

Positive Mental Wellbeing in the Transition to Motherhood: The
Impact of Poverty and Social Support

Louise Baxter

The thesis is submitted in partial fulfilment of the requirements for the award of the
degree of Doctor of Philosophy of the University of Portsmouth.

December 2018

Abstract

Whilst there is a substantial literature on the potential for poor mental health outcomes in the postnatal period, much less is known about the positive wellbeing of pregnant women and new mothers. The potential relationship between poverty and levels of subjective wellbeing in the transition to motherhood is also an under researched area.

The aim of this study was to measure wellbeing, quality of life, poverty and social support, and investigate potential relationships between these; and to explore possible barriers and facilitators of good mental health in the transition to motherhood.

Questionnaires using validated measures of subjective wellbeing, quality of life, social support levels and deprivation were administered to participants in the last trimester of pregnancy and again at 3-4 months post-delivery. In-depth interviews were undertaken with a separate group of mothers with children under the age of 2 to explore their mental health experiences in the transition to motherhood.

Social support levels were significantly lower in the 'living in poverty' group at both time points, and there was a significant reduction in social support in both groups from pregnancy to early motherhood. Subjective wellbeing scores were also significantly lower in the 'living in poverty' group at both time points. Regression analysis found a significant relationship between poverty and wellbeing, which was mediated by social support score, suggesting that high levels of social support can mitigate the effects of poverty on wellbeing.

Thematic analysis of the interview transcripts identified an overarching theme of 'Resistance and Resilience'. Positive support, getting outside and staying active were clear facilitators of good mental health in new mothers. Lack of financial resources, and negative judgements, were barriers to wellbeing.

Social support from a close relationship can mitigate the effects of poverty on mental wellbeing and could bolster confidence in a new mother's identity. More intensive support from health care professionals or services for women who do not have partners may also be beneficial. This may need to go beyond practical support to advocating for women's decisions to be effective in bolstering mental wellbeing.

Table of Contents

Abstract	ii
Table of Contents	iii
List of tables	vii
List of figures	viii
Declaration and word count	ix
Abbreviations	x
Acknowledgements.....	xii
Dissemination.....	xiii
1 Chapter One: Positive mental health and becoming a mother: what is the evidence?	1
1.1 Introduction: Positive mental health and wellbeing at a time of transition.....	1
1.1.1 Centralising the mother in maternal mental health research	1
1.1.2 Why is this important?	3
1.1.3 How this review was approached	4
1.1.4 Definitions: positive mental health, and socio-economic position	6
1.2 How does identity transition, and how is this important to mental health?.....	11
1.2.1 How do women become ‘mothers’?.....	11
1.2.2 Maternal role attainment	12
1.2.3 The evolution to ‘Becoming a Mother (BAM)’	13
1.2.4 Returning women to the ‘transition to motherhood’	15
1.3 What might be affecting wellbeing in the transition to motherhood?	16
1.3.1 Importance of social determinants for mental wellbeing	16
1.3.2 SEP and subjective wellbeing	17
1.3.3 Extent and determinants of maternal mental wellbeing: the evidence.....	18
1.3.4 Social identity theory: the effect of group membership and support.....	30
1.3.5 The cultural narratives of motherhood and impact of these on transition...	33
1.4 The theoretical framework and literature gap: what this study can contribute ..	35
1.4.1 How this research will address this gap.....	36
1.5 The proposed research questions	38
2 Chapter Two: Philosophical foundations, paradigmatic stance, methodological choices	
39	
2.1 Introduction.....	39

2.2	Positivism and post-positivism	40
2.3	A pragmatic approach	41
2.4	Critical Realism	42
2.4.1	‘Realist ontology; constructivist epistemology’	43
2.4.2	Critical Realism and methodology: Mixed methods	43
2.4.3	Reflexivity	45
2.4.4	The role of theory: Induction and Deduction	46
2.5	Beyond the ‘paradigm wars’: the adopted research approach	47
3	Chapter Three: Mental wellbeing and quality of life in pregnancy and early motherhood: Findings from the Portsmouth Birth Cohort.....	49
3.1	Research design and strategy.....	49
3.1.1	The participants: The Portsmouth Birth Cohort Study	49
3.1.2	Recruitment and Consent	50
3.1.3	Questionnaire administration.....	51
3.1.4	Instruments	53
3.1.5	Data analysis procedures	58
3.2	Background to the participants.....	61
3.2.1	Poverty status	62
3.2.2	The picture of social support in the sample.....	65
3.3	Quality of life in pregnancy and early motherhood	66
3.3.1	Quality of life scores in pregnancy and early motherhood	67
3.3.2	Quality of life scores according to reported negative financial concerns	68
3.3.3	Roles of poverty and social support in quality of life in pregnancy.....	69
3.3.4	Areas of importance nominated in the MGI in pregnancy	69
3.3.5	Areas of importance nominated in the MGI in early motherhood.....	70
3.4	Subjective mental wellbeing in pregnancy and early motherhood.....	72
3.4.1	Wellbeing scores and poverty status.....	72
3.4.2	Social support and wellbeing scores	73
3.4.3	Possible confounding variables, and the relationship with wellbeing	73
3.4.4	The roles of poverty status and social support in wellbeing	77
3.4.5	The interaction of poverty, social support and time, and impact on maternal wellbeing.....	81
3.5	Discussion	82
3.5.1	Statement of principal findings from the questionnaire study	82

3.5.2	Strengths of the quantitative study	83
3.5.3	Limitations of the quantitative study.....	85
3.5.4	Comparison with the literature.....	87
3.5.5	Summary	92
4	Chapter Four: Resistance and Resilience: Positive mental health and wellbeing in the context of becoming a mother	93
4.1	Research Design & Strategy	93
4.1.1	Ensuring study rigour	94
4.1.2	The position of the researcher.....	94
4.1.3	Ethical approval for the study.....	95
4.1.4	Recruitment and consent.....	95
4.1.5	Data generation	98
4.1.6	Data analysis	99
4.2	The findings	102
4.3	Uncertainty.....	103
4.3.1	Preparation and anticipation	103
4.3.2	Control.....	107
4.4	Clashing identities	108
4.4.1	Loss.....	108
4.4.2	‘I still want to be myself’	110
4.5	Navigating judgement	113
4.5.1	Unhelpful support	114
4.5.2	Judgements of others.....	117
4.5.3	‘I felt like I had to be super’	119
4.6	Resisting and Rebuilding	121
4.6.1	Staying active and getting outside.....	121
4.6.2	Positive support	124
4.6.3	Resilience and Self –acceptance	129
4.7	Discussion	131
4.7.1	Interpretation and Comparison with the literature.....	131
4.7.2	Strengths and limitations of the qualitative study	144
4.7.3	Reflexivity and rigour	145
5	Chapter Five: Implications and future work	148
5.1	The study aims.....	148

5.2	Insights from the critical realist, mixed methods approach	148
5.3	Theoretical implications of the study findings	150
5.3.1	The determinants of mental wellbeing.....	150
5.3.2	The implications for theories of ‘transition to motherhood’	152
5.3.3	The Social Identity Model of Identity Change (SIMIC)	154
5.3.4	Dominant cultural narratives of motherhood	158
5.4	Conclusions and recommendations for further research	161
5.4.1	Implications of these findings for policy and practice	161
5.4.2	Suggestions for future research.....	165
6	Appendix A: NHS Ethical Opinion.....	167
7	Appendix B: HRA Approval Letter	170
8	Appendix C: Participant Information Sheet (Birth Cohort Study).....	174
9	Appendix D: Consent Form (Birth Cohort Study).....	179
10	Appendix E: Pregnancy Questionnaire.....	180
11	Appendix F: Postnatal Questionnaire	190
12	Appendix G: Science Faculty Ethics Approval (Qualitative Study)	198
13	Appendix H: Participant Information Sheet (Qualitative Study).....	204
14	Appendix I: Consent Form (Qualitative Study)	209
15	Appendix J: Interview Topic Guide.....	210
16	Appendix K: Coding Manual	212
17	Appendix L: Research Ethics Review Checklist UPR16.....	218
18	References.....	221

List of tables

Table 1: Literature searching strategy	5
Table 2: Abridged set of ONS recommended income groups	55
Table 3: WEMWBS questions	56
Table 4: Modified equivalence scale applied to income (taken from ONS Family Spending 2015)	61
Table 5: ANOVA of number of unaffordable items and income.....	62
Table 6: Summary of binary regression results, unaffordable items and equivalised income	63
Table 7: Material deprivation using PSE vs child poverty levels in Portsmouth.....	64
Table 8: Group characteristics by poverty status	65
Table 9: BSSS score by poverty status.....	66
Table 10: Mother-Generated Index scores by poverty status.....	68
Table 11: Antenatal themes nominated in the MGI	70
Table 12: Postnatal themes nominated in the MGI.....	71
Table 13: Questionnaire scores in pregnancy, by group (DS3).....	73
Table 14: Relationship between potential confounding variables and antenatal wellbeing scores	74
Table 15: Relationship between potential confounding variables and postnatal wellbeing scores	76
Table 16: Regression model, effect of poverty status and social support level on wellbeing in pregnancy.....	78
Table 17: Regression model, effect of poverty status and social support on wellbeing in early motherhood	80

List of figures

Figure 1: Items included in the deprivation measure	54
Figure 2: Resistance and Resilience: Themes and subthemes.....	103

Declaration and word count

Whilst registered as a candidate for the above degree, I have not been registered for any other research award. The results and conclusions embodied in this thesis are the work of the named candidate and have not been submitted for any other academic award

Word Count: 68,856

Abbreviations

ANOVA	Analysis of Variance
BAM	Becoming a Mother
BSSS	Berlin Social Support Scale
CINAHL	Cumulative Index of Nursing and Allied Health Literature
HSE	Health Survey for England
IPR	Introjection-projection-rejection
JRF	Joseph Rowntree Foundation
MGI	Mother Generated Index
MRA	Maternal Role Attainment
MSSS	Maternal Social Support Scale
NCT	National Childbirth Trust
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
ONS	Office for National Statistics
PortCo	Portsmouth Birth Cohort Study
PSE	Poverty and Social Exclusion Survey
PTSD	Post traumatic stress disorder
SED	Socio-economically disadvantaged
SEP	Socio-economic position
SES	Socio-economic status
SF-12/ 36	Short Form 12 or 36 item quality of life measure
SFEC	Science Faculty Ethics Committee
SIMIC	Social Identity Model of Identity Change
SPSS	Statistical Package for Social Sciences
SWB	Subjective wellbeing
TTM	Transition to Motherhood

UK	United Kingdom
US	United States
VIF	Variance Inflation Factor
WEMWBS	Warwick-Edinburgh Mental Wellbeing Score
WHO	World Health Organisation
WHOQOL-bref	Abbreviated WHO quality of life measure

Acknowledgements

My profound thanks go to all of the women who took part in this study, and shared with me their thoughts, feelings, fears and dreams, and all at one of the busiest and most important times of their lives. Thank you for taking part in this research, and I hope I have done your stories justice.

I would like to also thank two new mothers who read and commented on early versions of the questionnaires and interview topic guides for their time and very helpful comments. Thanks also to the research midwives involved with recruitment to the Portsmouth Birth Cohort, especially Zoe Garner, who acted as the NHS PI for the quantitative study.

Thank you to my supervisory team, Dr Isobel Ryder, Dr Karen Burnell and Dr Suzannah Helps. Thank you for your guidance, and for your support, encouragement, and kindness throughout this process.

Thanks too to all of my colleagues, in both the Research and Nursing teams at the University of Portsmouth, who have been so encouraging in the late stages of writing up.

And finally, to my family: Elliott, Alfie, Charlie and Poppy. Thank you for your unwavering belief, inspirational chats, insightful questions, and wonderful distractions. This is for you.

Dissemination

Baxter, L., Helps, S., Burnell, K., and Ryder, I. (2018, June). *Mental wellbeing and quality of life in pregnancy and early motherhood: Findings from the Portsmouth Birth Cohort*. Poster presented at: Portsmouth Hospital Trust-University of Portsmouth Health and Technology Conference, Portsmouth, UK.

1 Chapter One: Positive mental health and becoming a mother: what is the evidence?

1.1 Introduction: Positive mental health and wellbeing at a time of transition

Research on positive experiences in the psychological and health literature on becoming a mother is still in its very early stages (Athan, 2011; Currie, 2009; Currie, 2018). Whilst there is a substantial literature on the potential for poor mental health outcomes in the postnatal period, (for example Haran, van Driel, Mitchell, & Brodribb, 2014; Leigh et al., 2008; Räisänen et al., 2014; Robertson, Grace, Wallington, & Stewart, .2004) much less is known about the positive wellbeing of mothers, and therefore the holistic picture of mental health in pregnant women and new mothers (Currie, 2018; Ibanez, Blondel, Prunet, Kaminski, & Saurel-Cubizolles, 2015).

In this chapter, both theoretical and empirical evidence are considered in order to paint a picture of the current state of the literature with regards to maternal mental wellbeing in the context of the transition to motherhood. The chapter will consider the literature encompassing the transition to motherhood, and the potential effect of the social circumstances in which transition takes place, for example, socio-economic position (SEP) and levels of social support.

1.1.1 Centralising the mother in maternal mental health research

Women's experiences of mental health and wellbeing during pregnancy and motherhood have historically been marginalised within the psychological and health research literature (Athan & Reel, 2015; Currie, 2009). This was challenged and disrupted by feminist theorists writing in the 1970s and 1980s, who explored women's own perspectives and social circumstances when becoming mothers (Athan & Reel, 2015, p. 315). Feminist work on motherhood has been divided into three broad stages by Snitow (who concentrates on writings from the USA) (Snitow, 1992). She has argued that the first stage is characterised by 'demon texts' (1963 – 1975): feminist work which, in critiquing the position of women as mothers as drudgery, were perceived to be 'anti-mother'. A number of Radical Feminist theorists argued during this period that motherhood, or more controversially the act of giving birth to children itself, was the root of women's oppression; and why women might continue to collude in their own subjugation was

further explored (Bailey, 1999; Rogan, Shmied, Barclay, Everitt, & Wyllie, 1997). These texts have also been criticised by Black feminists as not accounting for Black women's experiences of racism outside the home, which may have meant that work within the home, and roles as mothers, may have offered a sanctuary (Snitow, 1992). The second phase of writing, from the mid-1970s to early 1980s, allowed space for more positive analyses of motherhood, and which Snitow has characterised as "the period in which feminism tried to take on the issue of motherhood seriously, to criticise the institution, explore the actual experience, theorise the social and political implications" (Snitow, 1992, p. 34). For example, Ann Oakley documented the experiences of women becoming mothers (Oakley, 1981), challenging the prevailing assumption of medicalised childbirth and "the dream of domestic contentment" (Oakley, 1981, p. 2). Adrienne Rich in 1976 "was one of the first to undertake a feminist analysis of motherhood that emphasised the potential of motherhood as a source of creativity and joy" (Rogan, Shmied, Barclay, Everitt, & Wyllie, 1997, p878). This period was then followed, Snitow argues, by a politically constituted backlash against feminist writing on motherhood: "really anger at children or mothers" (Snitow, 1992, p. 42).

