arrived at the delivery room ready to work towards as advocates for their partners. Entering the delivery room with these plans gave fathers a sense of not needing to worry about making decisions should the time arise. One father explained how he felt that having made plans with his partner gave them an advantage:

“We talked about things I was going to say to make her think about better things... So we tried... to engage in those things - they didn't always work, but I guess we had a strategy going in that a lot of people wouldn't have” (Andrew: Paragraph 45).

Even where fathers did not discuss having made a written birth plan, discourses of having spent considerable time during pregnancy visualising their own role

within the delivery room were common. In addition to plans to be their partner's advocate, fathers expressed a clear desire to attend the birth, anticipated specific roles within the delivery room, and had rehearsed at length what they wanted to say and do during labour. Not all fathers, however, continued to value having developed these plans and expectations for the delivery room. For some couples optimistic or unrealistic birth plans became problematic and were viewed as increasing the potential for distress around birth once events began not to go according to plan:

"They had a portfolio... that [mother] had created... which I think is nice but I think naive actually... it's one way to set people up for a fall... [mother] said she wanted a natural birth, hardly any intervention. You know, we were obviously picturing this perfect... idea of err... orthodox birth, but... it wasn't to be..." (Edward: Paragraph 37)

Second to the antenatal anticipation of birth fathers also described prior life experiences as important in their ability to cope within the delivery room:

"I mean, I've sort of been lucky that I've seen what I have in my past. It doesn't change the emotional turmoil inside, that's still high, but visually I'm probably more prepared" (Christian: Paragraph 28).

This father went on to raise doubts as to how younger fathers, with fewer relevant experiences might cope with the reality of traumatic birth:

"I saw one guy; he must have been in his early twenties... He couldn't deal with [the baby crying]... He was too young... Not enough life experience. I

think you need life experience to help you” (Christian: Paragraph 28).

Previous experience obtained through fathers’ occupations were also described as having a positive impact on their ability to make their voice heard within the delivery room, and fulfil their planned role of advocate. Prior experience of working with medical teams gave some fathers a sense of being able to approach and question health professionals when they felt they needed to. Recognising his experience and confidence was not universal; one father questioned:

“Because I work with [medical professionals]... if there was any sort of hesitation on their part I would have said something... I don’t know if someone who didn’t work for the NHS would have though?” (Christian: Paragraph 24).

2.4.2. Taking Control

Having arrived in the delivery room, fathers described their efforts to retain control over the process; efforts which were especially important during the traumatic events themselves. During the early stages of labour, this involved a search for practical tasks, such as updating family and friends, and taking an active interest in the care provided to mothers.

“[making plans for pain relief] felt empowering, because it felt, suddenly I could do something about her pain. (Benjamin: Paragraph18).

As medical interventions took place fathers experienced a sense of loss of control over events, and sought to regain and maintain these active roles, providing them

with a sense of having something tangible to do to help. This helped fathers not only to feel that they were of use to their parents, but also served to occupy their time and avoid them having to think about events outside their control:

“There’s times you feel in control [and] there’s times when you think, well what can I really do? ... So I would be updating people so I thought well I am providing a service here ... but... I guess you don’t want to think about all the things that you can’t be in control of. I can’t sit there and take away her pain, I can’t... (Benjamin: Paragraph 37).

Despite their attempts, however, fathers reported that it was often hard to maintain an active role within the labour room, because of their lack of knowledge, and the busyness of the medical team:

“I went in sort of a mode of just sort of, a clinical mode straight away, you got to sign this, you’ve got to do this... But it is a strange scenario. You’re very much a spare part. Being the dad stood there, there’s nobody talking to you really, and there’s no one explaining anything to you really because there’s too much going on” (Felix: Paragraph 12).

Where fathers felt that information and specific roles were actively offered to them by staff, they expressed gratitude, feeling relieved to be involved and informed. However, where fathers felt under-involved or under-consulted by staff, they expressed frustration at the loss of these potential practical roles:

“I could have been given some stuff to do... Because they were coming in and doing [observations] and things... they could have said, 'Can you do

them?' I can count her pulse and... Yeah, I could have done that and I think any dad can count" (David: Paragraph 102)

As labour progressed and the trauma unfolded fathers heightened their efforts to take control of the situation. For these fathers, the medical interventions, with the accompanying influx of medical professionals were seen as directly responsible for the loss of the control and active roles they had planned and hoped for. Here, fathers described needing knowledge to help them deal with their own emotions and allow them to keep their wives as the central focus within the delivery room:

"I think to prepare men for what might be coming, you know, would enable them to have more confidence so [midwives] could focus on mum and baby in the room and not have to deal with fathers, shouldn't have to deal with fathers who are frantic, or squeamish or demanding, all of those things" (Andrew: Paragraph 81).

The desire to stay strong for mum was raised by several fathers, and was not always an easy task. In an effort not to add to the difficulties he perceived his wife to be facing, one father described having to leave the room to hide his distress:

"I just had to remove myself so, one, you know I could kind of gather myself together, and two, so that... I was trying to be strong so she wouldn't see me fall to pieces because that wouldn't help her at all really because she was already... erm... going through the mill" (Edward: Paragraph 9).

Not having knowledge and information is repeatedly raised as being the hardest part of fathers' struggle to maintain control over their situation. This is typified by the accounts of fathers for whom waiting outside the operating theatre to be called in for their wife's emergency caesarean left them without either the ability to seek information or the practical coping skills they had previously been relying on:

"I was outside for about twenty minutes, no phone so I couldn't call anyone or do any of those things that could have just distracted me... and then not knowing what was going on" (David: Paragraph 52).

"I was terrified for her, terrified for the baby... it's just so poorly done, to be sat on a plastic chair outside a closed door on your own with nothing going on, you just don't know what's going on, nobody's talking to you again... you almost feel like, 'You've got to come along for the ride so there's your seat, just sit on it and shut up, wait' " (Felix: Paragraph 16).

2.4.3. Forced Observing

As complications began to arise, fathers' accounts turned to discussion of being pushed into the role of observer. Although many were able to return at later stages to take control once again, phases of forced observing of the often graphic events that were unfolding were described as particularly hard to manage. Whilst some fathers declined the invitation to watch interventions, either to focus on their partner, or to avoid the graphic nature, others described feeling unprepared for the visceral nature of interventions, birth and the appearance of the baby in the moments following birth:

“I didn’t know what was going on because to be honest the classes and all that stuff that we’d had before, there’s nothing, we didn’t attend anything where they told us anything about actually giving birth... so I had no idea what to expect” (Felix: Paragraph 12)

Lack of information and knowledge affected fathers here too, with fathers describing the impact of staff’s silence in the first few moments after birth:

“[The team] just kind of turned their back on me and took [the baby] away... and they were...they were blowing air around her... But they looked anxious, so I was anxious... so it just made me feel really anxious like... watching your daughter being born and dying in the same ten minutes” (Edward: Paragraph 21).

Even where fathers had previous experience of birth and were unaffected by the graphic nature of the interventions, they described finding it hard to watch, and struggling to accept the events that were unfolding:

“The trauma that happened afterwards when she had to be cut - that was... I’ve seen worse... but when it happens to someone that’s dear to you that’s different” (Christian: Paragraph 20).

“[dwelling on] the denial I suppose... that it would happen to us, because we know no one else who have had a caesarean or anything like that of the medical friends. So it was kind of... well it won’t happen to us” (David: Paragraph 88)

Watching complications during the moments of birth, fathers spoke of a sense of juggling feelings of trauma and euphoria:

“His birth was euphoric; I would describe it as euphoric... Doctors are stitching away - so a trauma there... lots and lots of blood and, my son’s there - fantastic. So I had two sides to look at... I felt both that things. I mean it’s... It’s two types - euphoria on one side, and I mean I had to deal with the cutting and that side...which wasn’t nice, [an] awful thing... That was hard” (Christian: Paragraph 38).

“And... the little one, and the first cry... and it is, it’s lovely. And then the paediatrician takes her and you go back and all hell’s broken loose here, and all I see is blood dripping on the floor and I’m like thinking what’s going on here?” (Benjamin: Paragraph 20)

One father felt his lack of preparation around the visual reality of birth was shared by the majority of men in his social network, and describes the impact he felt this had upon their experience of the birth:

“I felt that there’s more that could be potentially done around that first, kind of couple of minutes, or couple of seconds probably. Just sort of preparing you for that... Almost without exception, the [other first-time fathers] were kind of quite worried for the first minute that should have been a happy minute” (Andrew: Paragraph 15).

2.4.4. Helpless Passivity

As a final part of the action-observer cycle, fathers also discussed having feelings

of helplessness and a lack of an active role, which contrasted with the involvement they had hoped to have during labour and delivery. Fathers spoke of feeling separate from their partner, whose internal focus on contractions and labour isolated them even as they sat alongside each other during labour:

“There are times, its completely, absolutely unavoidable, whereby there will always be a time when you will sit there and feel like you’re alone because there is nothing, nothing you can do, there is too much going on
(Benjamin: Paragraph 21)

Other fathers went on to describe:

“It doesn’t matter how much you try to help, you just can’t be there... You can’t be truly empathic because you haven’t got a clue what’s going on for that person” (Edward: Paragraph 7)

“I think you, you just have to realise that it’s not about you, so you go, and you sit in the background, and you just show support.” (Andrew, Paragraph 70).

As fathers faced this isolation from their partners and traumatic events began to unfold, they described feeling pushed along a predetermined path towards birth by professionals they perceived as following set routines, rather than reacting to the couple’s own situation, wishes and needs:

“They kept make, you know making her try positions that clearly weren’t working. Even to a lay man it was obvious that it wasn’t working. Almost

you felt that the midwife was following the set routine as opposed to looking and thinking about what was in front of her”

(Andrew: Paragraph 3)

Being pushed along the path towards birth in this way led fathers to speak of helplessness and being unable to do anything beyond stand by passively as events occurred:

“[mother] was in a lot of pain at the time and battling through the early stages of labour - and that was horrible to see and I don’t think I’d prepared myself for it, because, to see the person you love in that state, really in a lot of pain, really upset and nothing I could do at all – I felt a bit helpless to be honest” (Felix: Paragraph 3)

“To me it was helpless.... There was only so much I could do to get her comfortable. I couldn’t push for her... Emotionally it does affect - it’s a feeling of helplessness” (Christian: Paragraph 6).