This latter backlash has seen the research focus move from women's own broad, contextualised, experiences, to a more narrow approach of the measurement of illness and disorder, within the health literature. Rather than centralising women's experiences this has had a role in fostering a significant, continuing, cross-disciplinary body of research exploring the *problematic* impact of becoming a mother, predominantly the incidence, prevalence and experience of postnatal (and increasingly antenatal) mental health needs. The majority of the extensive health literature that explores maternal mental health now focuses upon illness or disorder, its causes, risk factors and potential effects (Jomeen, 2004; Rallis, Skouteris, McCabe, & Milgrom, 2014). This body of research has reported that 10 – 25% of women experience perinatal depression (Rallis et al., 2014) with up to 45% of women experiencing anxiety across this period (Rallis et al., 2014). More recent literature also encompasses varied aspects of poor maternal mental health, such as investigation of biochemical markers of depression including hormonal changes, (Cheng & Pickler, 2010) maternal stress as part of the experience of perinatal distress, (Rallis et al.,

2014) and the importance of considering both antenatal and postnatal experiences of depression (Leigh et al., 2008; Robertson et al., 2004).

This research literature has substantially increased understanding of women's mental health in the perinatal period, and into early motherhood. In England and Wales this has led to National Institute for Health and Care Excellence (NICE) guidelines addressing both depression, anxiety and more severe mental disorders (National Institute for Health and Care Excellence, 2014). However, this has not meant a commensurate focus on positive mental health and wellbeing in this field: "prevalence rates for a host of mental illnesses are measured, but little attention is paid to the mothers who do not display distress" (Athan & Reel, 2015, p. 313; Currie, 2009).

A substantial proportion of this research justifies a focus upon maternal mental health through the influence of this upon the child's physical or mental development (for example Habel, Feeley, Hayton, Bell, & Zelkowitz, 2015; Zhang & Jin Shenghua, 2016, Galbally et al., 2017; Milgrom, Westley, & Gemmill, 2004; Noonan, Burns, & Violato, 2018). This has the effect of conflating maternal mental health, particularly illness, with parenting 'quality', and suggests that the implications for child development constitute the sole reason for interest in improving maternal wellbeing. Mothers are sought to be understood only with respect to their children's development (Ruddick, 1994). The focus is not on improving the lives of women becoming mothers, as their health is an adjunct to the 'real' problem: "our empathetic thrust lies squarely with the child" (Athan & Reel, 2015, p. 312).

The work of feminist theorists and researchers has been a significant contributing factor for the centralisation of women's experiences of maternal mental health in health research. This chapter will argue that research which emphasises new mothers' own experiences of good mental health and wellbeing is needed, in order to understand the possible barriers to this that women becoming mothers may face.

1.1.2 Why is this important?

Good mental health is crucial throughout the life course. The World Health Organisation (WHO) defines health as "not merely the absence of disease", but as "state of complete physical, mental and social wellbeing" (Huber et al., 2011, p. 1). Levels of subjective

wellbeing (SWB) have been shown to predict both mortality in healthy populations, and mortality and morbidity across conditions such as coronary heart disease, HIV and kidney disease (Barry, 2009; Diener & Chan, 2011; Xu & Roberts, 2010). There is evidence that higher levels of SWB are associated with lower rates of risk taking behaviours, such as smoking or unhealthy eating (De Neve, Diener, Tay, & Xuereb, 2013). Moving beyond the impact on physical health, SWB is linked to higher levels of social involvement, including altruistic behaviour such as volunteering and blood donation, (De Neve et al., 2013) implying that levels of wellbeing are not only important to the individual, but contribute to the local and wider community as well.

It is important therefore to understand the full range of mental health experiences at this life stage in order to both comprehend and promote maternal mental health (Ibanez et al., 2015). The focus of the health literature, as discussed above, on mental illness or disorder in the ante- and postnatal stages risks pathologising this period, and although the prevalence of postnatal depression is high, this represents a minority of the women pregnant and becoming mothers at any time. This may also represent missed opportunities to understand mental health promotion, and mental ill health prevention in this population, through the reduction of mental illness prevalence (Huppert, 2009).

1.1.3 How this review was approached

In order to explore the literature addressing positive mental health in women becoming mothers, and the possible impact of poverty and social support, a systematic search for the relevant research studies was undertaken, using the strategy outlined below. Along with searching the reference lists of selected papers, further studies employing relevant theories were also sought.

The search terms used, and the databases in which these were applied are shown in Table 1 below:

Table 1: Literature searching strategy

Search terms used	Databases searched
<p>preg* or antenatal or "ante natal" or ante-natal or prenatal or "pre natal" or pre-natal or perinatal or antepartum or "ante partum" or ante-partum or postnatal or post-natal or "post natal" or postpartum or "post partum" or post-partum or mother*</p> <p>AND</p> <p>"subjective well-being" or "subjective wellbeing" or "subjective wellbeing" or happiness or happy or satisfaction or pleasure or enjoyment or fulfilment or "positive affect"</p>	<p>Medline, CINHAL, PsychINFO, SocINDEX, Web of Science core collection</p>
<p>preg* or antenatal or "ante natal" or ante-natal or prenatal or "pre natal" or pre-natal or perinatal or antepartum or "ante partum" or ante-partum or postnatal or post-natal or "post natal" or postpartum or "post partum" or post-partum or mother*</p> <p>AND</p> <p>"quality of life" or "qol"</p>	<p>Medline, CINHAL, PsychINFO, SocINDEX, Web of Science core collection</p>

Quantitative studies were included where they addressed the levels of subjective wellbeing in motherhood compared with the general population, or compared the levels of subjective wellbeing in mothers according to their socio-economic status. 'Quality of life' studies were included where this was explicitly measured. Studies looking exclusively at the quality of life or wellbeing of only women with depression or depressive symptoms were excluded. Conference abstracts or posters were excluded where results were not reported. Studies that reported wellbeing in 'parents' were included where the wellbeing or quality of life of mothers was reported separately.

Qualitative studies were included in this review where they address the phenomenon of becoming a mother and considered the impact of socio-economic circumstances upon mental wellbeing at this time. Furthermore, qualitative studies that explicitly considered

the positive aspects of becoming a mother, and the impact of this on the adaptation to or development of that identity and role were sought.

The papers that were included as part of this review have been considered with attention given to the potentially relevant theoretical frameworks which address either transition to motherhood, or life transitions and mental wellbeing more broadly.

1.1.4 Definitions: positive mental health, and socio-economic position

1.1.4.1 *What is 'positive mental health'?*

Huppert defines positive mental health as 'a combination of subjective well-being and being fully functional' (Huppert, 2005, p. 307). Therefore, the definition employed here will encompass measures of both subjective (self-reported) well-being, and quality of life. 'Quality of Life' has been included, as this is often used interchangeably in the literature with 'well-being' (Rapley, 2003), and because these measures may capture areas of life which contribute to 'functioning', such as physical health, which may not be included in mental wellbeing measures. Both subjective wellbeing and quality of life are defined in further detail below.

1.1.4.2 *Subjective wellbeing*

Subjective wellbeing (SWB) refers to the self-reported, positive aspects of mental health (Tennant et al., 2007), and comprises two aspects: the 'hedonic' which includes happiness, pleasure, and enjoyment; and 'eudemonic', which encompasses purpose, meaning and fulfilment (Chanfreau et al 2008). Both the hedonic and eudemonic aspects are required for a state of positive wellbeing. This is because separately they may not lead to an overall positive state: for example, feelings such as happiness could be the result, for example, of an unhealthy coping strategy such as illicit drug use, and pursuing a life of meaning may not in and of itself lead to happiness or feeling contented (Huppert, 2005).

A broad definition has been employed in identifying literature for this review, in order to capture as many papers covering positive mental health in new mothers as possible.

Subjective wellbeing is measured in the literature various ways, including scales measuring positive and negative affect; several constructs of wellbeing, and single questions covering life satisfaction or happiness within a recent period of time (Huppert, 2009).

1.1.4.3 Quality of life

Quality of life is a concept with a contested definition. It is broadly defined by the World Health Organisation (WHO) as “an individual’s perception of their position in life in the context of the culture and value systems in which they live, and in relation to their *goals, expectations, standards and concerns*” (WHOQOL Group, 1993, emphasis added). Thus, its measurement can potentially capture a positive, negative, or more complex ‘perception of position in life’ than the sole use of measurements of disease or disorder. However, many research instruments used to capture quality of life focus on disorder and physical limitations (Huppert, 2009). The WHO definition is reflected by the definition that Symon uses: ‘the extent to which hopes and ambitions are matched by experience’, in his research with women in the postnatal period, with the aim of medical care being to ‘narrow the gap between a patient’s hopes and aspirations and what actually happens’ (Symon, McGreavey, & Picken, 2003b, p. 865). However, the term ‘quality of life’ is used broadly in the literature, sometimes including definitions which overlap with wellbeing (Ngai & Ngu, 2013), and sometimes with little definition. Therefore where ‘quality of life’ levels have been measured, along with the impact of socio-economic position on these, the paper has been included in this review.

1.1.4.4 Defining socio-economic position

Definitions of ‘socio-economic status’ (SES) or ‘socio-economic position’ (SEP) are used interchangeably in the health literature. Sometimes this label is used without further definition, or is comprised of variables such as education, occupational or income level. There is often little explicit theoretical positioning in order to explain the authors’ assumptions regarding the impact of education or income, upon mental health or illness, although these may represent very different mechanisms and may impact on wellbeing in different ways (Bartley, 2004).

There is a large body of evidence that shows that individual health outcomes, such as postnatal mental illness, are affected by inequality of socio-economic position (Galobardes et al 2007; O’Campo and Urquia 2012; Goyal et al 2007). SEP is usually measured using proxy indicators such as income, educational level or area deprivation in the health literature (Galobardes et al 2007) and these have often been found to be risk factors for poor postnatal mental health, although not consistently.

The lack of consistency in the evidence for a link between low SEP and antenatal and postnatal mental illness may be due in part to the different exposures selected. Proxy measures of low SEP, have been criticised for their inability to directly measure poverty (Gordon 2006), the concomitant lower power and social exclusion faced by those experiencing it, and for the inherent assumptions in their uncritical use that individuals with the same levels of income or education have the same power to access services (Braveman et al 2005). For example, a low income captured at one point in time may not reveal wealth accrued previously, or access to other resources (Braveman et al 2005); conversely a high income may be a recent or one-off event not conferring financial security. Occupational status may mask inequalities along gender or ethnic minority lines in actual income, similarly educational attainment can mask gender or race discrimination in the jobs market (Braveman et al 2005).

However, income is “regarded as one of the clearest indicators of socioeconomic status... in the developed world” (Hansen & Kneale 2011). Theoretical and empirical work links low income to poor health outcomes (Benzeval et al 2014). Several pathways are proposed, including through the effects of stress, in turn through bio-chemical effects (Benzeval et al 2014), or through damage to identity and social ‘prestige’ (Bartley 2004; Benzeval et al 2014).

Where the medical literature has considered the role of SEP as a risk factor in postnatal depression, income has emerged as a significant factor (Horwitz et al 2007; Lee et al 2000). Low income was the strongest predictor of increased risk of postnatal depression in a large study of approximately 4,000 women, where education and occupational prestige were also included as predictors, and other factors were controlled for (Segre et al 2007). Income was reported by Leigh and Milgrom (2008) to be a significant predictor of antenatal depression, which in turn was a key risk factor for postnatal depression. Seguin et al (1999) found the additional stressor of ‘financial difficulties’ in women who were already on a low income was significantly associated with scores on the Beck Depression Inventory. Various indicators of socioeconomic position such as low income and financial strain were found to be positively associated with postpartum depression in

a systematic review and meta-analysis and this was found to be “consistent across cultures and countries” (Robertson et al 2004, p293). Goyal et al combined four measures of low SEP in their study of perinatal depressive symptoms, and found that women with all four factors (low income, low educational level, unmarried and unemployed) were 11 times more likely to develop perinatal depression than those without any, at 3 months after the birth of their child (Goyal et al 2010). There appears to also be a link between persistence of depression and low SEP, (Goyal et al 2010) and in some cases this association with persistence is stronger than with the risk of developing depression initially (Lorant et al 2003). This could indicate that women with low incomes are more vulnerable to persistent postnatal depression, and its deleterious effects. A systematic review and meta-analysis of antenatal risk factors for postnatal depression found that there was a clear gap in the research for examining “specific risk factors in women of lower socioeconomic status” (Robertson et al 2004, p289).

Evidence suggests that deprivation is associated with poor mental well-being in adults (Bellis et al 2012; Chenfreau et al 2008). Quality of life and wellbeing in the transition to motherhood are under-researched areas; (Emmanuel & Sun 2013; Symon et al 2002, Symon 2003) their measurement would allow a broader picture of adaptation to motherhood to emerge (Emmanuel & Sun 2013), and are therefore important to include in a study of mothers’ well-being and mental health (Goyal et al 2010). Understanding the extent of any link between poverty, deprivation, and subjective well-being and quality of life could contribute to understanding how to support women during the antenatal and postnatal periods (Alderdice et al 2013).

In this review, studies that employ various indicators of SEP, such as education, income, occupation and composite measures, have been included where these have been used by the author to show their impact on wellbeing, quality of life or adaptation to motherhood in pregnant women or new mothers.

1.1.4.5 Social support

‘Social support’ is a broad term, and can refer to the positive support received from others: ‘the degree to which a person’s basic social needs are gratified through

interaction with others' (Rosenfeld 1997, p5). This might indicate support from a close intimate relationship, such as that from a partner, or the support from extended family. This phrase may also refer to the support from close friends, a wider circle of friends, acquaintances, or networks or groups that we are part of. These different types of support may in turn have differing effects on mental health and wellbeing (Bogossian, 2007).