Helplessness led fathers to seek practical tasks to allow them move them back around the cycle to regain feelings of control over the delivery, but for all fathers, during interventions and complications, practical tasks remained elusive:

“I just wanted to do something other than rub her back, which was all I could do... it was all she asked me to do but it was just that was my job... basically that’s all that I could do. I would end up with a shiny hand, from rubbing so much. So it was rubbish really” (David, paragraph 32).

“There was nothing at all that I could do. She was screaming, you know, whatever you say when you’re in that scenario, you’re wrong... Whatever you say is always going to be wrong, and you’ve just got to... switch off because she’s the one suffering and you’re trying to be a support whatever way you possibly can (Felix: Paragraph 10).

Often, even those tasks which fathers had always anticipated to be a significant part of their role during birth were taken away due to interventions around the moments of birth. One father was particularly struck by the realisation that he was not going to be able to cut the umbilical cord during his daughter’s birth:

“Guess what, Dad - the kind of thing you were really looking forward to which is cutting the cord? You ain’t going to be doing that either! And that just felt like suddenly... I’m not, I’m not.... back in control. I mean, I did nothing, I was the person that held her hand” (Benjamin: Paragraph 18).

Summing up the extent of his feelings of helplessness and passivity in the face of complications, one father recalls:

“I’ve never seen [mother] in so much pain. I’ve never been... never felt that close to her but also not been that unable to help her” (Andrew: Paragraph 47).

2.4.5. Confidence in system and team

The cycle described of moving between taking control, forced observing and helpless passivity takes places within the context of the confidence held in the team and system. All fathers spoke at length about feelings of receiving variable

care from teams, with changeovers in shifts during labour making a significant impact on their experiences of care:

“It just feels like a bit of a lottery, in terms of who you get and who delivers the birth” (Andrew: Paragraph 13)

“We’d had one member of staff, she’d been lovely... really supportive and then all of a sudden... switch over... different person... different attitude and... you just felt lost really” (Edward: Paragraph 17).

Where confidence in the team was high, fathers felt able to rely on the team around them, and more able to relinquish control and responsibility for care when events demanded:

“I wasn't actually worried about the operations because I know that [the hospital], they've got a good rep - they've got good obstetricians there, and its once in a blue moon that things go wrong, and then the anaesthetists are very, very good, that helped” (David, paragraph 50).

Where fathers felt less certain about entrusting their wife’s care to the team, they described losing confidence in professionals, making judgments about their experience and ability to respond to the unforeseen complications, and beginning to seek support outside of the room:

“Almost you felt that the midwife was following the set routine as opposed to looking and thinking about what was in front of her. And I guess it got to a point where I lost completely confidence in her... I actually sort of

stopped engaging with that person altogether, that midwife, and if I needed to I was going outside and talking to others”

(Andrew: Paragraph 3)

For some fathers a sense that professionals were so used to seeing birth that they were no longer able to be truly empathic to anxious parents was raised, and the negative responses to fathers’ calls for information or support stuck clearly within the memories of these fathers:

“But the midwife who told her, “that’s parenthood, get used to it”, she wants a kick up the bum! I was livid... Right, okay, you’ve said that how’s that going to help us? How’s that going to help [mother]? How’s that going to help me deal with it? Obviously, she might have been a having a bad day... but that’s the job. I mean, she has to deal with that while she deals with birth - she needs to keep that separate” (Christian: Paragraph 26).

“For [midwives] it’s a process that they do every day as a job, but... so I think that’s the problem... you up against... the fact that for these people it’s a job... When I’d go out into the hallway... and you feel like you are disturbing them to try and get something, you know, to try and just get an answer about something that you needed a bit of assurance about”

(Edward: Paragraph 77-79).

Lack of confidence however, did not always result from negative appraisal of the specific care team. Fathers raised some doubts as to the adequacy of the maternity systems as a whole. These revolved around the availability of doctors for emergency care, perceptions of perpetually changing clinical guidance leading

to teams providing conflicting advice, and the extent to which guidance left space for parents' own wishes to be heard:

“[The NHS] needs to move a lot more in terms of flexibility in saying that say, “this is your birth, this is your, when you write that birth plan, we will do everything to deliver that”... They’ve had their opportunity to dissuade us... that opportunity is the past, we’re now in the zone of us having decided those things, and unless there something that comes up that makes that not a very good idea, then, then we should be listened to”
(Andrew: Paragraph 92).

2.4.6. Adjusting postnatally

For all fathers, the immediate postnatal period was marked by attempts to adjust, both to the events that occurred and to their new parental role. Fathers valued the time that they had with their family in the delivery room after the birth, and expressed relief and euphoria at having come through the experience.

For most fathers however, this time together was cut short by the need to clear the delivery room. When mothers were moved to the postnatal ward, most fathers, due to arriving outside of visiting hours, were asked to leave. For these fathers, whilst they appreciated the reasoning, the change was abrupt and unwelcome:

“I was literally told you’ve got like thirty seconds and it felt you know, Big Brother house: you’ve got a minute to say your goodbyes. It’s like, ‘Well, no! No, no, no, I want to keep going!’ It was a really, really strange feeling” (Benjamin: Paragraph 26)

On leaving the hospital, several fathers spoke of being overcome with an unexpected rush of emotion, pent-up during delivery, which was released on speaking to friends and family about the birth:

“I remember being all upset and emotional and it all kind of coming out in a flood... it was all just such a roller coaster, and it all came out... and you know... in one fell swoop” (Edward: Paragraph 49).

Looking back on their birth experiences during the interview, fathers considered the complex nature of the events that had occurred and spoke of having reached conclusions about the causes of the complications. In seeking this closure, one father spoke of actively sitting down with his wife to share their personal experiences of the birth, to reduce some of the isolation and separation he had felt during the delivery:

“We needed to almost... relive it together so we knew what the other person was thinking at different points. I think it needs that... that really helped me to get... not get over it, but come to terms with it” (Andrew: Paragraph 20).

All fathers felt that having shared the experience had strengthened their marriages, and although the effects of birth were hard to differentiate from the wider effects of parenthood, most described feeling closer and more of a family unit since the birth:

“It’s closer, stronger bond. More protective, of course - of both of them, that’s increased. Things are probably better... because we’ve increased the relationship... it was good before but now it’s better.... I think that’s fatherhood... I mean it just changes you way of thinking” Christian: Paragraph 12).

2.4.7. Imagining the future

Having clarified their understanding of the events leading to intervention, and thought about how, and by whom, things might have been changed, fathers considered the impact of their experiences. Thinking to the future, participants spoke about the potential effects on any subsequent pregnancies and births, and of how service provision could be altered in order to better meet their needs.

Fathers identified that first-time parents are particularly at risk of being affected by feeling out of control, uninformed and helpless during birth, and felt that, should they choose to have another child, they would be better prepared next time around. Two fathers within the study had gone on to have a second child since the traumatic birth, and reported feeling that their prior experience of birth led to better preparation, increased confidence and autonomy during their subsequent experiences of birth:

“It was all very new and you didn’t really know what to do [during the first birth] and I felt like a spare part really - just stood there holding the baby really. It was different second time around, I was a lot more conscious of what was going on, I knew what was going on” (Felix: Paragraph 6)

In discussing potential changes to maternity services, fathers focussed on antenatal, perinatal support and education. During pregnancy, fathers felt that providing easily accessible preparation and education for fathers planning to attend the birth would help reduce distress. They spoke of needing support to be targeted specifically at expectant fathers, discussing a wide range of potential interventions and delivery methods in detail to prepare men for what they might be faced with:

“Never, for both of us, did anyone say, ‘Do you understand what’s going to happen?’ I think it’s just assumed that you know what’s going to happen, but you don’t...I think more explaining, and, really, just a bit of recognition that you’re actually there” (Felix: Paragraph 36).

“I don’t think it would be a bad thing to say, “well let’s have a look, and just see what a normal c-section is like”. So that you do know what’s going on, on the other side [of the screen] because from our point of view... and say, ‘this is a caesarean, it is very quick, and it’s actually, most of the time absolutely fine’ ” (David: Paragraph 114).

All fathers felt that having more information and feeling staff were open to being asked questions during the delivery would have improved their experiences, as well as building trust and relations between fathers and health professionals:

“Just fostering that kind of culture in the hospital... the nurses just being a bit more approachable. I think that’s all it would take, because we have got lots of questions, but I’m sure we don’t ask them most of the time because we feel like, what are we moaning about? Why should we

moan?... It's a really defensive moment actually, and I'm sure it could be a lot better from the nurses' point of view" (Edward: Paragraph 83)

Finally, fathers recognised the potential value of their informed input and wanted professionals to consider how fathers might be used as a resource within the delivery room:

"If you [talk things through] to the dad you'd kill two birds with one stone because, one: you would also be prepping the mum at the same time, and two, if the dad relaxed I'm sure the mum would as well... because he is the stone sometimes for the mum" (Edward: Paragraph 81)

"Simple things like [timing contractions] would have been dead easy to do... and it would have saved their time as well. Because they could come in and said, 'what's this, that and the other?'... The government have been saying we are going to get more volunteers aren't we, so why don't we use dads? Give them something practical to do" (David: Paragraph 102).

2.5. Discussion

The aims of the current paper were to further understanding of fathers' experiences of attending traumatic childbirth, and to explore their views regarding support and service provision. A model of paternal experiences of attending traumatic childbirth is illustrated in figure 2.

In summary, fathers were found to be eager to be part of their children's births, anticipating and preparing for active roles within the delivery room. During early

labour, fathers strove to attain these roles, within the context of their individual life experiences and their confidence in the care provided by health care professionals. As labour progressed and difficulties arose, fathers described a sense of loss of agency and role, feeling forced into helpless and passive observer roles by the medical interventions. In response, fathers repeatedly made efforts to regain and maintain control over the situation and their emotional reactions to it. The moments of birth were therefore experienced as a mix of trauma and euphoria, which fathers took time to process and adjust to postnatally. Finally, fathers discussed the positive impacts of their experiences on their marriages and their confidence around any future births, as well as making suggestions for future service provision. These findings are mirrored within the wider research into the experiences of fathers present during “normal” childbirth; parallel themes of unexpected passivity, strengthened marital relationships and calls for greater paternal involvement in labour and pain management are particularly resonant (Chandler & Field, 1997; Chapman, 1992).