In addition, having a number of contacts within a social network is not necessarily protective of health alone: it is the quality of the relationships which dictates their supportive nature (Bogossian, 2007). Linked to this, the research evidence suggests that it is an individual's perception of the support they receive as opposed to the 'actual' received support which impacts upon the individual's mental health (Bogossian, 2007). Bogossian offers a relevant example, which is where the support that a health professional may feel that they have offered, may not be what their patient takes from the interaction. The important effect on mental wellbeing will be in the patient's perception of the support they received (Bogossian, 2007).

In addition to the different sources of support, social support is broken down into four different types. 'Emotional support' is defined as "intimacy and attachment, reassurance and confiding in and relying on one another" (Bogossian, 2007, p. 170). 'Informational support' relates to advice and help with problem solving. 'Tangible support' is that which offers practical help, and 'comparison support' is that which comes from people advising or helping from the position of being in the same situation (Bogossian, 2007).

Different pathways for the impact of social support on mental health are posited (Bogossian, 2007). For example, the 'main or direct effects' pathways suggests that social support may have a direct effect on physiology, by impacting upon the "neuro-endocrine and psycho-immunologic pathways which affect physical health" (Bogossian, 2007, p. 172). A 'buffer effects model' suggests that the social support moderates the effects of stress. This is distinguished from the main effects theory by the suggestion that the social support protects against or reduces 'psychological risk factors' (Bogossian, 2007, p. 172).

Social support is a determinant of both mental disorder, and positive mental health (Barry, 2009). Research which includes social support will therefore be reviewed here in

consideration of the impact of SEP on positive mental health in the transition to motherhood, in order to account for its possible protective role in this relationship.

1.1.4.5.1 The local context: Poverty and Portsmouth

Concerns about the extent of the relationship between low income and mental health and wellbeing are pertinent for the Portsmouth area. Deprivation levels are high: 25.2% of children live in poverty in Portsmouth (Public Health England, 2014), compared with 18.6% in England. In some wards of the city, such as Charles Dickens, this rises to 44.2% (Portsmouth City Council, 2015). Child poverty in the area has a cost of around £121 million each year (Portsmouth City Council 2013). The picture of poverty in the city in working age adults is less clear, however the City Council reports that 15% of working age adults lived in relative low income households (Portsmouth City Council, 2015). The numbers of people accessing food banks between 2011 and 2012 is reported to have doubled, and 12.5% of households were on average due to lose £976 due to housing benefit reforms in Portsmouth. These figures illustrate the extent of financial insecurity in this area. Health indicators used by Public Health England show that Portsmouth is 'significantly worse' than England for levels of children living in poverty and family homelessness, among others. These issues form the backdrop to the Portsmouth Joint Strategic Needs Assessment, in which tackling poverty is an area for focus, and addressing the mental health and wellbeing needs in Portsmouth is a priority work stream. This focus on general mental health is reflected in the national mental health strategy, since the prioritising of mental health, and its parity with physical health has been made an explicit duty of the Secretary of State for Health (Portsmouth City Council 2013).

1.2 How does identity transition, and how is this important to mental health?

1.2.1 How do women become 'mothers'?

In order to understand how becoming a mother impacts on women's mental health, it is necessary to define the process involved. Whilst pregnancy and labour are important times of physical and mental transition, research shows that adoptive mothers struggle with similar levels of depression and types of depressive symptoms (Mott, Schiller,

Richards, O'Hara, & Stuart, 2011). This suggests that the hormonal changes associated with giving birth are not the only processes to impact on mental health at this time. It appears that women who become the primary carers for infants face similar issues in early motherhood. This suggests then, that it is the process of transition from 'non-mother' to 'mother' that holds some of the keys to understanding mental health in this period beyond the obvious physical changes that biological mothers experience.

1.2.2 Maternal role attainment

The theory of 'maternal role attainment' (MRA), of how women become mothers, developed by Rubin in 1967, is influential throughout the nursing and midwifery literature and continues to pervade research on pregnancy and adaptation in the first year of motherhood (Fowles, 1996; Jirapaet, 2001; Özkan & Polat, 2011; Rubin, 1967). This theory, developed from observation of, and interviews with, both first time mothers and mothers with children, posits that women go through certain processes in what is a linear, homogenous, journey to motherhood. This process "integrates the mothering behaviours into her established role set so she is comfortable with her identity as a mother" (Jirapaet, 2001, p. 26). The behaviours that are incorporated are reflective of social beliefs about what kind of behaviour a mother should demonstrate (Jirapaet 2001); therefore the type of 'acceptable' maternal identity is tightly constrained. The first stage of this journey is mimicry, whereby models such as other pregnant women are observed and copied. In women who have had children before, the self from previous pregnancies might also be used as a model. The next stage is role play, where this mimicry becomes 'acting out' perhaps with a family member's child. 'Fantasy' follows, where "wishes, fears, daydreams and dreams proliferate and indicate a deepening in involvement" (Rubin, 1967, p. 242). This then leads to 'Introjection – projection – rejection' (IPR), a stage similar to mimicry, but now the behaviour itself originates with the mother or mother-to-be, and tested against the model. This might then be rejected if it does not fit well with the model (Rubin, 1967). Mimicry occurs early in the process, to practice for future events. IPR emerges later, when mothers "had past experiences and some ongoing experiences to evoke and compare" (Rubin, 1967, p. 242). Rubin argues that this is how key mothering decisions on such aspects as feeding, bathing and nappies, are made (rather than simply 'copied'). Within this aspect of the journey is the clearest indication that the approval or

otherwise of others is used by women in order to make decisions, but there is also room for the mother to reject these if they do “not ‘fit’ with what she felt inside of her, she was reluctant, dubious or rejecting of the interpretation” (Rubin 1967, p 243). All of these stages allow an ‘ideal-self’ image as a mother to be built, (Mercer, 2004) and a ‘successful’ transition is embodied by the comfort in and commitment to this role of mother: this indicated ‘role achievement’. Finally, there is also “grief work” (Rubin, 1967, p. 243): previous roles are eradicated as part of this stage, but this is not portrayed as an easy process for the mothers, and is described as an acceptance rather than a completed task.

This explanatory model of early motherhood leaves little room for complexity or resistance. Each mother is assumed to go through each of the stages and eventually arrive at feeling comfortable and committed to being a mother, with little to no disruption or questioning of the ‘journey’. The mental health and wellbeing of mothers is not explicitly addressed in the MRA theoretical framework. Although the ‘comfort’ a mother feels in the role is part of the assessment of whether she has achieved her maternal identity, her mental health on the journey is not mentioned. The happiness or broader life satisfaction of the mother is constrained within satisfaction with the role, and the effects of other roles on motherhood are not referred to outside the work done to remove these from the mother’s identity.

More contemporary exponents of the MRA framework also do not consider positive mental health and wellbeing, although a “sense of balance, confidence and competence in her role performance” is referred to by Koniak-Griffin (Koniak-Griffin, 1993, p. 258). Where research using this framework has explicitly considered mental health, this is more generally about “presence/ absence of depression” (Fowles, 1996; Koniak-Griffin, 1993, p. 259) than positive mental health. In turn, the concern with the mothers’ mental wellbeing is related again to its impact on the baby, in terms of attachment, and socialising the baby (Athán & Reel, 2015; Koniak-Griffin, 1993).

1.2.3 The evolution to ‘Becoming a Mother (BAM)’

The MRA theory has received criticism for its assessment of attainment of motherhood as a “static situation, rather than a fluctuating process” (Mercer 2004, p226). Mercer has expanded the theory, and re-named it ‘Becoming a Mother’ (BAM) to try and encapsulate

the research she has reviewed, which seems to suggest the process is not so linear: for example, adaptiveness scores decreased in a group of mothers at 8 months from 4 months, and parental satisfaction did not increase alongside ability to care for the baby (Mercer 2004). However, the key difference between 'Becoming a Mother' and 'Maternal Role Attainment' is that the former accounts for a "*continued* expansion of the self as a mother" (Mercer, 2004, p. 231, emphasis added). This theory evolution allows for the social and environmental circumstances in which the transition takes place to be accounted for and also for "concomitant growth development and new self-definition" (Mercer, 2004, p. 231). However, a mother's mental health and wellbeing are still not explicitly considered within this theory. Despite the expanded framework allowing for research to look at differences within how women become mothers, and for a more fluid proposed timeline, the stages themselves are still prescriptive.

Several research studies accept the tenets of MRA, later BAM, and seek to uncover what might help or hinder the journey through this process (Fowles, 1996; Jirapaet, 2001; Koniak-Griffin, 1993; Özkan & Polat, 2011). Mental health and well-being are not explicitly considered in these studies although Fowles (1996) looks at the relationship between role attainment and post-natal depression, concluding that the latter negatively impacts on the former (Fowles, 1996). However, Jirapaet looked at the journeys of marginalised women (Thai low-income women with HIV,) thus widening the possible application of the theory (Jirapaet, 2001). He found that the women limited the stigma they were exposed to by keeping their HIV status a secret, except for perhaps one trusted contact. Success in the motherhood role was very important to the women as a source of approval, and to minimise the stigmatised identity. This 'coping' involved successfully managing threats to the maternal identity, which was helped where there was social support in place, perhaps from a husband, or the tightly knit extended family network, where this was still in place (Jirapaet, 2001). Each of the mothers assessed in this study were "comfortable in their maternal roles" (Jirapaet, 2001, p. 25), in spite of these challenges and threats.

Within both aspects of this 'transition to motherhood' theory, it is an assumption that mental wellbeing automatically follows where women have transitioned into the motherhood identity, and sloughed off other identities. Mental wellbeing and its threat from, or to, this transition are not explicitly considered, and neither is the fact that

women can still have babies, be mothers, and still have varying degrees of life satisfaction. Indeed, the maintaining of other identities, such as a work or volunteering based identity may itself be crucial to 'comfort' and satisfaction in the mothering role, in some women. Equally it might well be possible to live with some uncertainty in the role, and still maintain high mental wellbeing.

1.2.4 Returning women to the 'transition to motherhood'

The Rubin/ Mercer theoretical framework is the dominant theoretical approach within midwifery (Parratt & Fahy, 2011). However, it is "baby-centric" rather than focused upon the mothers themselves (Parratt & Fahy, 2011, p. 446): "The focus of the theory is not on the woman or her individual inner experiences; it is on how she is mothering the baby...[t]he transition to motherhood metanarrative positions women as a means to a valued end; that is, as someone to look after the baby" (Parratt & Fahy, 2011, p. 449). The theories reflect the focus of preceding and subsequent research on the development of the infant. Overall, these theories render the differences in how women become mothers invisible. The role is delineated in a way that may not reflect all women's experiences, and certain attributes of a maternal identity are deemed 'good' or 'bad', achieved or not achieved. Given the high prevalence of depression, anxiety and mental disorder among pregnant women and new mothers, this would suggest a high proportion of women lacking 'comfort' in this role, but does this then suggest that they do not identify as 'mothers', or are to be defined as 'bad' mothers?

Motherhood as a developmental phase for women has been obscured within the developmental psychology literature (Athán & Reel, 2015), and yet where it has been foregrounded, as in the work of Rubin and Mercer, this has meant an acceptance of the "problematic assumption...that mothers are the functional agents of their children" (Athán & Reel, 2015, p. 312). As a result there remains a lack of research and interest in mothers themselves:

"This objectifying gaze...emphasises the functional or dysfunctional impact of women on their children, and rates their performance based on their effectiveness or defectiveness...their own subjectivity is often rendered secondary if not entirely irrelevant to the problem at hand" (Athán & Reel, 2015, p. 312)

This focus on the effects of women's 'performance' as mothers on their children has also lent itself to the focus on disorder or poor mental health, and the subsequent deleterious effects on their children. A mothers' wellbeing, happiness or growth around the time of transition is not considered to anywhere near the same extent. The possible differences between mothers, and their responses to this transition, have also been marginalised (Parratt & Fahy, 2011).

1.3 What might be affecting wellbeing in the transition to motherhood?

Some of the key theories that address transition to motherhood in nursing and midwifery do not fully account for differences between women that become mothers, yet the high prevalence of anxiety and depression among pregnant women and new mothers suggest that women have different responses to this. What then might be affecting women in this stage? This section will consider what factors might be contributing to differential experiences of mental health among new mothers.

1.3.1 Importance of social determinants for mental wellbeing

As outlined above, there is evidence that SEP, particularly as indicated by poverty or low income, is linked to poor mental health outcomes for new mothers. There are broadly three explanatory models usually applied in the health literature to account for health inequalities in individuals and groups (Bartley, 2017). 'Materialist' explanations refer to the direct effect of poor housing or working conditions, such as damp housing environments or chemicals in the workplace; whilst 'behavioural' approaches refer to types of behaviour observed in groups with poorer health outcomes. For example, people on lower incomes are observed to engage in more risky behaviours, such as drinking alcohol and smoking, and are therefore at greater risk of a range of worse health outcomes. These latter explanations can have the effect of locating the reasons for health inequalities in a society with individuals, or behaviour, perceived as endemic to certain groups for worse health, as opposed to their social, environmental or economic contexts (Bartley, 2017). The third model is the 'psycho-social' explanation, which goes beyond these direct effects, to look at how the stress which might arise from experiencing poor and unequal social and economic conditions may then lead to poorer health outcomes

(Bartley, 2017). Within this model, social support is an important factor as it may help to protect against the stress of unequal living conditions (Bartley, 2017).

1.3.2 SEP and subjective wellbeing

Whilst there is still some debate as to whether there is overlap between the drivers of mental illness and mental health (Friedli, 2009; Huppert, 2009) research is emerging to suggest SEP, particularly income and employment status, does play a role in achieving and maintaining positive mental health. Keyes found that some socio-demographic characteristics were associated with higher levels of positive mental health; for example gender, age, marital and educational status (Keyes, 2002). He did not include income or poverty, but did find that employed people in his study had an odds ratio of 1.2 (95% CI 1.1 – 1.6) of having very good or excellent mental and emotional health, compared to those without employment (Keyes, 2002). The finding that positive mental health was higher for men was repeated in the Eurobarometer 2002 survey of 10,578 people across 11 European countries (Barry, 2009). This study, along with the British Household Panel Survey, found income to be an important issue in levels of subjective wellbeing (Barry, 2009) although neither study established causality. The WHO commission on the social determinants of health has reported on a body of evidence which suggests that it is inequality of living conditions which has significant “negative impact on people’s mental health and their sense of emotional and social wellbeing” (Barry, 2009, p. 11). Again, both the definitions used, and the proposed mechanism at work, are important here, as conversely other research, particularly from economic researchers, suggests that there is a ‘ceiling effect’ at work in the relationship between income and SWB, and that past a certain standard of living, increased individual income will not increase SWB further (Cummins, 2000; Dolan, Peasgood, & White, 2008). Evidence for the ceiling effect comes from an early study employing the Warwick Edinburgh Mental Wellbeing scale (WEMWBS) which shows an increase in median score across income groups, until this drops off among the highest earners (Tennant et al., 2007). The review by Dolan and colleagues further supports the suggestion by Friedli (2009) that the *inequality* of income is the important factor in damage to SWB, rather than actual income, and this possible mechanism and its implications for intervention to improve SWB level, warrants further investigation (Dolan et al., 2008).

If, as Huppert suggests, those drivers of mental ill health that are associated with SEP also drive mental wellbeing, this should be more carefully explored. The emerging literature which seeks to understand any relationship between SEP as indicated by poverty or deprivation does not account for the interaction between life transitions, such as transition to motherhood, poverty and SWB. Understanding the extent of any link between income, poverty and subjective well-being and quality of life could contribute to understanding how to support women during the antenatal and postnatal periods (Alderdice, McNeill, & Lynn, 2013). The emerging literature exploring both SEP and wellbeing in new mothers will be reviewed below.

1.3.3 Extent and determinants of maternal mental wellbeing: the evidence

Whilst positive mental wellbeing at transition to motherhood is under researched, there are studies in this area, a small sub-section of which also consider the impact of SEP, and these are considered below.

1.3.3.1 Levels of wellbeing

Three studies have investigated levels of wellbeing in new mothers, however different measures have been employed, and the results are contradictory. Holton and colleagues (Holton, Fisher, & Rowe, 2010) used the Personal Wellbeing Index and Satisfaction With Life scale, and compared the wellbeing of mothers of young children (median age 4 years) with women without children, and found that the wellbeing of the mothers in the sample was significantly higher than that of women without children (74.6 vs. 70.7, 95% CI of the difference -6.6, -1.2, $p=.005$). Life satisfaction was also higher in mothers: 18.8 vs. 17.3 (95% CI of the difference -2.2, -0.8).

Nelson et al measured wellbeing in parents using differing measures (happiness, life satisfaction and meaning in life), and despite parents overall reporting higher levels of life satisfaction and happiness than non-parents, when these results were analysed by age and sex, it was found that mothers did not have higher wellbeing on these measures than non-mothers (Nelson, Kushlev, English, Dunn, & Lyubomirsky, 2013).

Mothers in Green and Kafestios' study were positive after having their babies, both with regard to the baby themselves, and their new roles: 66% scored the maximum for

'enjoying the baby' and 79% for being 'proud of being a mother' (Green & Kafetsios, 1997).

1.3.3.2 Wellbeing and its relationship with SEP in motherhood

Holton and colleagues investigated the impact of various socio-demographic variables in their comparison of wellbeing between mothers and non-mothers (Holton et al., 2010) including education level, occupational level, and 'socio-economic status' which was here defined as a binary variable: 'live in an area of socio-economic advantage' or '..of socioeconomic disadvantage' (Holton et al., 2010). Using this the authors found that socio-economic status "had a significant positive relationship with life satisfaction and subjective wellbeing" (Holton et al., 2010, p232), but the relationship with education was not significant here.

Educational level is considered in relationship to a composite measure of 'positive experiences of motherhood' (POSMO) in a study carried out in South-East England. (Green & Kafetsios, 1997). Educational attainment was found to have a small, but significant correlation with POSMO, and to make a further small contribution to the model at the antenatal stage to the overall positive experience. There is no explanation for the role educational level might have at this stage. Educational level was also found to have a relationship with mood patterns in women who have just given birth (Buttner, Brock, & O'Hara, 2015). The authors' measure included both positive affect and negative effect in the 10 days after birth, and found that highly educated women had a lower level of negative affect compared to those with lower educational attainment, and although negative affect peaked in highly educated women by day 5, women with lower education levels had higher levels of negative affect through to day 10 (Buttner et al., 2015). Similarly, the positive affect of more highly educated women dipped until day 7 or 8, and then increased. However, this study focuses on the immediate days after birth, and does not tell us about happiness or wellbeing in new mothers after that time.

One study specifically investigated the relationship of income to wellbeing. This found that there was no relationship with membership of a "highly satisfied" subset of mothers (Athan, 2011). However, the study participants were not diverse with respect to income, which may have impacted on this finding. Social support was found to be linked to

income in the study; furthermore the highly satisfied group was found to lose less social support when this tailed off in both groups. In terms of income the groups were split at lower than \$50,000, \$51,000-100,000 and greater than \$100,000. The rationale for these thresholds is not given.

Therefore, in this small body of research, it appears that there is weak evidence for a relationship between education level and wellbeing in new mothers, however the base is small, and measures and groups heterogeneous. Further research on this is needed.

1.3.3.3 Quality of life and SEP in Pregnancy

Lower levels of quality of life in pregnancy were found in two studies of adolescent mothers (Campos, Barbieri, Torloni, & Guazzelli, 2012; Drescher, Monga, Williams, Promecene-Cook, & Schneider, 2003). In the first study, the WHOQoL-bref instrument was used. This instrument includes two general questions on health and quality of life, and a further 24 questions encompassing aspects such as physical, psychological, the environment, and social relationships. While in all domains the adolescent mother group scores were lower than the adolescent group without children, this was only statistically significant in the physical and social relationship domains, and not overall (Campos et al., 2012). Using the SF-36, (the Medical Outcomes Study Short-Form 36, which encompasses 36 generic questions on quality of life, under eight domains: mental health, physical functioning, body pain, general health, emotional, social and physical role functioning, and vitality,) Drescher et al found that quality of life was lower in all domains for the pregnant teenagers in their study, with the exception of vitality. This again was statistically different in the physical functioning domain. However, these scores were compared with norms for all ages, and norms for a group of women aged 18-24 years, which may mean the differences were related to age (Drescher et al., 2003).

There was no difference between the mean quality of life scores reported by four groups (teens without children, teens with children, adults without children and adults with children) in one study (Wrennick, Schneider, & Monga, 2005). Again a normative population of women aged 18-24 was used, and all groups then scored lower on the physical functioning and role domains in comparison. Whilst the adults in this sample

were of similar age to the normative group, again this may not be an appropriate control for the teen groups.

Three studies reported the mean quality of life levels obtained in their samples, but did not compare these to any control group or published norms (Barbarosa dos Santos, Santos, Monteiro, Rezende do Prado, & Lameira Maciel Amaral, 2015; Fatemeh, Azam, & Nahid, 2010; Ramírez-Vélez, 2011). Fatemeh and colleagues found that the highest mean score in their sample, using the SF-36, was in the mental health domain (66.75 ± 17.93). Ramírez-Vélez, using the SF-12 measure, (a shortened version of the SF-36 described above, with fewer questions still within eight domains) reported that the highest mean scores were obtained in the vitality (56 ± 11) and mental health (51 ± 10) domains (Ramírez-Vélez, 2011). However, a lack of control group, or norms to compare these results to, makes them of limited usefulness. Barbarosa dos Santos and colleagues reported the highest mean in the physical domain of the WHOQoL measure, with the social and psychological domains reporting the next highest scores (75 ± 11.6 , 74 ± 12.4 and 73.3 ± 105.6) respectively (Barbarosa dos Santos et al., 2015).

Three studies found that SEP was associated with quality of life scores in pregnancy (Fatemeh et al., 2010; Hueston & Kasik-Miller, 1998; Ramírez-Vélez, 2011). Fatemeh and colleagues found a "significant association" between both the physical functioning and mental health domains, and educational levels (Fatemeh et al., 2010, p. 698), but no further details or results are reported. They also state that income is correlated with the SF-36, but again, no other detail is given. Ramírez-Vélez found, using the SF-12 measure, that the positive correlations between physical role, general health, social function, emotional role and mental health and 'socio-economic level' were statistically significant, along with that of education level and general health. However, what comprises 'socio-economic level' in the context of this study is unclear. The authors also point out that their recruitment was in clinics in areas of low socio-economic status, which may limit the usefulness of the findings in terms of possibility of comparison (Ramírez-Vélez, 2011). Hueston and Kasik-Miller also report that scores in general and mental health domains were higher in 'affluent' patients – but that these differences declined as pregnancy progressed (Hueston & Kasik-Miller, 1998).

One of the included studies did not find an association between a measure of SEP (income lower than the equivalent of two minimum wages) and quality of life levels measured using the WHOQoL-bref questionnaire, in their pregnant sample (Barbarosa dos Santos et al., 2015). One study collected SEP data but did not report the association between SEP variables and quality of life in pregnancy (Campos et al., 2012).

Therefore, the small evidence base around SEP and quality of life in pregnancy is further limited by issues of quality in methods, quality of life tools, SEP measures and reporting quality.

1.3.3.4 Post-natal quality of life

An Australian study examining the mental component summary (MCS) of the SF-12 found that this score was not significantly different when comparing mothers with childless women (46.0 vs 45.7, 95% CI of the difference -2.2, -1.5, $p=.742$) (Holton et al., 2010).

Another study compared the quality of life of women at six to eight weeks postpartum, with 12 to 14 postpartum. These were reported as separate dimensions. Each dimension, as measured by the SF-36, was significantly higher at the later time point, showing that quality of life, as measured in this study has improved with time (Bahrami, Karimian, Bahrami, & Bolbolhaghghi, 2014). However, these scores were not compared with a control group or normative population score, and therefore do not demonstrate whether quality of life levels are higher or lower in women with children versus those without. The SQOLAD measure (Specific Quality of Life After Delivery, which includes 30 questions within different domains) was also used, and scores were reported to have increased between the different time points. These results were not fully reported in the paper, and there is little further detail on the measure itself (Bahrami et al., 2014).

Two studies used the pregnancy and motherhood specific Mother-Generated Index (MGI) measure to report quality of life levels in postnatal populations. The measure is comprised of the mean score where the mother is asked to score each of the eight areas she has nominated as being most affected by having a baby. She scores these from 0 (worst) to 10 (best), and a secondary score where the mother assigns points to denote the importance of each area (Symon, MacKay, & Ruta, 2003). Bodhare and colleagues used the instrument in research with Southern Indian mothers who were 6-8 weeks

postpartum. The mean primary MGI score of the sample was 3.49 ± 1.13 . This score is lower than 5, which had been shown in a previous study to be associated with higher rates of both physical problems and mental distress (Bodhare et al., 2015, p 357). In total, 90% of the sample scored lower than 5 on the primary score. Nagpal and colleagues also administered the MGI in a sample of postnatal mothers in India. Here, the mean primary score was 3.6 (3.3 to 3.9) again indicating a low postnatal quality of life in this sample (Nagpal et al., 2008).

Three studies using the MGI measure all found an association between SEP and the primary MGI score (Bodhare et al., 2015; Nagpal et al., 2008; Symon et al., 2003). Bodhare and colleagues found that the highest primary score was in respondents with higher education levels. They calculated a 'middle' and 'lower' SES group using the Kuppuswamy social scale measure, and the middle group reported higher primary scores than the lower. SES was significant in each model, even where depressive symptoms and levels of social support were included. 'Financial worries' - which are not measured by generic quality of life instruments - were mentioned by 40% of the sample (Bodhare et al., 2015). An association between lower quality of life scores and lower socio-economic status were reported by Nagpal and colleagues (Nagpal et al., 2008) however it is unclear if this relationship is statistically significant. The domains reported by the participants support this finding however: the lowest scores for 'financial worries' were reported by those in the 'low' socio-economic group, and this group spent the most 'points' on financial concerns, (as opposed to the physical problems and weight related concerns of the 'high' and 'middle' groups respectively). Symon and colleagues, using the MGI tool, reported their results by highest and lowest scoring quartile groups, and found that the most of each of these reported "happiness with the baby" and tiredness (Symon, MacKay, & Ruta, 2003). Financial concerns were nominated by both groups in this sample, but mentioned more often by the lower scoring group.

Ak yn and colleagues found that the 'perceived economic status' of the women in their sample and their quality of life scores were statistically significantly associated: women who thought of themselves as comfortably off also reported the highest quality of life scores. The relationship between monthly income and quality of life score was also

statistically significant (Akyn, Ege, Kocoolu, Demiroeren, & Yylmaz, 2009). However, this is difficult to interpret, as the authors have not provided detail on the dimensions of the scale, or what is measured.

Postpartum quality of life, in the evidence reviewed here, appears to have an association with measures of SEP. Once again, however, the evidence base is small, of variable quality, often employing inappropriate comparisons and measures to test SEP. The possible mechanisms are not considered or under-explained.

1.3.3.5 Longitudinal studies across pregnancy and postpartum

Four studies examined quality of life across both pregnancy and the postpartum period.

Mortazavi and colleagues found that the mean scores of physical and social relationships aspects of the WHOQoL questionnaire increased significantly from the antenatal to the postnatal periods (Mortazavi, Mousavi, Chaman, & Khosravi, 2014). There was a slight increase and decrease in the psychological and environmental domains respectively, but these were not statistically significant. The total quality of life score in this sample increased from 66.32 ± 13.7 to 68.38 ± 13.6 , ($p = 0.002$). These are not compared with a control group or normative population. One study reported on 2 domains of the SF-36, physical function and vitality, across pregnancy and up to 8 weeks postpartum (Haas et al., 2005). This study found that physical function scores reduced across pregnancy, and increased again, approaching pre-conception levels by 8-12 weeks postpartum (Haas et al., 2005). The vitality scores also decreased, but more slowly, and did not return to pre-conception levels by the postpartum measurement (Haas et al., 2005). These levels were not compared with a control group. Symon and colleagues used the MGI measure as part of a wider randomised controlled trial in the UK. This study found that the scores remained the same across the transition (7.6 ± 1.51 vs. 7.6 ± 1.48) (Symon, Downe, Finlayson, Knapp, & Diggle, 2015).

Two papers that examined quality of life across both pregnancy and the postpartum period found an association with the measure of SEP they were using, and quality of life scores. Family income and age were found to only predict the environmental domain, and maternal occupation the social domain. Antenatal psychiatric disorders were the factors affecting global antenatal scores (Mortazavi et al., 2014). In Haas and colleagues'

study, women were asked prior to pregnancy whether they had experienced not having enough money for food or housing. Women who responded positively were twice as likely as women who had not to report 'fair' or 'poor' health (AOR 2.11, CI 1.49 to 2.98) or poor physical function (OR 1.99 CI 1.37 to 2.88). These results were the same when tested again in pregnancy and postpartum (Haas et al., 2005).