Perhaps the most striking comparison is the importance of providing fathers with adequate information and education, both prior to and during labour, to help them manage their birth experiences. This was a key concept within the current research, and concurs with the findings of previous studies which show that fathers attending childbirth feel most supported and valued when given opportunities to ask questions and to choose how, and when, to interact with their partners and the medical teams involved (Backstrom & Hertfelt Wahn, 2011).

In addition to these similarities, however, the current research found that attending traumatic childbirth has its own impacts on fathers. In particular, observing unexpected graphic and invasive medical interventions is discussed by

fathers as significantly reducing their ability to maintain the agency and active role within the delivery room they had expected and planned for antenatally. At the same time, for fathers present during traumatic childbirth, the threat to both mother and child increases, further elevating the potential for paternal post-natal psychological distress (American Psychiatric Association, 2000). Past calls for adequate provision of support and information to ensure fathers' psychological wellbeing are therefore shown by the current research to be of even greater importance for fathers whose experiences of childbirth have involved a difficult or prolonged labour or delivery (Backstrom & Hertfelt Wahn, 2011; Chan & Paterson-Brown, 2002; Chandler & Field, 1997).

Recent research has recommended further consideration of fathers' roles within the delivery room, noting that their antenatal expectations of active roles are rarely met, and that the majority of fathers eventually take on passive, witnessing roles to which they struggle to adjust (Chapman, 1992; Dallos & Nokes, 2011), an experience reiterated within the current findings. This paper therefore adds weight to previous calls for increased clarity around potential roles for fathers attending labour and delivery, and suggests that all prospective fathers, not just those for whom childbirth is traumatic, would benefit from such increased public and professional clarity.

Despite the immediate effects of trauma within the delivery room, fathers in the current research described few long-term effects. Participants reported that their experiences had not affected their desire for more children, and raised only positive effects on their relationships and postnatal wellbeing. Their descriptions of stronger marital relationships are supported in the wider literature, with discourses of becoming "a more united tag team" raised within a recent meta-

synthesis of father's experiences of their transition into fatherhood (Chin, Hall & Daiches, 2011).

In considering these findings, however, it is important to note that the current research elicited specific information about the immediate perinatal period and so additional long-term effects cannot be ruled out for participants. Previous research has linked high levels of distress, lack of fulfilment and loss of confidence during labour to increased severity of depressive symptomology in fathers in the six months following birth. It is acknowledged that similar findings might have been observed in the current study had accounts of the wider impacts been accessed (Bradley & Slade, 2011; Bradley, Slade & Leviston, 2008). Despite this, participants were clear that having attended the birth, despite its traumatic nature, had had marked positive effects on their marriages and their readiness for any future births. No lasting negative effects were declared by these fathers.

Overall, therefore, discussion of the current findings indicates that although fathers attending traumatic childbirth face particular challenges to their search for continued agency and role within the delivery room, there are nonetheless many similarities to be observed between their experiences and those of fathers facing "normal" deliveries. At present, fathers within both the current and previous research feel that service provision does not yet meet their needs reliably, and whilst fathers were anxious not to be thought to be attempting to distract care away from mother and child, continued academic and clinical service provider consideration of this gap in service provision is required (Allen, 1998; Draper, 1997; Longworth, 2006). Discussion of how this consideration might proceed follows.

2.5.1. Methodological limitations

Although, attention was paid to ensuring the rigour of the methodology was upheld, and theoretical sampling was used to strengthen the concepts contained within categories, the relatively small sample size affects the generalisability of the findings. Morrow (2005) highlights that whilst small sample size alone is not necessarily a concern for qualitative research, there is, nonetheless a need to ensure the data is adequate for describing the experiences explored. One way of ascertaining adequacy is by the active search for disconfirming evidence, to ensure that the data does not simply reflect a researcher's natural tendency to seek confirmation of the emerging findings (Morrow, 2005). The use of theoretical sampling in the current study allowed some access to this evidence; for example, by accessing the experiences of fathers with medical training, or who had witnessed subsequent births to explore the impact of greater knowledge and experience (Coyne, 1997). Restricted time and participant numbers meant that an exhaustive search for disconfirming evidence was not possible within the current study.

The sample size of the research holds another potential limitation for the research. Fathers interviewed were relatively homogeneous in terms of ethnicity, socio-economic status and geographic location, and, as such, care should be taken in generalising the findings to populations outside this particular sample.

Time limitation may also have affected the extents to which interviews reflect participants' genuine and complete viewpoints and experiences. Morrow (2005) describes this as "truth value" and writes that it is only by immersion in the setting, culture and context of participants that a researcher may be certain that the findings generated from these accounts warrant the interpretations that they

will ultimately make. During the current research, time constraints on the researcher and participants meant that just one interview, of around an hour, was possible with each participant. Had time been less of an issue, the use of alternative data sources, such as focus groups, participant observation or matched accounts of mothers and professionals, could have been used to provide richer data of more certain “truth value” (Morrow, 2005).

On a final note, the impact of gender within the research is also a consideration. As noted previously, the dual role of mother and researcher held by the primary investigator should be considered for its impact on the findings. In order to minimise the potential impact of the primary researcher’s perspective on the interpretations of findings, initial coding was cross-checked against that of other researchers. However, although no obvious negative effects of role and gender were noted during the interview process, research suggests that issues around gender and social roles may nonetheless have subtle impacts on the disclosures made and experiences discussed by participants, as well as the manner in which researchers choose to approach and interpret data collection (Golombisky, 2006; Herod, 1993; Jenson, 2008; Stanley & Slattery, 2003).

2.5.2. Recommendations for Further Research

As has been discussed, this paper has explored the experiences of a small group of exclusively white, married and university educated fathers from a specific region of the United Kingdom. Future research is required to establish whether these experiences are shared within the wider male population. Consideration should be given to the experiences of fathers across a wider social milieu of the UK, and how the experiences described by fathers from different backgrounds might differ. In particular, it is important to explore the experiences of fathers from

different cultural and ethnic groups, for whom birth attendance may hold different meaning and impact. Given the importance attributed here to the knowledge and experience a father brings to the delivery room, accounts from younger fathers would also be of particular interest.

Whilst the current qualitative approach is appropriate for exploring individual experiences, in order to ensure that the findings are representative of the experiences of new fathers as a wider population, quantitative research is also required. The use of these methods in future research will allow further testing of the validity of the model developed and the determination of the wider incidence and prevalence of identified themes.

Similarly, given the need identified within the current research for increased provision of information and support to fathers, future research should also seek to ascertain the true impact of providing targeted antenatal or perinatal support and education programs for fathers. Prospective and longitudinal quantitative methods should be used to test the efficacy of such interventions at reducing perinatal distress in fathers as well as the implications of the routine addition of such support for labouring mothers and maternity services caring for them. Emphasis should be placed on developing randomised controlled trials of promising interventions, in order to increase the likelihood of their adoption within wider clinical services.

2.5.3. Clinical Implications

Many of the issues raised by fathers as important for future service provision have been previously raised within research regarding mothers following a traumatic labour or delivery. Bailham and Joseph (2003) recommend routine

screening of mothers for PTSD during the perinatal period and Czarnocka and Slade (2000) have also recommended examination of the care provided during labour to maximise mothers' perceptions of control and support. Given the findings of the current study, it is suggested that this consideration is also extended to encompass provision for fathers.

However, whilst calls for increased perinatal education and empowerment may be applicable to both parents, fathers expressed a clear desire for differentiated support, separate to that currently provided for mothers. In particular, it was felt that support for fathers, who have only limited contact with traditional services prior to and following the birth, must be made available through practical and easily accessible means. Once in the delivery room, fathers were clear that they did not want to distract from the care provided to the mother or child, and felt that antenatal provision would facilitate them to manage both their experiences, and the support of their partner more effectively. Fathers requested targeted antenatal provision aimed at preparing them more adequately for birth by giving them honest and practical information about a range of potential delivery scenarios, and where their roles might lie within each.

Joint working should be considered between adult mental health services and maternity services to provide specific antenatal classes for fathers, alongside those currently provided for mothers and couples, as well as working on clinical guidance advocating a defined role for, and support of, fathers during the birth. The development and wider use of measures to identify fathers most at risk of perinatal distress, such as the Birth Participation Scale (Martin, 2008) and sensitive provision for their individual needs, would stand to greatly improve the

perinatal wellbeing of fathers, and in turn increase the wellbeing of labouring mothers benefitting from empowered and effective partner support within the delivery room.

On a final note, it is important to consider the impact of perinatal distress upon children. Clinically significant symptoms of childbirth-related PTSD have been shown to negatively impact on both the parent-baby bond and parenting capacity, which in turn may impact upon attachment, developmental and the mental health needs of children (Bailham & Joseph, 2003; Gittleman, Klein, Smider & Essex 1998; Nicholls & Ayers, 2007; Parfitt & Ayers, 2009). Clearly, therefore, there is not only a need for service provision to address adult mental health needs following traumatic birth, but consideration must also be made as to the potential impact on parenting, children and development. Clinical psychologists working within Child and Adolescent Mental Health services should also consider ways of working alongside maternity services, to provide both preventative psycho-education advice to parents antenatally, and routine postnatal assessment to identify families where therapeutic intervention to one or both parents might be required.