Again, there is a limited and mixed evidence base for quality of life scores across both pregnancy and the postpartum period. A lack of comparison groups in or scores render judgements of the results difficult.

The measures of quality of life used were more consistent (seven of the studies used the SF-36 and SF-12) and these measures are frequently employed to assess quality of life in pregnancy and early motherhood (for example, Hueston & Kasik-Miller, 1998; Ramírez-Vélez, 2011 and Wrennick, Schneider, & Monga, 2005). The SF-36 and 12 were not developed originally to assess quality of life, (Symon, 2003) they are not validated in women in the postnatal period (Webster, Nicholas, Velacott, Cridland, & Fawcett, 2011) and due to the generic nature of these measures, they may not be appropriate for use in childbearing women, who are not, after all, necessarily 'ill' (Symon, 2003). Quality of life in pregnant women and new mothers may therefore not be fully captured by these generic instruments, and their focus on "limitations" (Symon, 2003, p. 2/8). None of the research using generic measures of health related quality of life included in Symon's 2003 review, for example, broaden their focus beyond illness or limitation to include a positive perspective (Symon, 2003). The research base can therefore serve to reinforce the medical model, pathologising pregnancy and early motherhood, even as it examines the broader concept of quality of life. Using generic measures in pregnant women and new mothers may lead to misleading conclusions: one study using the SF-36 measure found that women did not perceive their physical health to be poor, even where their SF-36 scores on the physical component scale were decreasing; instead they saw declining physical quality of life as a 'normal' aspect of pregnancy (Chang et al., 2014).

1.3.3.6 The effect of SEP on wellbeing when becoming a mother

Emmanuel and colleagues studied 605 women both during late pregnancy and 12 weeks postpartum. The women answered questionnaires on becoming a parent and social support. The study reported that education level (the chosen SEP measure in this study,)

was not statistically significantly associated with maternal role development (Emmanuel, Creedy, St John, Gamble, & Brown, 2008). In contrast, Kiehl and colleagues used a composite measure of social status (the Hollingshead social scale which combines education and employment.) They found that both social status and mothers' employment were positively correlated with maternal adaptation (Kiehl & White, 2003). The study was carried out in Norway, Sweden and the US, and these results also differed by country: in the US higher social status was correlated with satisfaction with life after the birth of the baby, ($r = 0.40$, $p = 0.009$). Life satisfaction is often used as an aspect of measuring subjective wellbeing.

There is an extensive body of literature, undertaken within the qualitative paradigm, investigating aspects of becoming a mother (Brunton, Wiggins, Oakley, & EPPI-Centre, 2011). Many studies identified by the search outlined in this chapter explored this transition.

The groups of women studied range from the very specific, such as homeless teenagers negotiating motherhood (Hanna, 2001) through an attempt to locate the 'normal' in the process of becoming a mother (Barclay, Everitt, Rogan, Schmied, & Wyllie, 1997) to the explicit attempt to explore heterogeneous experiences within a group of socio-economically disadvantaged women (SED) (Kurtz Landy, Sword, & Valaitis, 2009). Some key similar themes emerged: including the change in identity (Barclay et al., 1997; Hanna, 2001; Sethi, 1995; Smith, 1999; Gichia 2000), self-sacrifice (Ngai, Wai-Chi Chan, & Ip, 2010; Sethi, 1995) and the 'dual nature' of motherhood (Gichia, 2000; Hanna, 2001; Sheeran, Jones, & Rowe, 2015). Although positive mental wellbeing is not the focus of these papers, it did emerge in this latter theme, and in the theme of 'health and wellbeing' in the Kurtz Landy study (Kurtz Landy et al., 2009) in which the majority of participants "felt they were doing alright emotionally" (Kurtz Landy et al., 2009, p. 201).

Transformation of the self, or the redefinition of the self as part of becoming a mother emerged as a theme in four studies (Barclay et al., 1997; Hanna, 2001; Sethi, 1995; Smith, 1999). Barclay and colleagues found that becoming a mother had a 'beginning' and an 'endpoint', and the process required huge change as they concluded that, "mothers undergo a profound reconstruction of self" (Barclay et al., 1997, p. 727). The teenage mothers in Hanna's study found becoming mothers a transformational experience, and an

opportunity for change; a chance to parent differently from their own parents (Hanna, 2001). In three studies the growth and transformation resulted from the challenges of early motherhood, in the Sethi study this is a result of resolving those tensions (Barclay et al., 1997; Sethi, 1995; Smith, 1999).

In contrast to a transformation from one identity to another, for the mothers in Gichia's study of poor urban African-American mothers, this process encompassed growing from 'girlhood' to 'womanhood' and as such was an "accomplishment", indicating its perception as an almost essential role for them to have taken on (Gichia, 2000).

Alongside this theme of transformation, is that of 'self-sacrifice' along the way. In Ngai and colleagues' study 'self-sacrifice' has a central role in becoming a competent mother, in the eyes of the mothers in the study (Ngai et al., 2010). This is complemented by the process reported by Barclay and colleagues; a sub theme was 'drained' as the mothers are overwhelmed by the demands on them, and struggle with 'aloneness' in some cases due to lack of partner support (Barclay et al., 1997, p. 722). In Sethi's study, this was the first theme to emerge, the 'giving of the self' (Sethi, 1995). Smith reports that women turn away from the outer world, such as their work, in pregnancy, before returning to this later in motherhood, as part of the path to 'transformation' (Smith, 1999).

A "dual nature of motherhood" (Sheeran et al., 2015, p. 516) was identified in three of the studies. The participants in these studies reported complex experiences of motherhood, encompassing both the positive and negative (Gichia, 2000; Hanna, 2001) and a sense of enjoyment, even in the face of significant difficulties. Sheeran and colleagues for example found that the theme of 'delight' emerged across their interviews with teenage mothers with premature babies, but this was alongside practical difficulties, and amongst some of their participants financial strain did impact on their early experiences of becoming mothers (Sheeran et al., 2015).

However, any link between becoming a mother and positive wellbeing is not explicitly addressed by these studies. Three of the studies have in some way addressed the early experiences of becoming a mother and socio-economic position, such as through the deliberate inclusion of women who have poor SEP, such as homeless teenage mothers (Hanna, 2001). The only study to explicitly address the impact of socio-economic status

on the early postpartum experiences of mothers was Kurtz Landy and colleagues, although it should be noted that there are studies which focus on the experience of post-natal depression which specifically include low-income women as participants (for example, Abrams & Curran, 2009, 2011).

In the study which explicitly examined the experiences of SED women becoming mothers, the difficulties involved in becoming a mother that were shared with the women in the other studies, were compounded by lack of money, and the social exclusion this engendered (Kurtz Landy et al., 2009). In addition to the common themes of adjustment that emerge in the studies on becoming a mother, poverty and deprivation intervene in the lives of SED women. The women in the Kurtz Landy study speak of needing to access food banks, and the additional challenges of public transport with a new born baby in order to reach them (Kurtz Landy et al., 2009). And while the women involved speak of “doing alright emotionally” (Kurtz Landy et al., 2009, p. 201), the stress, of financial difficulties among other aspects, contributed to other health problems and, the authors argue, impacted upon their wellbeing. The young women in Hanna’s study were able to negotiate a lack of money and resources and channelled what they did have into “fulfilling their motherhood ideologies” (Hanna, 2001, p. 459).

Both the Kurtz Landy and Hanna studies identified a theme of stigmatisation through living publicly examined lives” (Kurtz Landy et al., 2009). The women felt stigmatised as they had to claim welfare support, and the teenage mothers in particular felt that the general public passed judgement on them. This judgement due to use of welfare is echoed by the teenagers in Hanna’s study, and the author writes that these negative attitudes are internalised by the mothers (Hanna, 2001). In both the Gichia study, and the Barclay study, evaluations or judgements of others are used to assess success or failure, and to build an identity as a mother (Barclay et al., 1997; Gichia, 2000).

The link between maternal identity and social circumstances has been explored by Abrams and Curran, but here they examined this in the context of postnatal depression, rather than positive mental health. These authors argue that the literature addressing identity transition and construction in postnatal depression is “overwhelmingly focused on middle class populations despite the fact that low-income status is a known risk factor” for postnatal depression (Abrams & Curran, 2011, p. 373). Their findings supported the theory

that poverty compromises the ideal mothering identity. Participants felt their depression was exacerbated by poverty as they were unable then to fulfil what they perceived to be essential roles for their children: “mothers framed their financial struggles as an additional threat to an already compromised maternal self” (Abrams & Curran, 2011, p. 378). Single mothers viewed themselves as ‘failures’, contradicting the mothers’ pictures of idealised families. In spite of these challenges to the maternal identity, either originating in, or exacerbated by, poverty, mothers did “actively [seek] to construct a positive sense of maternal identity” (Abrams & Curran, 2011, p. 379), through self-sacrifice, children’s development through ‘engaged mothering’ and pleasure derived from mothering. However, a key issue for the mothers was: “ the conditions of poverty, the experience of depression, and the intersections between the two were problematic insofar as they posed a challenge to the realisation of an idealised mothering image” (Abrams & Curran, 2011, p. 382) How do the conditions in which women become mothers affect both their personal identity, social identity and the social groups which they might be leaving or joining? It appears it would be erroneous to suggest there is just one ‘motherhood’ group.

An important finding in Abrams and Curran’s research is that although their participants had postnatal depression they were trying to construct positive identities alongside this experience. The evidence here is that women will not necessarily perceive themselves to be experiencing wholly ‘good’ or ‘poor’ mental health. However, the impact of the women’s financial circumstance on their ability to construct positive maternal identities, and consequently on their mental health is clear: “Women’s concerns about their ability to provide materially for children, and the related risks that their income and health statuses posed to children’s well- being, did tend to undermine the formation of a positive maternal identity” (Abrams & Curran, 2011, p. 382).

Bailey’s research, conversely, focused on middle class women, so the effects of their financial circumstances is likely to be different. The middle class women in Bailey’s study felt motherhood to represent ‘progress’ for them and an uplift in their status, whether or not they had planned to become pregnant. Although this study differs from Abrams and Curran in that the women are pregnant, and have not yet become mothers, this contrasts with the fears of the mothers in the Abrams and Curran study, where the mothers with low incomes felt ‘not good enough’ as mothers when they felt as if they were not providing.

However, this study does reflect the same themes of self-sacrifice as found in the Abrams and Curran study, and the women in Bailey's study saw the time of their pregnancy as a useful period of psychological self-adjustment (Bailey, 1999)

As demonstrated here, the literature is limited in this area, but does show that the social circumstances in which women build and construct their identities impacts on identity building and transition when becoming mothers, and that this is an important way in which women may differ in this period.

This literature demonstrates that the focus upon pathology in women becoming mothers is not restricted to quantitative psychological, medical or nursing literature; the qualitative literature to some extent follows suit. The experience of becoming and being a mother, however, is complex as this picture suggests: "it is replete with dialectical tensions" (Arendell, 2000, p. 1196). Motherhood may well be fulfilling or lead to feelings of limited potential; it may bring happiness, or poor mental health, or both (Arendell, 2000). Whilst distress of different kinds is reported as high across the perinatal period (Arendell, 2000; Howard et al., 2018), what has not emerged (to the same extent) is research to understand the mental health and wellbeing of those women, the 75- 90%, who are not experiencing perinatal anxiety or depression. Therefore, we know little about the mental health of the majority of mothers, and consequently, much less is known about the drivers of, and barriers to, 'good' mental health at this time of significant transition for many women.

1.3.4 Social identity theory: the effect of group membership and support

The perhaps uniquely "shared identity of motherhood" (Afflerback, Anthony, Carter, & Grauerholz, 2014, p. 3) is also pertinent when considering the mental wellbeing of mothers. To assess this, the 'Social Identity Model of Identity Change' (SIMIC) may be useful: "central to the SIMIC reasoning is the idea that our self-concept is largely determined by the social groups we belong to" (Jetten & Pachana, 2012, p. 99).

Motherhood, it could be argued, is both a personal and social identity. Women who have children both personally become mothers, and join a recognisable group, (however heterogeneous the membership) of 'mothers'. The SIMIC model suggests that there are processes in life transitions which may obstruct the development or acceptance of the new identity. It may be necessary to relinquish a former identity, with its concomitant

group membership or network, and transition is more difficult for those who identify very positively with the pre-transition identity (Jetten & Pachana, 2012). Readiness to accept the identity is also key to a smooth transition, this model suggests: “[t]aking on a new identity not only provides grounding and a sense of belonging, it also forms the basis for receiving and benefiting from new sources of social support” (Jetten & Pachana, 2012, p. 101). Within this model, new mothers who are able to embrace the new identity of ‘mother’, and who are not attached to a particular identity prior to becoming a mother will experience the easiest transition. Jetten and Pachana argue that the social context in which this change takes place is important, but they do not appear to be referring to structural social factors, rather the presence and nature of social networks: “[c]hange affects relationships between all identities, the centrality of identities to self-definition, and the extent to which social identity forms the basis for social support” (Jetten & Pachana, 2012, p. 102). This means that having a number of social identities, and these identities being compatible with any new identity, will lead to enhanced wellbeing following a transition: “social identities can buffer against the negative consequences of change”, because of the increased social support members can offer (Jetten & Pachana, 2012, p. 103). So, where new mothers may experience intersecting stressors of poverty and identity transition, the impact of group membership may help to assuage these. Problems may conversely arise for mothers who become part of this group but do not yet identify strongly enough with the new group to feel these benefits.

Whilst this theory does not specifically address transition into the group ‘motherhood’, its application may allow for differences between women in how they develop their maternal identity, according to their social context. But this needs further development, to explore how other aspects of women’s social circumstances affect their ability to access social support, for example, will also affect the development of their maternal identity, and the resultant feelings of wellbeing and positive mental health. Can mothers who face financial struggle afford to develop and maintain multiple groups identities to ease and buffer against life transitions?

1.3.4.1 The effect of groups and social support on maternal mental wellbeing and transition to motherhood

Social support appears throughout the maternal mental health literature as a crucial variable in maternal wellbeing, quality of life, and the experience of becoming a mother. Research from both quantitative and qualitative approaches highlights the importance of social support when considering wellbeing.