2.6. References

- Allen S (1998) A qualitative analysis of the process, mediating variables and impact of traumatic childbirth *Journal of Reproductive and Infant Psychology* 16(1): 107-131.
- American Psychiatric Association (2000) Diagnostic and statistical manual of mental disorders DSM-IV-TR. 4th edition. Washington DC: American Psychiatric Association.
- Atlas.ti. Version 4.2. (1999) *Computer Software*. Berlin: Scientific Software Development.
- Ayers S & Pickering D (2001) Do women get posttraumatic stress disorder as a result of childbirth? A prospective study of incidence. *Birth* 2: 111-118.
- Ayers S, Wright DB & Wells N (2007) Symptoms of post-traumatic stress disorder in couples after birth: association with the couple's relationship and parent-baby bond. *Journal of Reproductive and Infant Psychology* 25(1): 40-50.
- Backstrom C & Hertfelt Wahn E (2011) Support during labour: first-time fathers' descriptions of requested and received support during the birth of their child. *Midwifery* 27(1): 67-73.
- Bailham D & Joseph S (2003) Post-traumatic stress following childbirth: a review of the emerging literature and directions for research and practice *Psychology, Health and Medicine* 8(2): 159-168.
- Bradley R & Slade P (2011) A review of mental health problems in fathers following the birth of a child. *Journal of Reproductive and Infant Psychology* 29(1): 19-42.
- Bradley R, Slade P & Leviston A (2008) Low rates of PTSD in men attending childbirth: A preliminary study_ *British Journal of Clinical Psychology* 47(3): 295-302.

- British Psychological Society (2009) *Ethical Principles for Conducting Research with Human Participants*. Available at: www.bps.org.uk/the-society/code-of-conduct/support-for-researchers_home.cfm.
- Burgess A (2008) Maternal and infant health in the perinatal period: the father's role, Available at: www.fatherhoodinstitute.org/uploads/publications/356.pdf.
- Chan KKL & Paterson-Brown S (2002) How do father feel after accompanying their partner in labor and delivery? *Journal of Obstetrics and Gynaecology* 22(1): 11-15.
- Chandler S & Field PA (1997) Becoming a father: First-time fathers' experience of labor and delivery. *Journal of Nurse Midwifery* 42(1): 17-24.
- Chapman L (1992) Expectant fathers and labor epidurals. *American Journal of Maternal Child Nursing* 25(3): 133-138.
- Charmaz K (2006) *Constructing Grounded Theory: practical guide through qualitative analysis*. London: Sage Publications Ltd.
- Chin R, Hall P & Daiches A (2011) Fathers' experience of their transition to fatherhood: a metasynthesis. *Journal of Reproductive and Infant Psychology* 29(1): 4-18.
- Chiovitti, R.F. and Piran, N. (2003) Rigour and Ground Theory Research *Journal of Advanced Nursing* 44 (4) p427-435.
- Coyne IT (1997) Sampling in qualitative research - Purposeful and theoretical sampling; merging or clear boundaries. *Journal of Advanced Nursing* 26: 623-630.
- Creedy D, Shochet I and Horsfall J (2000) Childbirth and the Development of Acute Trauma Symptoms: Incidence and Contributing Factors *Birth* 27(2): 104-111.

- Czarnocka J & Slade P (2000) Prevalence and predictors of post-traumatic stress symptoms following childbirth *British Journal of Clinical Psychology* 39(1): 35-51.
- Dallos R & Nokes L (2011) Distress, loss and adjustment following the birth of a baby: A Qualitative Exploration of One New Father's Experiences. *Journal of Constructivist Psychology* 24(2): p144-167.
- Draper J (1997) Whose welfare in the delivery room? A discussion of the increasing trend of fathers' birth attendance. *Midwifery* 13: 132-138.
- Gittleman MG, Klein MH, Smider NA & Essex MJ (1998) Recollections of parental behaviour, adult attachment and mental health: mediating and moderating effects *Psychological Medicine* 28: 1443-1455.
- Glaser B and Strauss A (1967) *The Discovery of Grounded Theory – Strategies of qualitative research*. New York: Aldine de Gruyter.
- Golafshani N (2003) Understanding reliability and validity in qualitative research. *The Qualitative Report* 8(4): 597-607.
- Golombisky K (2006) Gendering the Interview: feminist reflections on gender performance in research. *Women's studies in Communication* 29(2): 165-192.
- Herod A (1993) Gender issues in the use of interviewing as a research method. *Professional Geographer* 45(3): 305-317.
- Hodnett ED, Gates S, Hofmeyr GJ, Sakala C, Weston J (2011) Continuous support for women during childbirth. *Cochrane Database of Systematic Review* 2011 (2). CD003766.
- Jenson T (2008) I, 'speaking as a mother': Notes on becoming a researcher and not getting onto supernanny. *Feminism & Psychology* 18: 384-388.

- Kiernan K & Smith K (2003) Unmarried parenthood: new insights from the Millennium Cohort Study. *Population Trends* 114: 26-33. London: Office of Population, Censuses and Survey.
- Kitzinger C & Kitzinger S (2007) Birth trauma: talking with women and the value of conversation analysis. *British Journal of Midwifery* 15(5): 256-264.
- Longworth H (2006) Should fathers be in the labour room? Yes, for support not intervention. *British Journal of Midwifery* 14(5): 288-289.
- Martin CJH (2008) A tool to measure fathers' attitudes and needs in relation to birth. *British Journal of Midwifery* 16(7): 432-437.
- National Health Service (2005). NHS Maternity Services Quantitative Research (October) Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4124246.
- Nichols K & Ayers S (2007) Childbirth-related post-traumatic stress disorder in couples: A qualitative study. *Health Psychology* 12(4): 491-509.
- Palkowitz R (1987) Fathers' motives for birth attendance. *Maternal Child Nursing Journal* 16: 123-129.
- Parfitt YM & Ayers S (2009) The effect of post-natal symptoms of post-traumatic stress and depression on the couple's relationship and parent-baby bond. *Journal of Reproductive and Infant Psychology* 27(2): 127-142.
- Stanley, C.A & Slattery, P. (2003) Who reveals what to whom? Critical reflections on conducting qualitative inquiry as an interdisciplinary, biracial male/female research team. *Qualitative Inquiry* 9(5). pp705-728.
- White T, Matthey S, Boyd K & Barnett B (2006) Postnatal depression and post-traumatic stress after childbirth: Prevalence, course and co-occurrence. *Journal of Reproductive and Infant Psychology* 24(2): 107-112.

Zaers S, Waschke M & Ehlert U (2008) Depressive symptoms and symptoms of post-traumatic stress disorder in women after childbirth *Journal of Psychosomatic Obstetrics and Gynaecology* 29(1): 61-71.

Chapter Three

Parenthood and Gender in Perinatal Research

Target Journal: Psychology of Women Section Review

See Appendix 1(b) for instructions for Authors

Word Count (Excluding abstract and references): 3044

3.1 Abstract

In the course of carrying out a systematic literature review of the maternal psychological impact of breastfeeding and an empirical, qualitative exploration of fathers' experiences of traumatic childbirth, a reflective journal was kept by the researcher. Discussion is made of the observations and reflections contained within the journal, both on the impact of parenthood and gender on the process of conducting perinatal research, and of the impact of research on the researcher as a mother. The impact of multiple roles on the researcher, participants and the research itself are revealed, and calls made for wider acknowledgment of stance and position by researchers.

3.2 Introduction

In partial fulfilment of the requirements for the Doctorate in Clinical Psychology programme of the Universities of Coventry and Warwick a three-part thesis is submitted. In addition to a reflective paper, doctoral trainees are also required to prepare a critical review of the literature and an original empirical research paper.

For my thesis, I chose to focus on the impact of the perinatal period on parents. In view of this, I carried out a systematic review of the literature on the psychological impact of breastfeeding on mothers, and a qualitative exploration of fathers' experiences of attending traumatic childbirth. Throughout this process, I also kept a reflective journal, starting during my initial considerations of the research proposal, submitted at the end of the first year of training, and continuing throughout the process of writing the thesis up for submission at the end of my third year of training.

Of all the themes raised within the reflections, recollections and observations documented within my journal, one in particular raised interesting questions for me about my stance within the research; that of my dual role as not only a woman researcher but also as a mother. The aim of the current paper is to explore some of these questions, their meaning for me and my research, and the wider implications for parents conducting research into the perinatal period.

3.3 Researcher position

Since starting my Doctoral training in Clinical Psychology in 2007, much of my time has been consumed by my position as a doctoral student; however, this is not my only role. Like many other mature students, I am a wife, a daughter, a sister, a colleague and a friend, but also, of most importance to my research, I

am the mother of two children under the age of 5; a daughter, Olivia, and a son, Alexander, aged 4 ½ and 2 ½ years respectively at the time of writing. I began doctoral training shortly after Olivia's first birthday, and took maternity leave during my second year of training following the birth of Alexander.

3.4 Development of research interests

My dual role as a married mother-of-two enrolled on a full-time, three year doctoral program not only challenged my patience, time management skills, and boundaries, but has also had a significant impact on my developing research interests. The topic for my empirical papers arose directly out of my own experiences of labour and delivery. Having given birth to my eldest child just a year before commencing training, I was interested in exploring what I saw as an imbalance in the approaches of both health professionals and wider society towards fathers during the perinatal period.

During pregnancy and antenatal classes, I spoke with both mothers and fathers who felt that whilst it was socially expected that fathers would attend the birth, in reality they had received little support or preparation for the role of birth partner. Mothers described feeling that they had fared better during the birth than their partners, who they perceived as having to stand by and watch while events beyond their control unrolled. One mother, who had received a general anaesthetic for an emergency Caesarean section, reported that she was still unclear exactly what had happened during the birth, because her partner had refused to speak about it. I became interested in how the increasing trend of fathers attending their children's births impacted upon their wellbeing, and whether services had adapted in line with this changing social norm.

After Olivia's birth, I failed to initiate breastfeeding, despite having very strong antenatal expectations that I would do so. Perceiving myself as having fallen at the first hurdle, I struggled with the early months of motherhood, and put a great deal of pressure on myself to "do better next time". When Alexander was born, two years later, I breastfed for six weeks, readmitting us both to hospital in an attempt to persevere, before finally giving in to the pain of bleeding and cracked nipples, and a need for his care to be shared in order to continue to mother Olivia. These experiences contrasted strongly with my views about breastfeeding as a bonding, mutually pleasurable experience for mother and baby, and I began to wonder how I had developed these expectations in the first place, and whether other mothers shared my experiences.

My research proposal was written and submitted just after Olivia's second birthday, whilst I was pregnant with Alexander. To me, there was no question that I would focus my research on the perinatal experiences of parents, not only because of my own questions and experiences, but because of the wider need I felt to highlight the importance of examining parental wellbeing during this vulnerable time.