Athan found that her group of 'highly satisfied mothers' did lose support after the birth, as did the whole group, but for this group support tailed off less quickly. Although the link is not directly made, elsewhere in the study Athan finds that social support is linked to income in her sample (Athan, 2011). Green and colleagues found that their measure of positive experience of motherhood, and social support were positively and significantly correlated (Green & Kafetsios, 1997); their questions were focused on partner support, rather than on wider support networks. Emmanuel and colleagues found that social support was the crucial factor in maternal role development, (Emmanuel et al., 2008) and a higher health related quality of life (Emmanuel, St John, & Sun, 2012). These effects were independent of the SEP measure used (education). However, the model explained a very small amount of the variance (13%). Again, in the latter study, social support from a husband, or partner, was measured. Gebuza and colleagues, looking at social support and life satisfaction, found that the latter was linked to an increase in wellbeing, but this was measured at a time when support would arguably be highest for women, in the first day after childbirth (Gebuza, Kaźmierczak, Mieczkowska, Gierszewska, & Kotzbach, 2014). Bodhare and colleagues found that while SEP was significant in their models examining quality of life, a better fit was achieved when social support was added (Bodhare et al., 2015). Hueston and Kasik-Miller found in contrast found that quality of life in their small sample was not affected by social support or SEP measures (Hueston & Kasik-Miller, 1998)

Whilst the quantitative research reviewed here paints a mixed picture of the relationship between social support and wellbeing, it emerged as crucial in the qualitative literature. Haga and colleagues found differences in women according to approach to motherhood, but that social support emerged as a theme that transcended these, and was key to all the mothers experiences (Haga, Lynne, Slinning, & Kraft, 2012). Hanna found that the

young teenage mothers in her study would reject external help with mothering to avoid the impression that they could not cope, but were more likely to accept practical support (Hanna, 2001). Women felt isolated and alone in the first few months of motherhood and the role of relationships with others and building new relationships and for these to become a part of their new identity was a theme in two of the studies (Barclay et al., 1997; Sethi, 1995). 'Precarious social support' emerged as a key theme for the SED women in Kurtz Landy's study (Kurtz Landy et al., 2009, p. 198). This stemmed from conflict in families, families and friends that are also stressed and in difficulty, and a lack of physically close support due to immigration. The younger women in the study reported that they had lost friends since becoming mothers (Kurtz Landy et al., 2009).

This summary of research suggests that the role of social support is central in the transition to motherhood, when mothers are asked about their experiences. However, the nature of social support, and how it effects identity transition and wellbeing response, may be mediated by the wider social circumstances women become mothers in.

1.3.5 The cultural narratives of motherhood and impact of these on transition

If women's wellbeing is affected by identity change at both the personal and group level, then there is also the much wider social context, in which women construct their identities, to be accounted for.

'Intensive mothering', is the dominant cultural narrative of motherhood in the US (Afflerback et al., 2014; Arendell, 2000), but is also pervasive in the UK (Budde, Hogg, Banister, & Dixon, 2017). This discourse defines motherhood as "exclusively dyadic, time-consuming, child centered, emotionally encompassing, and economically demanding" (Abrams & Curran, 2011, p. 374). 'Success' as a mother is measured using the children's academic and social attainment, and prioritised at the cost of the mother, both emotionally and financially (Henderson, Harmon, & Newman, 2016). There is evidence that postnatal depression, at least, is experienced differently by mothers according to their cultural background (Abrams & Curran, 2011) highlighting the importance and impact of dominant cultural narratives around mothering. This also supports the challenge of post-structuralist feminist writers to the dominant transition to motherhood theory that suggests a

homogenous journey to identifying as a mother (Parratt & Fahy, 2011). Although arguably a feature of 'middle-class' motherhood 'intensive mothering' dominates popular culture, featuring in media portrayals and guide books (Afflerback et al., 2014): Henderson and colleagues found in their study that women regardless of SEP are exposed to these messages (Henderson et al., 2016). Importantly, their participants' mental wellbeing was affected by these messages, even where they had explicitly rejected them (Henderson et al., 2016). Whether these standards are subscribed to or not, they are still definitive: "[t]hese ideals are generally accepted as "real" by those entering this social group, even while mothers acknowledge them to be unrealistic or hypothetical" (Afflerback et al., 2014, p. 3). An understanding of the power and influence of these discourses is key to understanding maternal mental health (Henderson et al., 2016).

Applying the SIMIC model of identity change to this transition suggests that women are joining a group, 'mothers', and it is how they view this group that determines whether it is compatible with other identities and groups they occupy. The group itself may comprise an idealised image, and this is where the cultural narratives of motherhood at play in the mothers' society will intersect with identity transition, and consequently, wellbeing and mental health. These cultural narratives are pertinent here as these are the standards to which mothers are holding themselves, comparing themselves to, or aligning themselves against (Abrams & Curran, 2011; Bailey, 1999; McLeish & Redshaw, 2017; Mulherin & Johnstone, 2016) .

Lewis and Nicholson found that cultural narratives of motherhood compounded the sense of loss for the women in their study (Lewis & Nicolson, 1998). The simplifying nature of such constructions "were another element of loss, particularly expectations that motherhood would be a fulfilling and happy experience" (Lewis & Nicolson, 1998, p. 184). The narratives themselves lead to a feeling of loss when the standards they demand are not met, the feeling of loss of self, and the resultant impact on wellbeing: "Women may need to deny the losses they experience in order to present themselves, to themselves and others, as adequate mothers, at the same time as they are aware that they have lost elements of their lives which were important to them" (Lewis & Nicolson, 1998, p. 188).

Lewis and Nicholson suggest that depression might be a response to motherhood itself rather than the reason why women might find motherhood difficult (Lewis & Nicholson, 1998).

Social psychological theory suggests that dominant cultural narratives are key to shaping a sense of identity and therefore to our wellbeing (Eaton, Ohan, Stritzke, & Corrigan, 2016). The potential stigma from a lack of social support, for example either from a primary relationship or wider supportive social group, or the potential stigma from poverty that might impact on your ability to conform to cultural narratives of motherhood, or maintain membership of supportive social group might all work in complex ways to impact on the transition to motherhood, and a sense of positive mental wellbeing at this time. Self-stigma, which has also been found to damage both wellbeing and social relationships, (Eaton et al., 2016) may also be relevant here.

1.4 The theoretical framework and literature gap: what this study can contribute

The theoretical frameworks and literature reviewed here suggest that mothers with a combination of membership of established social groups, supportive relationships and access to financial resources may in turn have the resources to maintain these group memberships, and conform to dominant cultural narratives of motherhood. They may therefore be more likely to experience degrees of social approval, as opposed to social stigma (Bartley, 2017). This may have positive consequences for wellbeing at this time of transition: “Identity may be supported or threatened by any of the major forms of inequality” (Bartley, 2004, p. 19) and “social integration requires time and effort to be devoted to maintain identity sustaining relationships” (Bartley, 2004, p. 19). Research exploring wellbeing at the time of transition to motherhood should also account not only for the possible pressure or stigma experienced, or resisted, by mothers who feel challenged by dominant ideals of motherhood, but also the ways that fulfilling or adhering to these may support wellbeing, particularly where linked to wider ideals of ‘womanhood’ and gender conformity (Bailey, 1999). How is identity change negotiated when mothers do not just join a homogenous or normative group ‘mother’, but ‘single mother’ or ‘mother

living in poverty' or 'adolescent mother', when your identity may contravene the powerful dominant cultural discourses around motherhood. It may be that women do not passively absorb these narratives, but question and resist them, and this could lead to improved wellbeing.

There is an extensive literature addressing wide and varied aspects of becoming a mother, as outlined above. The research into maternal mental health in the context of the transition to motherhood focuses predominantly on mental ill health and disorder, whether this is through the measure of incidence and prevalence, or through a wider concern with identity transition, construction and negotiation. There is limited research which explores positive mental health in the transition to motherhood, however, the results of this are contradictory and when considering SEP some confusion is introduced by the variety of indicators employed, and lack of theoretical consideration of the possible mechanisms at work through which wellbeing might be affected. Despite the importance of social support in the literature in terms of impact on mental ill health, both in mothers, and more broadly, the impact of group membership, and ability to resist or maintain cultural ideals, on becoming a mother is not usually considered. Therefore, the insights that might be gained from understanding the impact of differential socio-economic position on ability to move groups, and to maintain previous group memberships are lacking.

1.4.1 [How this research will address this gap](#)

The inconsistent measurement of SEP across the studies (income, with thresholds or cut-offs used without explanation of their theoretical significance, education, occupation or composite measures including all three) make it difficult to compare the results.

Examining poverty may not be the ultimate aim of these papers, but even where income is presented there is no interrogation or explanation of whether these categories are meaningful, and what the differences in them might explain about the differences in wellbeing or quality of life between these groups. This lack of theoretical underpinning to the use of SEP measures in these papers makes it unclear what role SEP is expected to have, what mechanism might be at work between the socio-economic position of the participant and their quality of life. This is an important question, because the evidence base is mixed, and this may be due in part to the different measures that are used, but

are brought together under the SEP banner. Future research should make clear how education, occupation or income might be impacting on mental health (Bartley, 2004).

1.4.1.1 Broadening the focus

The experience of wellbeing and positive mental health in the transition to motherhood will not be captured by only focussing on pathology and mental disorder. The dualities are missed; there is a need for research that can bring these together. In this review one qualitative study explicitly addressed the impact of socio-economic disadvantage (SED) on this 'process' of becoming a mother (Kurtz Landy et al., 2009). This found that SED impacted on all the areas of becoming a mother leading to feelings of stigma and shame. This reflects findings from studies of low income women with postnatal depression and shows that this experience can be distinct due to poverty and low resources (Abrams & Curran, 2009, 2011). Further research to draw together commonalities and differences, across the complex spectrum of women's experiences during pregnancy and after childbirth, is needed.

1.4.1.2 The importance of considering 'social support', and its relationship to both mental health and SEP

The evidence from studies in this review appears to suggest a crucial role for social support. For example, there is some evidence that good social support is linked to higher SES (Athanasopoulos, 2011). An exploration of social support more widely defined than that from primary relationships can be undertaken by qualitative research, for example the social exclusion experienced by the women in the study by Kurtz Landy and colleagues (Kurtz Landy et al., 2009).

Despite acknowledgements that not enough is known about the positive mental health of mothers, research is still predominantly focussed on the drivers of poor mental health in this group (Ibanez et al., 2015). In order for the ambitious WHO definition of health to be fulfilled, research into overall mental health, including subjective wellbeing, quality of life, and the context in which women become mothers, is needed in order to complement that into ante- and post-natal depression. This review has shown that there are clear research gaps pertaining to subjective wellbeing, quality of life, and maternal adaptation, in pregnant women and new mothers. There is also a gap in understanding of the social drivers of good mental health, which lags behind that of knowledge of the relationship

between SEP and poor mental health. This may be due in part to the variety of proxy variables used to measure SEP, and the potential for these to have differing relationships with mental health. There are also only a very small number of studies that include any measurement of SEP when addressing the question of SWB, quality of life and maternal adaptation, and these are of varying methodological quality. Qualitative research can help build understanding of the transition to becoming a mother and the relationship between this and wellbeing, but only a very few qualitative studies have explicitly examined this through the lens of social disadvantage or inequality. Further research is needed in order to contribute to our understanding of the levels of wellbeing in maternal mental health, how these are developed and maintained during the transition to motherhood.

1.5 The proposed research questions

The research will address the gaps outlined above by answering the following research questions:

1. What are the levels of subjective wellbeing and quality of life, of social support, and of material deprivation and poverty in pregnant women and new mothers in Portsmouth?
2. Is there a relationship between income, poverty, wellbeing, and quality of life during pregnancy for mothers in Portsmouth?
3. Is there a relationship between income, poverty, wellbeing, and quality of life during the postnatal period for mothers in Portsmouth?
4. What role, if any, does social support play in this relationship?
5. To explore women's experiences of mental wellbeing in the context of becoming a mother; what might support, or undermine this?

2 Chapter Two: Philosophical foundations, paradigmatic stance, methodological choices²

2.1 Introduction

It is clear from the previous chapter that there are important areas of understanding around new mothers' mental health that require further research and investigation. Prior to undertaking this research however, it is important to be clear about the assumptions underpinning the research. These assumptions will impact substantially upon the research methodology and methods (how research questions are formulated, and data is collected and analysed), and an understanding of these can allow the findings of research to make an explanatory contribution beyond the superficial (Cameron, 2011): "Research questions are not neutral but depend on, for example, the assumption one holds about the nature of reality or the nature of knowledge" (Biesta, 2010, p. 99).

These 'assumptions' refer to ontology, beliefs about the nature of the world which the research seeks to understand; and epistemology, beliefs about the type of knowledge that research can generate (Silverman, 2000; Teddlie & Tashakkori, 2010). Published research does not always include a discussion of its philosophical underpinnings, which can result in misconceptions about the nature of the findings in relation to theory (Braun & Clarke, 2006; Clark, 1998). Leaving philosophical assumptions implicit allows a simplistic view of research findings to perpetuate, which in turn strengthens the idea that different types of research approach are in opposition to each other (Clark, 1998).

Therefore, in order to pose and answer research questions decisions must be taken around how reality and knowledge are viewed. There are broadly three approaches to research which may be relevant to aspects of the proposed research project: positivism and post-positivism, realism and critical realism, and pragmatism are all considered briefly, in the context of this study of mental wellbeing and the transition to motherhood, below.

² Adapted from (Cameron, 2011)

2.2 Positivism and post-positivism

A positivist approach to ontology and knowledge generation, posits that there is an objective reality that can be measured, it is a 'realist' position. Positivism is interested only in observable phenomena. Therefore within this paradigm the researcher is objective and separate to the 'truth', which in turn can be measured by research instruments (Clark, 1998). Knowledge is separate from, and discovered (not produced) by humans (Ryan, 2006), and "assumes the existence of an objective reality i.e. one that is independent of the knower" (Clark, 1998, p. 1243). Importance is therefore given to a researcher's detachment from research, as objective, in order to prevent bias (Clark, 1998). A positivist approach would exclude qualitative research, where experiences, and the meanings attributed to them by research participants are a focus (Clark, 1998).

A purely positivist approach to research is rarely explicitly reported in the literature. It has been argued that is because post-positivism has 'superseded' positivism (Clark, 1998, p. 1245) and pure positivism is not a widely held position amongst researchers. Clark argues instead that more commonly a 'post-positivist' position is held, which he again terms a 'realist' position, and which allows a role for the existence of unobservable phenomena, such as experience. Furthermore this post-positivism does allow for the ways in which the researcher may impact on and affect the research process (Clark, 1998). Explanatory theories (unobservable knowledge) hold more power in post-positivism, as theory is rejected by pure positivism as unobservable and therefore not 'true'.