3.5 The impact of motherhood on the research process

Early in the process of writing my research proposal, I acknowledged in my reflective journal that the potential impact of my position as a mother, woman and student upon the research would need to be clarified. It is clear, however, from my early entries that I did not expect this to be more than a formality. In keeping with my undergraduate quantitative research, with its background in the positivist tradition, I expected bias and subjectivity to have only a minimal role within my consideration of the research.

The first challenge to this assumption came during the interview process. As within my clinical work, I had not intended to reveal any details of my personal life whilst conducting my interviews. I found this much harder than I had expected, and did disclose being a mother when asked by several participants. In part this is the result of the different boundaries within research and therapeutic relationships; however, I wonder whether this is the only explanation.

Whilst interviewing fathers about their experiences of birth, there were numerous occasions where they struggled to recall terminology and procedure, and looked to me for clarification. Providing an answer to these questions, or indeed failing to answer, often led fathers to ask whether I had children, and here I faced a dilemma. Although I felt it hard to justify diverting or evading these questions, as I might consider within my clinical work, whilst asking fathers to speak of their own personal experiences, I nonetheless felt uneasy about disclosure.

Jenson (2008) notes that parenting experts will often publish the number of children they have along with their credentials, or may risk being discredited on account of being childless. I felt that speaking parent-to-parent might reassure fathers not only about my credibility as a researcher, but also give a sense of a shared perspective which might aid their disclosure of any negative or ambivalent feelings around birth and parenthood. Certainly, on the occasions where I confirmed that I was indeed a parent, fathers visibly relaxed, and, so it seemed to me, spoke more freely during the remainder of the interview.

For me, two considerations arose out of these observations. Firstly, I wondered how different the interviews might have been had I not been a parent; would

being unable to assure fathers that in some way at least we shared similar experiences have reduced what they were willing to disclose? Certainly, other ethnographic researchers have commented on the increased rapport and freedom within interviews where participants identified researchers as sharing the social role of 'parent' (Mose-Brown & Masi De Casanova, 2009; Powell, 1999).

In contrast, however, I also considered whether sharing my role as a parent might have less positive effects on the research. Although a shared role implies shared knowledge and perspective, in reality the lived experiences of parenting are so diverse and individual that they are rarely shared entirely, even between parents of the same children (Bird & Brown, 1997; Doucet, 1995). I felt conscious of the potential biasing effect of these assumptions during the analysis of interviews, and, listening back to early interviews, I was aware that there were occasions where I did not ask participants to elaborate on passing comments simply due to the mutual expectation that I already understood what they meant. In later interviews, in order to reduce the impact of my role and the resultant assumptions, I compensated by seeking far more clarification on participants' accounts of their experiences than I felt I would have had I not yet had children. This precaution, despite leading me to feel that I was "asking the obvious" increased the extent to which the data felt truly grounded in participants' personal experiences, rather than in a shared social discourse between two parents.

As I progressed to the write-up phase, I continued to pay attention to the potential impact of my personal stance within the research, and was careful to distance myself from the findings of both my empirical paper and the emerging themes in my literature review. Doubts as to the success of this detachment flood my journal following a meeting early on in the write up process to discuss initial drafts

of my papers with my research team. Comments of “*it reads as though these are your experiences*” and “*you need to take a step back*” flowed alongside advice to “*take a less passive voice*”. Finding a way forward, finding a voice that is neither overly subjective, nor inactive, was at times a significant challenge to my positivist research beginnings. Finally, however, having reconciled myself with constructivist principles through considerable reading, I realised that by reflecting on and acknowledging my position within the research early on in the process, I could structure an emotive, convincing argument for an issue in which I believe strongly, without feeling the need to remove myself from it entirely, accepting that, in reality, no research can be seen as truly independent of its author’s world view.

3.6 Gender Issues in Qualitative Research

Alongside reflections on the impact of motherhood on research, my journal entries show a secondary, underlying theme. Although fathers’ overt questions about my parental status raised clear issues for the research, veiled within entries about these are thoughts on the secondary impact of gender on the qualitative research process.

The many and varied impacts of gender on research have been discussed extensively within previous literature. In particular, questions of how a researcher’s gender may impact on participant interviews and the information and data obtained have been raised. Although the majority of gender based papers, reflecting their positions within feminist research, recount the effects of researchers’ gender on interviews with women participants, there is some evidence that being a woman researcher may also impact on the interviews of male participants (Golombisky, 2006; Herod, 1995; Stanley & Slattery, 2003).

The impact of interviews being conducted by a woman interviewer is without a doubt complex, with arguments of gendered assumptions that possession of feminine communication styles makes for a “better listener” and therefore a “better” interviewer, contrasted against suggestions that perceiving a woman as a researcher affords her an “honorary male” status, counteracting any real effect of gender (Golombisky, 2006).

Despite this lack of clarity, efforts have nonetheless been documented within literature to overcome, or at least expose, the effects of gender on the interview process, such as Stanley and Slattery’s (2003) consideration of working as a mixed gender interviewing team. In my research, however, it is hard to define what these effects might have been, not least because the design and purpose of the research necessitated male-only interviews, conducted by a lone woman researcher not afforded the luxury of recruiting a male co-researcher to clarify the effects of gender on the interviews.

Within my reflective journal, particularly in early entries, I note concerns that gender might affect the interviews. I worried whether being a woman might inhibit fathers from discussing their experiences. In reality, however, it felt that the opposite was true, that once fathers started, their accounts were often effusive, feeling like an open flow of consciousness that I found it hard to interrupt. Golombisky (2006) would suggest, however, that this in itself is evidence of gender issues within the interviews, noting that male participants may “speak down” to a woman researcher, who finds herself unable to challenge or interrupt a dominant male discourse.

Giving this some consideration I wonder at the mechanisms by which this

reluctance to interrupt arose. I certainly did not feel spoken down to by the fathers, and wondered if this came back to the matriarchal nature of the topic under discussion, where my status as a woman lent me greater credence, going somewhat towards levelling the playing field of power and gender. I wonder instead, whether my reluctance to interrupt reflected by anxieties about allowing fathers, used to being marginalised within the female dominated maternity services, the space to express themselves freely for the course of the interview.

3.7 Multiple Roles, Gender and Motherhood

Where the themes of gender and motherhood are raised within my reflective journal, the potential impact on the research is often inextricably linked with the converse; the impact the research had on me, as a mother.

For me, most apparent throughout the research process, were the recurring issues of guilt and dissonance around perceived failure to meet expectations of a “good parent” that arose within parents’ stories. As mothers spoke of guilt around breastfeeding, and fathers spoke of feelings of helplessness and guilt at not achieving the roles they had hoped for during birth, their feelings resonated within my own experiences.

I deeply empathised with the distress described by parents within my own and past research, revisiting the depth at which their experiences had affected me during my own early days as a parent. I identified with each parent who spoke of ongoing struggles to reconcile the reality of those early weeks with prior expectations, feeling relieved to have passed through that particular labyrinth, yet knowing that there was almost certain to be another waiting for me around the next corner of family life. It occurred to me that clashes between reality and

expectation often stand hand-in-hand through parenthood, where the high and often duplicitous standards of social norms and values around “good parenting” are so ingrained that we cannot escape their power, even when we are not aware of their presence.

For me the conflicting ideals of a “good mother” were raised continually throughout the research. Raised to believe that academic achievement and economic independence were goals every bit as applicable to me as to my older brother, I also inherited a sense of the value of attentive, empathic parenting, heightened by my clinical training, which told me that, as a parent, my children must be my priority. Society taught me that, as a woman, my role as a mother would be more hands-on and fundamental to my children’s development than that of their father and that as such, from the moment of their birth, assessment of my accomplishments would forever be indexed by my achievements as their mother.

Despite solid evidence from my husband that not only did he not share my matricentric view of childrearing, but that he had every intention of playing an equal role in our own children’s upbringing, I nonetheless felt the pull of expectation throughout my research and training. Each weekend spent immersed in the literature, and every bedtime hurried in order to allow my return to transcription or data analysis, therefore held its own price to pay in maternal guilt.

The nature of the research served only to emphasise this guilt. As I interviewed fathers, sitting surrounded by the paraphernalia of babyhood, and, on occasion, the babies themselves, I felt deeply that in order to be there, I was absent from my own children’s lives. As fathers digressed from the interview schedule to

discuss their parenting philosophies, I self-consciously wondered how they perceived me, whether they assumed me to be childless due to my availability for evening and weekend interviews, or, for those who knew me to be a parent, whether they were judging my life choices.

Having pondered these observations almost cyclically through my reflective journal, I reach, at almost the final entry, the following conclusion:

“It occurs to me that in choosing to focus on perinatal research whilst having young children of my own, I have succeeded in choosing a research topic that is not only of sufficient personal interest to warrant three years of focus on the topic, but that is also of relevance and importance to the world in which I live, and on which, to whomever I talk, people have comments to make and stories to tell. The price of this relevance, however, is the personal cost of the research, the concerns it raises and the sometimes painful memories it brings back. It feels, almost, as if I have somehow also participated vicariously in the research.”

Whilst I acknowledge the, somewhat unexpected, cost of conducting highly personal research, I feel that I am justified in saying that the motivation and passion that such relevance affords is more than worth the emotional revelations along the way. Overall, I feel that where researchers are able to contain the effects upon them, conducting research in a personally significant area, can offer increased interest and relevance of their findings to “real-life” and the social world.

3.8 Conclusions and Implications for Research

Looking back at the research process I am struck that whilst one can wonder at the impact of researcher characteristics such as gender and parenthood on research, as well as the effects of the research upon researchers, and make suggestions as to how these effects might be mediated, there can be no assurances of objectivity or impartiality. The potential influences discussed within this paper are subtle and complex.

What is clear for researchers, however, is the importance of reflecting on and acknowledging our own position and stance within our research, continuing to consider the potential influences as we progress through to writing our final conclusions. Assurances of finding a neutral, passive observer stance within research are improbable and unnecessary in human social and psychological research. In conclusion, therefore, this paper calls for researchers, both qualitative and quantitative alike, to declare their epistemological positions within their subject fields, in recognition that failure to do so risks much greater muddying of the academic waters than the admission that we can never truly step outside of our own personal and social worlds, even in the pursuit of scientific objectivity.