The concept of post-positivism itself appears contested within the literature: it is discussed both as a type of amended positivism which privileges quantitative measurement and replication but also accounts for researcher bias and explanatory theory (Clark, 1998); but also as a more umbrella term, embracing the role of humans in the construction of knowledge, and qualitative methods used to explore this (Ryan, 2006). Clark acknowledges the limits of (his definition of) post-positivism in its continuing quest for measurement, causality, prediction. This research, in exploring both the relationships between subjective wellbeing and poverty, and women's experiences of positive mental health needed to reject a positivist approach, explore beyond solely

scientific measurement, and consider the impact of the imposition of a researcher's constructs and definitions upon the research.

2.3 A pragmatic approach

This therefore suggests that a mixed methods approach will be appropriate. Mixed methods should be employed to deepen understanding, not only to validate the findings of one type of research with another (Greene, 2008). Here, mixed methods are employed in order to ascertain the levels of wellbeing, and the contributions of poverty and social support to these in pregnancy and early motherhood, but also to try and understand what some of the underlying mechanisms might be. The key premise of mixed methods research is that combining qualitative and quantitative approaches will bring about a deeper comprehension of the area or phenomenon under review, than employment of one approach alone would bring (Cameron, 2011).

An assumption exists in much writing about research, that a pragmatic philosophical stance is essential to a mixed methods approach (Biesta, 2010; Cameron, 2011, Maxwell & Mittapalli, 2010, p. 3 of 33), and is the preferred stance of those employing mixed methods. Pragmatism “offers a very specific view of knowledge, one claiming that the only way we can acquire knowledge is through the *combination of action and reflection*” (Biesta, 2010, p. 112, emphasis in text). It is not about an external world, but “always about relationships between actions and consequences, never about a world ‘out there’” (Biesta, 2010, p. 112). Pragmatists argue that the research question is what should dictate the methods, rather than a philosophical stance (Biesta, 2010) and conversely that research philosophies are not “intrinsically linked” to certain research methods and design (Maxwell & Mittapalli, 2010, p. 3 of 33). This implies that any tensions between guiding paradigms might be safely disregarded (Maxwell & Mittapalli, 2010, p. 3 of 33).

Within a pragmatic position, the problems that need be solved are the focus, (Biesta, 2010, p. 97) and pragmatism itself is more useful as a set of ‘philosophical insights’ (Biesta, 2010). So, what pragmatism can offer to this research is the ability to break out of constructed paradigmatic prisons: “the suggestion that research which uses numbers or statistics is necessarily committed to, say, an objectivist epistemology is both wrong and

unhelpful” (Biesta, 2010, p. 102). Understanding the level of wellbeing and quality of life in new mothers, and the relationship this may have, for example, with poverty, does not therefore have to imply a position wherein the researcher is ‘objective’ and separate to the research, or exclude the possibility of furthering the research aims by seeking out the experiences of the mothers themselves. These research aims could all sit together under the pragmatic umbrella.

However, this purely pragmatic approach does not account for the impact of a researcher’s philosophies and assumptions about the world on their research approach (Maxwell & Mittapalli, 2010). This may limit the usefulness of the resulting research in contributing to wider philosophical debate and theory: “attending too little to philosophical ideas and traditions will mean that mixed methods researchers will be ‘insufficiently reflective and their practice is insufficiently problematized’” (Greene and Caracelli cited in Cameron, 2011).

So, in order to account for how research is inevitably couched within a social context which will include a researcher’s assumptions and own experiences of the world, a ‘critical realist’ perspective, and its relevance for this proposed research will now be discussed.

2.4 Critical Realism

Realism, as outlined above, is a philosophical position that holds that there is a real world, which exists outside of our perceptions and ideas about it. It is “the idea that there is a real world with which we interact, and to which our concepts and theories refer” (Maxwell & Mittapalli, 2010, p. 8 of 33). However, this is distinct from positivism, in that critical realism accepts that it is not possible for us to fully and objectively understand that real world, and that any understanding is partial and understood through our perspectives and particular situations: “all knowledge is partial, incomplete, and fallible” (Maxwell & Mittapalli, 2010, p. 9 of 33). This can be distinguished from the concept of objectivism in that critical realism accepts that there is a ‘reality’ but there will be different ways of understanding that reality.

2.4.1 'Realist ontology; constructivist epistemology'

Maxwell and Mittapalli argue that critical realism, is a position that combines “an integration of a realist ontology (there is a real world that exists independently of our perceptions, theories and constructions) with a constructivist epistemology (our understanding of this world is inevitably a construction from our own perspectives and standpoint, and there is no possibility of attaining a ‘God’s eye point of view’ that is independent of any particular viewpoint” (Maxwell & Mittapalli, 2010, p. 3 of 33). Thus, this research, which aims to measure, explore and offer explanations of wellbeing in new mothers emerges from a critical realist position. Motherhood is, on one hand real. There is a real baby, with real needs to be met. But the experiences of having the baby, and the impact upon mental health and wellbeing may be different, and the various influencers of these experiences and perceptions such as demographic characteristics, socio-economic position, the dominant cultural narratives around motherhood, may all combine and impact upon this in complex ways. Mothers’ own perceptions and understanding of this transition will be partial. This research aims to explore this both in terms of researcher determined variables, such as poverty and social support but also to explore what is important to the mother at this time, within the qualitative work.

It is not possible to discard a researcher’s own theories, values and suppositions about the world, as a pragmatic position might suggest. This could result in the distortion of results as readers and users of research cannot distinguish between research results and the assumptions of the researcher. Therefore, transparency is needed, and the clear adoption of a position about how the world works, so those using research can judge it on this basis. Critical realism, with its constructivist epistemology, offers a way to combine both qualitative and quantitative approaches, beyond potentially philosophically flimsy pragmatism, to combine to gain deeper understanding of social phenomena (Maxwell & Mittapalli, 2010).

2.4.2 Critical Realism and methodology: Mixed methods

Critical realism offers an approach which does not postulate a dualistic approach to mind and body, and accepts “the legitimacy of both mental and physical ways of making sense of the world” (Maxwell & Mittapalli, 2010, p. 17 of 33). This is important for a study

asking women to make sense of their mental health and wellbeing experiences, and trying to understand the potential impact of social structures and relationships upon this. It is therefore possible to explore how women may live in poverty and have good wellbeing for example, or not describe themselves as poor even where a measure may label them as such. This does not need to exclude the use of the measure, rather an understanding of the processes at work.

Critical realism therefore also rejects the causality of a positivist position, and instead advocates an adoption of causality that tries to understand the *underlying mechanisms* behind what is happening. This is therefore an ideal framework for a mixed methods approach exploring mental wellbeing: to measure subjective wellbeing and quality of life, but also to talk to mothers using qualitative, exploratory methods, and try to understand their perspectives on mental health during the transition to motherhood, and what might facilitate or hinder that. Is it financial issues, as explored in the quantitative research, and if so, can we increase understanding of why this might be? If financial issues are a problem for women in the transition to motherhood, how does this work, and what does it mean when living in the UK with paid maternity leave and an NHS free at the point of use? The first study undertaken here, in addressing the levels of wellbeing in new mothers, may offer some causal insights. The second will help with understanding and developing 'causal explanations' (Maxwell & Mittapalli, 2010, p. 16 of 33).

Along with paradigmatic stance, it is important to be clear about how the methods will be mixed (Cameron, 2011). In this research the 'mixing' has taken place at the analytical stage: the results of each study will be considered both separately, and as a whole at the discussion stage, in order to contribute to an early explanatory model (Cameron, 2011). The concept of 'validity' in research is framed and defined differently across paradigms. In a quantitative tradition, validity would refer to the extent to which an instrument in a questionnaire actually measures what it claims to (Heale & Twycross, 2015). In a qualitative study, reference is usually made instead to 'credibility', and how closely the data is reflected in the findings (Noble & Smith, 2015). Mittapalli and Maxwell refer to a 'validity of inferences' – where the claims made and analyses presented match what the results are saying (Maxwell & Mittapalli, 2010). This perspective encourages researchers

to be explicit about diversity and those cases that do not match or support the conclusions of the research (Maxwell & Mittapalli, 2010, p. 20 of 33). Therefore, critical realism is 'quite compatible with the idea that there are different valid *perspectives* on the world' (Maxwell & Mittapalli, 2010, p. 17 of 33, authors' emphasis). A key difference here between realism and constructivism is the acceptance of meaning, and how people make it, "as having explanatory significance" but of a real world, rather than a wholly constructed one (Maxwell & Mittapalli, 2010, p. 17 of 33).

Because of this focus upon understanding varied perspectives, acknowledging diversity of standpoint and perspective through which 'reality' is experienced and constructed, and seeking explanations and underlying mechanisms where possible, as opposed to causality, a mixed methods approach is well suited to research undertaken from a critical realist perspective. Maxwell and Mittapalli argue that the critical realist perspective in turn will enhance the use of these perspectives, by asking these questions of them, rather than only requiring a kind of triangulation of methods at a surface level (Maxwell & Mittapalli, 2010). This perspective also allows for a theoretical triangulation such as that adopted in this study, employing a combination of potentially useful frameworks, encompassing transition to motherhood theory, the social determinants of health framework, positive psychology, the impact of cultural narratives and SIMIC, bringing the insights of perspectives that might have only employed in 'one' or 'other' paradigm previously.

2.4.3 Reflexivity

Reflexivity is the application of detailed examination of the research practice, (Green & Thorogood, 2018), a "continual internal dialogue and critical self-evaluation of researcher's positionality as well as active acknowledgment and explicit recognition that this position may affect the research process and outcome" (Berger, 2015, p. 220). This should therefore include a consideration of the possible power relationships at work between researchers and research participants, making transparent the decisions that have been taken around interaction with participants and whether they might be harmed by taking part in the research, and an awareness of the researchers' 'power' in being able to select and "tell some stories rather than others" (Ramazanoglu & Holland, 2002, p.

119). This has implications for the research described here: the researcher was of a similar age and demographic background to many of the women who participated in this research, particularly those who were interviewed as part of the exploratory qualitative study.

The intention here was not to produce two entirely separate studies from separate paradigms. The study as a whole is situated within a critical realist approach. Therefore, where reflexivity would more usually be discussed within the qualitative methods section, it is being considered here, before both studies are described, in order to fully acknowledge the role and possible influence of the researcher upon both quantitative and qualitative research. This is rarely seen in the former, reinforcing the erroneous idea that this type of work is value free, and objective.

Reflexivity permeates all aspects of the research, and includes at one level consideration of the social and research contexts of the research (as outlined in Chapter 1), and a more personal consideration of the researcher's position in relation to the research and participants within it at another. The steps taken to mitigate the potential gaps in power between researchers and participants are discussed within the respective 'methods' sections of each study (Chapters 3 and 4) and the chapter discussing the overall implications of the study findings (Chapter 5).

2.4.4 The role of theory: Induction and Deduction

A potential issue for a mixed methods study might be the differing aims of quantitative and qualitative research: the former is usually perceived as theory and hypothesis testing (deductive) and the latter as generating theory, which emerges in turn from the data analysis (inductive). This could be another manifestation of the false dichotomy promoted between the two approaches, however, "we cannot analyse our data with a blank slate, as there are always theories and assumptions made that shape the ways in which we read the data" (Green & Thorogood, 2018, p. 23). The theories which shape both the questions that have been included in the questionnaires in this study, and which may be relevant to the data analysis in the qualitative study have been outlined and discussed in Chapter 1.

The role of inductive and deductive positions in the analysis of the data has also been considered in the discussion of 'research design and strategy' in Chapter 4.

2.5 Beyond the 'paradigm wars': the adopted research approach

The previous chapter demonstrated that there is a small amount of research into positive mental health in pregnancy and early motherhood, with a larger body of work focusing on health related quality of life measures. However, this latter research is often atheoretical, which minimises our understanding of how this might relate to wellbeing in the transition to parenthood, or where SEP variables have been included, what any of the mechanisms underlying the observed relationships might be.

A mixed methods approach, which emerges from a critical realist perspective, has been adopted here, and may be able to shed more light on both the levels of subjective wellbeing, and the possible relationships between financial restrictions, wider cultural narratives, and the barriers or enablers that will be of importance to, and suggested by the mothers themselves: "the goal [of mixed methods] is to create a dialogue between diverse perspectives on the phenomena being studied, so as to deepen, rather than simply broaden or triangulate, the understanding gained" (Maxwell & Mittapalli, 2010, p. 4 of 33)

A problem that may arise from a hard distinction between qualitative and quantitative research is "when researchers who use numbers and researchers who use text assume that they have nothing to share, even if their research is actually informed by similar assumptions about the nature of social reality or driven by similar ambitions about knowledge creation" (Biesta, 2010, p. 98). And so, whilst pragmatism can lead us to understand that both methods, approaches and types of data can help to understand the same (research) problem, this position cannot help us to contribute our findings 'back' into our understanding of 'reality' or 'knowledge' (Biesta, 2010).

This research attempts to go beyond the pragmatic to allow for the critical: an approach which seeks to centre women in their own experiences, and understand how SWB, and therefore positive mental health, is constructed, created and experienced as the result of a set of real social processes, with which the individual interacts, within social groups, and

as part of the wider culture within which women become mothers. This research approach accepts the critical standpoint. Within this is a feminist academic approach: women are centred within their experience of becoming mothers, and not in terms of their relationship with their children, or in terms of the implications for the children. Social structures and inequalities of power and resources and the resultant impact on health are acknowledged in asking and examining how poverty and limited financial resources might impact on how well women feel when they become mothers.

Quantitative methods may involve the imposition of researcher selected measures, and therefore the critical realist approach of seeking causal explanations will allow an understanding of mothers' own perspectives, particularly in terms of selection of measures which invite the mother's own definitions, but also in use of interviews to aim for a deeper understanding of mother's perspectives. This is important for critical realist research as this includes "explicit value analysis, and getting behind the numbers and mathematical models to causal mechanisms" (Maxwell & Mittapalli, 2010).

The critical realist values of "an emancipatory paradigm and promoting social justice" (Maxwell & Mittapalli, 2010, p. 22 of 33) are also reflected in this research. The aim is to tell the stories of more women of their mental health and experiences of transition to motherhood, to present diversity and similarity among these stories, to centre women within their own stories and experiences, and to bring to the fore the mental health experiences of women whose voices are not always heard in research on pregnancy and transition to motherhood (Abrams & Curran, 2011).