3.9 References

- Bird CE & Brown U (1997) Gender differences in the social and economic burdens of parenting and psychological distress. *Journal of Marriage and the Family* 59(4): 809-823.
- Doucet A (1995) Gender equality and gender differences in household work and parenting. *Women's Studies International Forum* 18(3): 271-284.
- Golombisky, K. (2006) Gendering the Interview: Feminist reflections on gender as performance in research. *Women's Studies in Communication* 29(2): 165-192.
- Herod, A. (1993) Gender issues in the use of interviewing as a research method. *Professional Geographer* 45(3): 305-317.
- Jenson, T. (2008) "Speaking as a Mother": Notes on becoming a researcher and not getting onto Supernanny. *Feminism and Psychology* 18: 384-388.
- Mose Brown T & Masi de Casanova E (2009) Mothers in the field: How motherhood shapes fieldwork and researcher-subject relations. *Women's Studies Quarterly* 37(3/4): 42-58.
- Powell, K. (1999) Exploring Motherhood: When the researcher has multiple roles. *Nursing Inquiry* 6(3): 20-22.
- Stanley, C.A. & Slattery, P (2003) Who reveals what to whom? Critical reflections on conducting qualitative inquiry as an Interdisciplinary, biracial, male/female research team. *Qualitative Inquiry* 9: 705-728.

Appendices

Appendix 1: Journal Submission Instructions for Authors

- a) Journal of Reproductive and Infant Psychology**
- b) Psychology of Women Section Review**

Appendix 2: Ethical Approval

- a) Coventry University Ethical Approval**
- b) Staffordshire Regional Ethics Committee Approval**
- c) Local Research & Development Approval**

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Appendices

Appendix 1: Journal Submission Instructions for Authors

- a) Journal of Reproductive and Infant Psychology**
- b) Psychology of Women Section Review**

Submission Instructions: The Journal of Health Psychology

Instructions for Authors:

1. Articles should be as short as is consistent with clear presentation of subject matter. There is no absolute limit on length but 6000 words, including footnotes and reference list, is a useful maximum. Tables and figures count as 500 words each which should be attached as separate pages at the end. INSERT HERE signs should be noted within the text. The title should indicate exactly, but as briefly as possible, the subject of the article. An abstract of 100 words should precede the main text, accompanied by up to five key words. Author bios are not necessary. Publication guidelines for intervention studies are published in volume 15, number 1, pages 5-7.
2. The Journal also publishes Brief Reports of up to 3000 words. Brief Reports should include an abstract of 100 words, and may include a table or figure in lieu of 500 words of the 3000-word maximum. All papers are reviewed 'blind' by expert peers.
3. Authors should provide a standard and a 'blind' electronic version of their article - one version containing names, affiliations, full mailing address plus telephone, fax, email address; and one containing the title only. In all cases, the Editor will screen manuscripts for their overall fit with the scope of the journal in terms of relevance, rigour, and interest to the readership. Those that fit will be further reviewed by two or more independent, expert and internationally representative reviewers.
4. The Journal requires authors to have obtained ethical approval from the appropriate local, regional or national review boards or committees. Of particular importance are the treatment of participants with dignity and respect, and the obtaining of fully informed consent. The methods section of the paper must contain reference to the forum used to obtain ethical approval.
5. Authors must follow the Guidelines to Reduce Bias in Language of the Publication Manual of the American Psychological Association (6th ed). These guidelines relate to level of specificity, labels, participation, gender, sexual orientation, racial and

ethnic identity, disabilities and age. Authors should also be sensitive to issues of social class, religion and culture.

6. Typescripts must be typed in double spacing throughout. Titles and section headings should be clear and brief with a maximum of three orders of heading. Lengthy quotations (exceeding 40 words) should be displayed, indented, in the text. American or UK spelling may be used, to the author's preference. Indicate italic type by underlining, and use single quotation marks. Dates should be in the form 9 May 1994. Take out points in USA and other such abbreviations.

7. Tables and figures should have short, descriptive titles. All footnotes to tables and their source(s) should be typed below the tables. Column headings should clearly define the data presented. Camera-ready artwork for all figures must be supplied. Artwork intended for same-size use should be a maximum size of 192:125 mm (page depth: page width). The title page should contain the word count of the manuscript (including all references).

8. HPQ uses the SAGE Harvard style of referencing and authors should follow this system. This means that after a quote or reference to research in the text, you should give, in brackets: 1. Author surname, 2. Year of publication. If you quote more than one source by the same author in the same year, use the letters a, b or c to distinguish. At the end of the paper you should list all references in alphabetical order, according to their source, in the following style:

- For a book:

Clark JM, Hockey L (1979) *Research for Nursing*. Leeds: Dobson Publishers.

- For a chapter in a book:

Gumley V (1988) Skin cancers. In: Tschudin V and Brown EB (eds) *Nursing the Patient with Cancer*. London: Hall House, 26-52.

- For an article:

Huth EJ, King K, and Lock S (1988) Uniform requirements for manuscripts submitted to biomedical journals. *British Medical Journal* 296(4): 401-405.

- For an article published ahead of print:

Huth EJ, King K, and Lock S (1988) Uniform requirements for manuscripts submitted to biomedical journals. *British Medical Journal* 00: 1-4 (accessed 7 October 2009).

- For a website

National Center for Professional Certification. (2002) Factors Affecting Organizational Climate and Retention. Available at:
www.cwla.org./programmes/triechmann/2002fbwfiles

- For an unpublished thesis

Clark JM (2001) Referencing style for journals. Unpublished doctoral thesis, University of Leicester, Leicester.

9. The corresponding author will receive page proofs for checking. He or she will be given controlled access to a PDF of the article and a complimentary copy (per author) of the whole issue after publication.

Submission Instructions: Psychology of Women Section Review

Notes for Contributors:

1. All papers and submissions for the Agora section will be peer-reviewed.
2. Copies of all submissions should be sent by e-mail attachment (in Word format) and/or three hard copies to the Editors (or Assistant Editor where specified). A separate cover page should be provided with the title of the paper, the author's names, their institutions, addresses and email addresses clearly marked. Authors are also invited to provide brief biographical information. Manuscripts should have the title clearly marked on the first page, and pages should be numbered. However, authors' names should not appear on the manuscript itself.
3. All figures should be of reproducible standard. References should conform to Society style, which is similar to the American Psychological Association (APA) system. The Society's *Style Guide* can be downloaded from: www.bps.org.uk/publications/submission-guidelines/submission-guidelines_home.cfm
4. Papers should be between 3000 and 6000 words long and submissions for the Agora between 200 and 2000 words. An abstract of up to 150 words should be provided with papers; however, no abstract is needed for Agora submissions.
5. Book reviews and reviews of research papers will normally be commissioned by the relevant Assistant Editors. Anyone interested in reviewing books or research papers should contact the Assistant Editor directly.
6. Authors should avoid the use of any sexist, racist, heterosexist or otherwise discriminatory language.

Appendix 2: Ethical Approval

- a) Coventry University Ethical Approval**
- b) Staffordshire Regional Ethics Committee Approval**
- c) Local Research & Development Approval**

Coventry University

Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

THE UNIVERSITY OF
WARWICK



Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

TO WHOM IT MAY CONCERN

RRU/Ethics/Sponsorlet

04 May 2011

Dear Sir/Madam

Researcher's name: Miss Rachel Johnson

Project Title: A qualitative exploration of paternal reactions to traumatic birth experiences

The above named student has successfully completed the Coventry University Ethical Approval process for her project to proceed.

I should like to confirm that Coventry University is happy to act as the sole sponsor for this student and attach details of our Public Liability Insurance documentation.

With kind regards

Yours faithfully

[No signature on copy: received via email]

Professor Ian Marshall
Pro-Vice-Chancellor, Research

Dean of Faculty of Health and Life Sciences

Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Chair of Department of Psychology

Professor Liz Robinson BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7652 3096



Commercial Insurance

158 Edmund Street
Birmingham
B3 2HB
Tel: 0121 253 3100
Fax: 0121 212 1200

TO WHOM IT MAY CONCERN

July 2010

Dear Sirs

COVENTRY UNIVERSITY AND/OR SUBSIDIARY COMPANIES

SUBSIDIARY COMPANIES: COVENTRY UNIVERSITY ENTERPRISES LTD, ACUA LTD AND
COVENTRY UNIVERSITY LONDON CAMPUS LTD

We act as Insurance Brokers to the above named client; we can confirm their Insurance Policies are in force and are arranged as detailed below:

Employers Liability

Insurer: QBE Insurance (Europe)
Policy Number: Y016796QBE0110A
Period of Insurance: 1 August 2010 to 31 July 2011 (both days inclusive)
Limit of Indemnity: £25,000,000 any one occurrence

Public/Products Liability

Insurer: QBE Insurance (Europe)
Policy Number: Y016796QBE0110A
Period of Insurance: 1 August 2010 to 31 July 2011 (both days inclusive)
Limit of Indemnity: £25,000,000 each and every occurrence - Public Liability
£25,000,000 each and every loss and in aggregate - Products Liability
Deductibles: £1,000 each and every Property Damage claim
Principal Extension: Students Liability

The information provided is a summary and is subject to the terms and conditions of the Policy. If you have any further queries, please do not hesitate to contact me.

Yours faithfully
For Aon Limited

ALISON RAY CERT CII
CLIENT SERVICE ADVISOR
Direct Dial: 0121 253 3256
Email: alison.ray@aon.co.uk

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Staffordshire Research Ethics Committee

Prospect House
Fishing Line Road
Redditch
Worcestershire
B97 6EW

Telephone: 01527 582535
Facsimile:

01 November 2010

Mrs Rachel R Johnson
Trainee Clinical Psychologist
Worcestershire Mental Health Partnership
Department of Clinical Psychology
James Starley Building
Priory Street, Coventry
CV1 5FB

Dear Mrs Johnson

Study Title: A qualitative exploration of paternal reactions to
traumatic birth experiences
REC reference number: 10/H1203/29

Thank you for your letter of 25 October 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a sub-committee of the REC. A list of the sub-committee members is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

However the subcommittee suggested that the 'Staffordshire Research Ethics Committee' should be named under 'Who has reviewed this study' on the Participant Information Sheet. The subcommittee also noted that it would be helpful to have the contact details in the Support Leaflet, including telephone numbers, of the Psychology Team who have offered support. These are not conditions of approval but the REC asks for the revised documents to be submitted for the file.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research (“R&D approval”) should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation’s involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Investigator CV		01 June 2010
Protocol	v.07/06/10	07 June 2010
CV Academic Supervisor		18 June 2010
REC application		15 June 2010
Covering Letter		16 August 2010
Letter from Sponsor		18 June 2010
Interview Schedules/Topic Guides	v16/08/10	16 August 2010
Questionnaire: Demographic Questionnaire	v.15/06/10	15 June 2010
Letter of invitation to participant	v.15/06/10	15 June 2010
Response to Request for Further Information		25 October 2010
Participant Information Sheet: Participant Introduction Sheet	v10.10.10	10 October 2010
Participant Information Sheet	v10.10.10	10 October 2010
Participant Consent Form: Consent to be contacted		23 August 2010
Participant Consent Form	v10.10.10	10 October 2010
What if I need more support?	v10.10.10	10 October 2010
Guidance Notes for Consent Form	10.10.10	10 October 2010
Evidence of insurance or indemnity		01 August 2009

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research

Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/H1203/29

Please quote this number on all correspondence

Yours sincerely



Jenny Tyers (Mrs) for and on behalf of
Dr Kathryn Kinmond
Chair

Email: jenny.tyers@westmidlands.nhs.uk

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments

"After ethical review – guidance for researchers"

Copy to: Professor Ian Marshall
Pro-Vice Chancellor (Research)
Coventry University
Priory Street
Coventry
CV1 5FB

Ms. Jo Williams
Research & Development Office
South Warwickshire General Hospitals NHS Trust
Room 2, Medical School Building
Lakin Road
Warwick
CV34 5BW

Room 2 Medical School Building
Warwick Hospital
Lakin Road
Warwick
CV34 5BW

01926 495321 ext. 4411

jo.williams@swft.nhs.uk

10th November 2010

Mrs R Johnson
17 Franchise Street
Kidderminster
Worcs
DY11 6RA

Dear Mrs Johnson,

Re: A Qualitative Exploration of Paternal Reactions to Traumatic Birth Experiences

R&D Approval No.: 08111001

Project Reference: SWH076

Protocol: 07/06/10

I can confirm that the R&D Department has reviewed the above project and is happy to grant Trust approval.

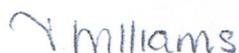
Your research activity is now covered by NHS indemnity as set out in HSG (96) 48, and your trial has been entered into the Trusts' database.

All research must be managed in accordance with the requirements of the Department of Health's Research Governance Framework (RGF) and to ICH-GCP standards. Your responsibilities are set out in the attached agreement.

The Trust employs the services of an external organisation to monitor 10% of all projects on an annual basis. You are contractually obliged to comply with the requests of this organisation as they have the authority to audit your site file at any time, in line with the Research Governance framework.

If you have any queries relating to R&D, please do not hesitate to contact me. The Trust wishes you success with your research.

Yours sincerely



Mrs Jo Williams
Research Manager

West Midlands (South) Comprehensive Local Research Network
Fourth Floor West Wing (ACF40002)
University Hospitals Coventry & Warwickshire NHS Trust
University Hospital
Clifford Bridge Road
Coventry
CV2 2DX
Tel: 024 7696 4941
Fax: 024 7696 6201

Monday 29th November 2010

Mrs Rachel Johnson
Trainee Clinical Psychologist
Department of Clinical Psychology
James Starley Building
Coventry University
Priory Street
Coventry
CV1 5FB

Dear Mrs Johnson

**Re: A Qualitative Exploration of Paternal Reactions to Traumatic Birth Experiences
Letter of access for research**

This letter confirms your right of access to conduct research through Coventry and Warwickshire Partnership NHS Trust for the purpose and on the terms and conditions set out below. This right of access commences on 29th November 2010 and ends on 31st July 2011 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

The information supplied about your role in research at Coventry and Warwickshire Partnership NHS Trust has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor to Coventry and Warwickshire Partnership NHS Trust premises. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through Coventry and Warwickshire Partnership NHS Trust, you will remain accountable to your employer, Coventry University, but you are required to follow the reasonable instructions of **Mike Oldridge** in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with Coventry and Warwickshire Partnership NHS Trust policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with Coventry and Warwickshire Partnership NHS Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on Coventry Teaching Primary Care Trust premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

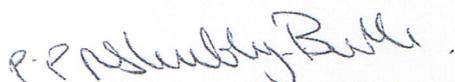
We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. As from 26 July 2010, your HEI employer may initiate your Independent Safeguarding Authority (ISA) registration (where applicable), and thereafter, will continue to monitor your ISA registration status via the on-line ISA service. Should you cease to be ISA-registered, this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity. You MUST stop undertaking any regulated activity.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

Coventry and Warwickshire Partnership NHS Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely



Dr Kelly Spencer
RM&G Manager

cc: University of Warwick HR Department

**Appendix 4: Methodology, participants & thematic content of
reviewed papers**

Table 1 Methodology, participants and thematic content of reviewed papers

Author(s) & year	Country	Measures & Design	Participants & Recruitment	Relevance to Themes
Amir, Dennerstein, Garland, Fisher & Farish (1996)	Australia	<ul style="list-style-type: none"> - Comparison of mothers with and without nipple pain - Edinburgh Postnatal Depression Scale & Profile of Mood Scale - Non-symptomatic group assessed once - Symptomatic group assessed weekly until resolution of pain 	<ul style="list-style-type: none"> - Symptomatic mothers: n=48, presenting with nipple pain at two clinics. - Non-symptomatic mothers: n=65 recruited through breastfeeding clinics and breastfeeding groups 	<ul style="list-style-type: none"> - Theme 4: Facing problems, uncertainty & change
Bottorff (1990)	Canada	<ul style="list-style-type: none"> - Phenomenological analysis of interviews on experiences of persisting with breastfeeding - Personal conversations use noted: no further details provided 	<ul style="list-style-type: none"> - Interviews with breastfeeding mothers: n=3 - No recruitment details provided 	<ul style="list-style-type: none"> - Theme 1: Expectations & beliefs - Theme 2: Identity & the internal world - Theme 3: Division & breastfeeding - Theme 4: Facing problems, uncertainty & change
Cooke, Schmied & Sheehan (2007)	Australia	<ul style="list-style-type: none"> - Self-report measures given antenatally, and at 2 weeks and 3 months post birth - Edinburgh Postnatal Depression Scale & Maternal Role Attainment Scale of Maternal Breast Feeding Evaluation Scale - ANOVA of EDPS/Anxiety/MRA relation to feeding duration - Kruskal-Wallis for MRA and duration 	<ul style="list-style-type: none"> - Mothers: n=365 accepted invite - All women registered to give birth in one of 3 hospitals, within a given 1 month period, invited to participate 	<ul style="list-style-type: none"> - Theme 1: Expectations & beliefs - Theme 2: Identity & the internal world - Theme 4: Facing problems, uncertainty & change

		<ul style="list-style-type: none"> - Chi-squared of problems relationship with duration - Logistic regression to examine predictors of early cessation - ANCOVA for interaction between MIRA, problems and feeding decision and EDPS at 3 months , controlling for anxiety and antenatal EDPS 		
Cooke, Sheehan & Schmied (2003)	Australia	<ul style="list-style-type: none"> - Self-report measure & questionnaire given antenatally, and at 2 weeks, 6 weeks and 3 months post birth - Maternal Breast Feeding Evaluation Scale - Frequency data plus MANOVA to explore breastfeeding experiences and MBFES factors - Open questions about reasons for current choice of infant feeding method – frequencies recorded. 	<ul style="list-style-type: none"> - Mothers: n=365 accepted invite - All women registered to give birth in one of 3 hospitals, within a given 1 month period, invited to participate - Not all women responded to the open-ended questions 	<ul style="list-style-type: none"> - Theme 2: Identity & the internal world - Theme 4: Facing problems, uncertainty & change
Crossley (2009)	UK	<ul style="list-style-type: none"> - Auto-ethnographic exploration of experiences of self and partner - Infant breastfed to 12 weeks, before discontinuing due to infant weight loss - Thematic analysis of dialogical interview transcript 	<ul style="list-style-type: none"> - Mother: n=1 - Father: n=1 	<ul style="list-style-type: none"> - Theme 1: Expectations & beliefs - Theme 2: Identity & the internal world - Theme 3: Division & breastfeeding - Theme 4: Facing problems, uncertainty & change

Dykes (2005)	UK	<ul style="list-style-type: none"> - Interviews with breastfeeding mothers and midwives - Observations (of 3-5 hours each) of interactions between breastfeeding mothers and midwives - Ethnographic approach, using thematic networks analysis 	<ul style="list-style-type: none"> - Interviewed mothers: 106 interviews, n=61 mothers - Interviewed midwives: 37 interviews, n=39 midwives - Observations of interactions: n=97 encounters - Recruited through two UK hospitals 	<ul style="list-style-type: none"> - Theme 1: Expectations & beliefs - Theme 2: Identity & the internal world - Theme 4: Facing problems, uncertainty & change
Faircloth (2010)	UK	<ul style="list-style-type: none"> - Semi-structured interviews and questionnaires with mothers who breastfeed for "extended" periods of time - Longitudinal, ethnographical approach: no further methodological details provided 	<ul style="list-style-type: none"> - Interviews: n=22 - Questionnaires: n=25 - Recruited through 10 local La Leche League groups 	<ul style="list-style-type: none"> - Theme 3: Division & breastfeeding
Grassley & Nelms (2008)	USA	<ul style="list-style-type: none"> - Mothers who had breastfed at least one child in last 2 years and whose children were between 4months and 4 years of age were interviewed about their stories of breastfeeding - Transcripts analysed by Gadamerian hermeneutics and storytelling. 	<ul style="list-style-type: none"> - Mothers: total n=13 - Initially recruited by purposive sampling from personal network of primary author (n=6). - Other women contacted the researcher after receiving flyer or hearing from another participants (n=7) 	<ul style="list-style-type: none"> - Theme 1: Expectations & beliefs - Theme 2: Identity & the internal world - Theme 3: Division & breastfeeding
Hauck & Irurita (2002)	Australia	<ul style="list-style-type: none"> - Grounded Theory - Audio-taped and transcribed interviews - Postal questionnaires to partners of mothers interviews 	<ul style="list-style-type: none"> - Mothers: n=33 - Recruited form a larger study being conducted into wider breastfeeding context (n=29). 	<ul style="list-style-type: none"> - Theme 1: Expectations & beliefs - Theme 3: Division & breastfeeding

		duration (fed for 2 days to 8 weeks) and long-duration (fed for 6 to 14 months)	breastfeeding, where (n=194) participants had volunteered to take part	breastfeeding
		- Two 1 hour interviews, 1-2 weeks apart, in participants' homes were audio-taped, transcribed and systematically analysed using phenomenological approach	- Mothers selected based on their experience – no further specification given	
Hills-Bonczyk, Tromiczak, Avery, Potter, Savik & Duckett (1994)	USA	- Prospective longitudinal design of breastfeeding, first-time mothers - Mother who fed for >12months and for <12months were compared using chart data and interviews - Information on duration of exclusive breastfeeding, return to work, feeding patterns at 12 months was sought from all women - Telephone interviews and postal questionnaires with mothers breastfeeding longer than 12months. Interviews continued until exclusive feeding ceased. - ANOVA & Scheffe post-hoc test analysis - Frequencies of themes from open ended questions also reported	- Long-term breastfeeding mothers: n=82 - Shorter-term breastfeeding mothers: n=541 - Part of a larger prospective study on breastfeeding in first-time mothers - Recruited through hospital; all first time, English speaking mothers with no additional health needs for mother or child were invited to participate.	- Theme 2: Identity & the internal world - Theme 3: Division & breastfeeding
Kelleher (2006)	USA	- Semi-structured interviews conducted at 1 month postpartum with mothers in wider study who had breastfed for any duration - Transcripts coded, arranged into themes,	- Mothers: n=52 - Recruited through postpartum wards of two hospitals	- Theme 1: Expectations & beliefs - Theme 2: Identity & the internal world

and memos generated for analysis			
		-	Theme 3: Division & breastfeeding Theme 4: Facing problems, uncertainty & change
Kendall-Tackett & Sugarman (1995)	USA	-	Theme 2: Identity & the internal world Theme 3: Division & breastfeeding
		-	Mothers who had breastfed >6 months: n=179
		-	Recruited through questionnaire distribution at La Leche League conferences over a 3 year period
		-	Closed ended self-report questionnaire including 96 items on reasons for continuation of breastfeeding, social emotional and physical experience and demographic data.
		-	Ratings of negative and positive aspects of breastfeeding, and of others' reactions and the impact of their reactions.
		-	Descriptive data and comparison of changes in distribution by Cochran's Q.
		-	Qualitative open responses unanalyzed but reported for illustration
Lamontagne, Hamelin & St-Pierre (2008)	Canada	-	Theme 2: Identity & the internal world Theme 3: Division & breastfeeding Theme 4: Facing problems, uncertainty & change
		-	Telephone: n=86
		-	Semi-structured interview: n=12
		-	Recruited either by random sampling of attendees of a breastfeeding clinic, or through identification from birth record in an area where no clinic was available.
		-	Interview participants recruited via purposive sampling designed
		-	80 item, quantitative questionnaire examining socio-demographic, economic, clinical and psycho-social characteristics as well as breastfeeding experience, support and experience of clinic
		-	1 hour semi-structured interview accessing breastfeeding experience
		-	Quantitative data analysed by Chi-square and Fisher's exact
		-	Qualitative data analysed by content

analysis		to maximize variation in breastfeeding duration	Theme 2: Identity & the internal world
Leff, Gagne & Jerrris (1994)	USA	<ul style="list-style-type: none"> - Constant comparative analysis of mother interviews on successful and unsuccessful breastfeeding - Mothers: n=26 - Recruited through pediatric practice or Women, Infants and Children (WIC) program. - Collection continued until saturation was reached 	
Manhire, Hagan & Floyd (2007)	New Zealand	<ul style="list-style-type: none"> - Thematic analysis of mothers' comments on their entire breastfeeding experience - Retrospective design – some mothers had long time since experience of breastfeeding. - Mothers: n=153 - Mothers who had given birth between 4 months and 3 years previously - Qualitative responses from previous questionnaire based study were analysed - Original participants were all mothers identified from regional hospital maternity database - 500 mothers (250 c-section births, 250 vaginal births) were selected at random from the original cohort and invited to participate. 	<ul style="list-style-type: none"> - Theme 2: Identity & the internal world - Theme 3: Division & breastfeeding
Mezzacappa(1997)	USA	<ul style="list-style-type: none"> - Self-report questionnaire on overall health, mood, stress and psychological and upper respiratory tract symptomology - Current: n=14 - Never: n=36 - Past: n=49 	<ul style="list-style-type: none"> - Theme 2: Identity & the internal world - Theme 4: Facing problems

		<ul style="list-style-type: none"> - 7 point scales and frequencies used - Multiple regression - Comparisons between current, never and past breastfeeding mothers 	<ul style="list-style-type: none"> - Recruited via questionnaire distribution in a pediatrician's waiting room - Participants were excluded if pregnant, had a tubal ligation, were on prescription medicine or breastfeeding status couldn't be determined. 	uncertainty & change
Mezzacappa, Guethlein & Katkin (2002)	USA	<ul style="list-style-type: none"> - Comparison between currently and past breastfeeding mothers - Self-report measures of perceived stress, upper respiratory infection symptoms and physician visits for psychological illnesses. - Online survey taking 5-10 minute to complete - Multivariate regression analyses 	<ul style="list-style-type: none"> - Currently breastfeeding: n=561 - Past breastfeeding: n=452 - Recruited via adverts and links on internet sites, resulting in a geographically diverse population. 	<ul style="list-style-type: none"> - Theme 2: Identity & the internal world - Theme 4: Facing problems, uncertainty & change
Mozingo, Davis, Droppleman & Merideth (2000)	USA	<ul style="list-style-type: none"> - Interviews investigating lived experience of women who initiate breastfeeding but stop within 2 weeks of birth - Phenomenological analysis of transcripts 	<ul style="list-style-type: none"> - Mothers: n=9 - Recruited through professional networks and community links 	<ul style="list-style-type: none"> - Theme 1: Expectations & beliefs - Theme 3: Division & breastfeeding - Theme 4: Facing problems, uncertainty & change
Reamer & Sugarman (1987)	USA	<ul style="list-style-type: none"> - Questionnaire with 51 short items, 52 free-response questions - Gathering information on characteristics, reasons for persisting despite social 	<ul style="list-style-type: none"> - Long-term (>6months) breastfeeding mothers: n=152 randomly selected from 1038 responses to be a small test 	<ul style="list-style-type: none"> - Theme 2: Identity & the internal world - Theme 3: Division & breastfeeding

		approval, and positive and negative emotional and physical experiences.	sample.
		Frequencies of responses reported with quotes as illustration	Recruited through La Leche League newsletter
Schmied & Barclay (1999)	Australia	<ul style="list-style-type: none"> - Wider Interviews exploring first-time mothers' experiences were used to explore experiences of breastfeeding - Discourse Analysis 	<ul style="list-style-type: none"> - Mothers: n=25, 1 antenatal and 4 postnatal (first week, 1 month, 3 months and 6 months post-birth) interviews each - Recruited by invitation to all parents attending prenatal classes held at hospital
			<ul style="list-style-type: none"> - Theme 1: Expectations & beliefs - Theme 2: Identity & the internal world - Theme 3: Division & breastfeeding - Theme 4: Facing problems, uncertainty & change
Scott & Mostyn (2003)	UK	<ul style="list-style-type: none"> - Focus group interviews exploring attitudes and experiences of low-income mothers in area where bottle-feeding is the cultural norm - Content Analysis 	<ul style="list-style-type: none"> - Mothers: n=19 participated in one of 4 focus groups - Recruited at random from all (n=668) women who had received support from a peer-support volunteer in a 3 ½ year period
			<ul style="list-style-type: none"> - Theme 1: Expectations & beliefs - Theme 3: Division & breastfeeding

**Appendix 5: Criteria for invitation to the Warwick Postnatal
Class**

Criteria for Invitation to Traumatic Childbirth Postnatal Group:

POSTNATAL FACTORS To be completed before discharge	Score	
Prolonged active pushing > 1.5 hours	3	Score: 7 and above High Risk Refer to Postnatal class
Large baby 4kg	3	
Instrumental delivery	6	
Episiotomy/2 nd degree tear	2	
Complex tear/extended episiotomy	4	
3 rd /4 th degree tear/urethral tear	10	
Grand multigravida (>5 pregnancies, >24 weeks)	8	
Single drainage by catheter >800mls	Tick	Any tick: Refer to Postnatal class
Indwelling catheter for > 24 hours	Tick	
No spontaneous void for >8 hours	Tick	
Episodes (>1) postnatal urinary incontinence	Tick	
Episodes (>1) postnatal faecal incontinence	Tick	
ANTENATAL FACTORS Interview with patient		
History of urinary incontinence > weekly last 2 years	Tick	Refer to Postnatal class
History of faecal incontinence/urgency	Tick	
Patient informed of postnatal classes	Yes / No	
Class information leaflet given	Yes / No	

Appendix 6: Interview Schedule

Semi-structure interview schedule used during participant interviews:

Interview Schedule

Version: V16/08/10

Question 1: What were your experiences of the birth of your baby?

Question 2: How do you think these experiences affected you and your family?

Question 3: How do you think your experiences were different from your child's mother's experiences?

Question 4: How did you manage the effects of your experience?

Question 5: What was your experience of the support offered to you by professionals?

Question 6: What are your views on the need for services for support fathers?