The first study, addressing the question of the levels of subjective wellbeing, quality of life and the possible relationship with poverty and social support, is reported in full (including methods, findings, and a discussion of these) in the next chapter.

3 Chapter Three: Mental wellbeing and quality of life in pregnancy and early motherhood: Findings from the Portsmouth Birth Cohort

3.1 Research design and strategy

In order to address the first three research questions outlined in Chapter One, a longitudinal study was undertaken, with the same group of participants completing questionnaires at two time points. The levels of subjective wellbeing, quality of life and social support were measured in both late pregnancy (around 28 – 30 weeks) and early motherhood (3-4 months after the delivery of the baby) in order to assess how positive mental health might be affected by pregnancy and early motherhood, and the role that might be played by poverty and social support. The income and deprivation items were included in the pregnancy questionnaire only.

The participants, and recruitment and consent procedures are detailed below.

3.1.1 The participants: The Portsmouth Birth Cohort Study

The Portsmouth Birth Cohort study (PortCo, <http://www.port.ac.uk/school-of-health-sciences-and-social-work/research/birth-cohort-project/>) is a longitudinal birth cohort study, a collaboration between the University of Portsmouth, Portsmouth Hospital NHS Trust, and Portsmouth City Council. Women giving birth in the Portsmouth area in 2016 and 2017 were recruited, and asked to register their children as part of the database. The children would then be followed up at six months, one year and two years of age. The women were recruited at their 12 week, 20 week, or late growth scan. At the time of recruitment, they were introduced to the cohort, and gave their informed consent to take part, and to be contacted by future studies that would be using the PortCo data (including this one). These future studies would require additional consent from the participants, and ethical approval. At recruitment the participants also completed a baseline questionnaire, including socio-demographic and health details about themselves, and any partner or biological children.

The participant information sheet, consent form and questionnaires were piloted for acceptability and ease of use with a group of recent mothers, prior to potential participants being contacted. These documents are included in Appendices C, D, E and F. The study was submitted to NHS proportionate ethical review, and received a favourable opinion (IRAS project ID 181157/ REC ref 15/LO/1629; please see Appendices A and B).

3.1.2 Recruitment and Consent

One hundred and sixteen women that had enrolled in the Portsmouth birth cohort registry in 2016 – 2017 were eligible to be invited to participate in this study. Those who had already agreed to participate in the PortCo, and had not been contacted to take part in another ongoing PhD study, were contacted by letter and asked if they would agree to take part in this study of maternal mental health. A comprehensive participant information sheet was enclosed at this stage. The letter also included a pre-printed, postage paid postcard, and envelope (to ensure confidentiality), that potential participants could post back to the researcher if they did want any further contact. If the postcard was not received after 10 days the potential participant was contacted via a follow-up phone call, to ask if they would like to be involved, or have any questions. If they indicated they would prefer not to be involved no further contact was made. After ten days, to allow any postcards to arrive, the women were telephoned to ask if they had had a chance to read the information sheet, and were asked if they would like to take part. If they replied no they were not contacted again. If the telephone call was unanswered, further calls were made: after the second attempt a voicemail message was left. One further attempt was subsequently made, if the call was still unanswered no further contact was undertaken.

An attempt was made to contact all of the women enrolled to PortCo between July 2016 and January 2017. Recruitment was stopped at this point, to allow there to be sufficient time for participants to complete the follow up at three or four months after delivery.

The women were asked to complete a questionnaire at two time-points. The first was when they were around 28 - 30 weeks pregnant. This first ('pregnancy') questionnaire contained the question on income, the adult material deprivation items, the Berlin Social

Support Scale (BSSS), the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) and the MGI. The second ('postnatal') questionnaire was completed at around three to four months after the birth of the baby and this repeated the BSSS, WEMWBS, and the MGI. The women's due dates were held by the PortCo study, and were used to indicate when to send the link to the online postnatal questionnaire.

3.1.3 Questionnaire administration

Those who wished to take part were offered the option of completing the pregnancy questionnaire either in person with a researcher, or online. These options were put in place in order to maximise the potential number of women who could participate if they wished: for example the online option meant that women with small children or work commitments for example could complete the questionnaire at a convenient time. The option to complete the questionnaire in person meant that questions could be read out or explained to those who felt they needed that option, or that participation was available to women who might not have had access to a computer or mobile phone. When the potential participants agreed to be a part of the study, a mutually agreed time and place for the first questionnaire to be administered was arranged, or the link to the online study emailed if this option had been selected.

Where an in-person meeting was chosen, the participant information leaflet was read through with the participant, with the study and its aims fully explained to the women. They were then asked to initial and sign the consent form. Although the women invited to take part in the study had already consented to be a part of PortCo additional consent was required to participate in the study and answer the additional questions. The potential participants were informed that they can withdraw from the study at any point up until their data was analysed. Participants were provided with telephone numbers and an email address to contact if they have any subsequent questions. Contact numbers for self-referral to health visitors, and Talking Change³ were included in the participant

³ Talking Change' is a free service available through the NHS in the area, providing talking therapies and self-management strategies to anyone over 16 who is experiencing anxiety and depression.

information leaflet, in the event that any of the topics in the questionnaire were found to be upsetting, or if mothers felt that they needed further support.

Where participants chose to complete the pregnancy questionnaire online, they were emailed a copy of the participant information sheet, and asked to read it, and then confirm via email if they had any questions, and if they were still willing to take part. Once this email was received, the participant was emailed the link to the online questionnaire, which was developed in Bristol Online Survey Software (now JISC surveys www.onlinesurveys.ac.uk). The online pregnancy questionnaire contained the consent form criteria for the participant to tick to indicate consent: the rest of the questionnaire could not be accessed unless these were completed. Telephone support and email support was offered to women in using the online survey if required. This is because some measures, such as the deprivation questions, and the MGI, may need some explanation when they are completed for the first time.

The postnatal questionnaire was available as a web-based survey, using the BRISTOL survey software, or as a postal survey, depending on the preference of the participants. Email or text reminders (via a secure web based text service) were used to prompt participants to complete their postnatal surveys, again according to the participants' preferences. No participants requested a postal copy of the questionnaire.

The first eight participants met with a researcher due to the online questionnaire awaiting a minor amendment approval from the NHS ethics committee. When both options were fully available only one participant elected to meet with a researcher. All of the postnatal questionnaires were completed online.

Participants were informed that their personal and study data would be confidential, and stored securely in line with University of Portsmouth policies, except where responses might indicate that they, or someone in their care may be at risk of harm.

Data collected as part of the Birth Cohort baseline questionnaire was also included in some of the analysis. The participants' personal information was separated from the

questionnaire before this data was analysed, and stored separately. The data collected, either online or in-person, was entered into SPSS for analysis. The paper questionnaires are stored securely in locked storage; the electronic data is password protected.

3.1.4 Instruments

3.1.4.1 *Measuring SEP: income and deprivation*

As was clear from the review of the evidence in this field, SEP variables such as education or income level are used interchangeably in the literature, whilst the mechanism for the effect they may be having on mental health is rarely explained. Educational and occupational position, or the resources that can be accessed, may impact life circumstances, and therefore wellbeing, in different but important ways (Bartley, 2004).

Therefore, in this study, poverty and material deprivation were included as the primary independent variable. 'Poverty' was defined here in the quantitative study as "[a] state of general deprivation which is characterised by *both* a low standard of consumption and a low level of income" (Ringen 1998, quoted in Gordon, 2006 emphasis added). In the UK, the definition of poverty is household income lower than 60% of the UK median household income, an arbitrary measure (Gordon, 2006). Including both low income and consumption in a definition of poverty accounts for households where they may be low income but high levels of wealth and assets which may lead to income only measures and definitions erroneously categorising those households as poor (Gordon, 2006). Research suggests that measuring both deprivation and income "reduces measurement error incurred when relying solely on income and that it more effectively identifies those living in poverty" (Treanor, 2014).

Poverty was therefore measured using the adult material deprivation items, developed from and based on the 'consensual method' of the Poverty and Social Exclusion Survey team at the University of Bristol (Pantazis, Gordon, & Levitas, 2006) and household income group. This method seeks to define poverty "from the viewpoint of the public's perception of minimum need" (Pantazis et al., 2006), and measures this by consulting a population sample in survey research. These questions can be used in surveys to directly

measure poverty. This measure of deprivation has been widely used in national surveys of poverty and resources, and has been incorporated into the Children’s Poverty Act (<http://www.poverty.ac.uk/pse-research/past-uk-research/family-resources-survey>). This method therefore is directly aligned with the theoretical proposal that material hardship prevents people from participating fully in their society, and that this leads to impact on mental health. This measure was included within the antenatal questionnaire only, to balance the likelihood that ability to afford basic items may not change in a sustained way between the last two months of pregnancy and the first three months of motherhood, and the potential time burden of completing the questionnaire on new mothers.

The items included in this measure are shown in Figure 1 below. The possible responses are ‘yes, we have this’; ‘we would like to have this but cannot afford it at the moment’ or ‘we don’t want or need this at the moment’. There are questions that refer to children that can also be used, in this study only the questions referring to adults were employed as these included and were relevant for first time parents. Permission to include the measure in the questionnaire was sought and obtained from the Poverty and Social Exclusion Survey team.

Figure 1: Items included in the deprivation measure

Keep your home adequately warm
Two pairs of all-weather shoes for each adult
Enough money to keep your home in a decent state of repair
A holiday away from home for one week a year, not staying with relatives
Replace any worn out furniture
A small amount of money to spend each week on yourself not on your family
Regular savings (of £10 a month) for rainy days or retirement
Insurance of contents of dwelling
Have friends or family for drink or meal at least once a month
A hobby or leisure activity
Replace or repair broken electrical goods such as refrigerator or washing machine

In order to calculate a ‘poverty threshold’ in the sample, and therefore compare the wellbeing and quality of life of those living in poverty with those who were not, the number of basics that participants could not afford had to be combined with the household income (see ‘data analysis procedures’, below). The Office for National Statistics’ abridged set of recommended income groups were included in the survey. These are outlined in Table 2 below.

Table 2: Abridged set of ONS recommended income groups

Group	WEEKLY	MONTHLY	ANNUAL
A	Up to £49	Up to £216	Up to £2,599
B	£50 up to £99	£217 up to £432	£2,600 up to £5,199
C	£100 up to £199	£433 up to £866	£5,200 up to £10,399
D	£200 up to £299	£867 up to £1,299	£10,400 up to £15,599
E	£300 up to £399	£1,300 up to £1,732	£15,600 up to £20,799
F	£400 up to £499	£1,733 up to £2,166	£20,800 up to £25,999
G	£500 up to £599	£2,167 up to £2,599	£26,000 up to £31,199
H	£600 up to £699	£2,600 up to £3,032	£31,200 up to £36,399
I	£700 up to £799	£3,033 up to £3,466	£36,400 up to £41,599
J	£800 up to £899	£3,467 up to £3,899	£41,600 up to £46,799
K	£900 up to £999	£3,900 up to £4,332	£46,800 up to £51,999
L	£1000 or more	£4,333 or more	£52,000 or more

3.1.4.2 Subjective Well-being: The Warwick-Edinburgh Mental Wellbeing Scale

The Warwick-Edinburgh mental wellbeing scale (WEMWBS) is a 14 item scale to measure mental wellbeing, an aspect of positive mental health. Here, mental wellbeing is defined as encompassing “both hedonic and eudemonic aspects, positive affect, satisfying inter-

personal relationships and positive functioning” (Tennant et al., 2007, p.3 of 13). The capacity of this measure to capture each of these aspects was a reason for its selection.

The WEMWBS measure is simple for participants to use, as it employs a Likert scale from 1-5 indicating none of the time, rarely, some of the time, often and all of the time. The final score can range from 14 to 70. This scale is validated for use in the UK population over the age of 16 (Stewart-Brown and Janmohamed 2008). The questions are shown in Table 3 below:

Table 3: WEMWBS questions

I've been feeling optimistic about the future
I've been feeling useful
I've been feeling relaxed
I've been feeling interested in other people
I've had energy to spare
I've been dealing with problems well
I've been thinking clearly
I've been feeling good about myself
I've been feeling close to other people
I've been feeling confident
I've been able to make up my own mind about things
I've been feeling loved
I've been interested in new things
I've been feeling cheerful

The WEMWBS has been reported to have good content and construct validity, and to be internally consistent, with a Cronbach's alpha score of 0.91 in the population sample (Tennant et al., 2007).

The WEMWBS was selected to address this study's research questions for a number of reasons. It has been shown in validation studies to be straightforward for respondents to

complete (Tennant et al., 2007). It measures positive mental wellbeing, as opposed to illness, disorder or reduced functioning (Tennant et al., 2007). The tool has also been used in national surveys in the UK, such as the Health Survey for England (HSE, <https://www.ucl.ac.uk/hssrg/studies/hse>) which means that mean population scores are available for comparison, including scores analysed by gender and by area deprivation score (Office for National Statistics, 2017).

3.1.4.3 Quality of Life: The Mother-Generated Index (MGI)

Antenatal and postnatal quality of life were measured using the MGI. This is a validated quality of life tool (Symon, MacDonald, & Ruta, 2002) designed to collect information about the areas of life that have been affected by motherhood that are important to the mother herself. This is in contrast to many widely used quality of life measures, such as the SF-36 OR EQ-5D, where the constructs measured are pre-designated by developers, and may not therefore match a mothers' own experiences of what impacts her life at this time (Symon et al., 2002). The MGI has three aspects: the areas of life that the mother nominates, and whether these are positive or negative; the score, determined on a visual analogue scale, that she assigns to each of these areas, and a 'spending points' exercise to establish which of these areas she would spend the most points on in order to change.

A primary quality of life score (1-10) was calculated from the score on the visual analogue scale. This was then weighted by the secondary score of importance (denoted by the number of points spent to change it). The qualitative responses to the MGI quality of life tool were coded and analysed thematically (Symon et al., 2002) in order to understand their relationships to the mother's socio-economic position, as indicated or poverty, or by the indication of negative financial circumstances in the MGI. The MGI is included in the antenatal and postnatal questionnaires, in Appendix E, and Appendix F.

The MGI gives useful additional context to the subjective wellbeing scores, and allows an analysis of both the areas of life that are impacting negatively or positively on new mothers' quality of life and whether there is a relationship with poverty and deprivation,

and the levels of social support a mother has received, both in pregnancy and in the early post-natal period. Use of this tool allows a nuanced understanding of the quality of life of mothers, and the relationship, positive and negative, with SEP.

3.1.4.4 Social Support: The Berlin Social Support Scale

The Berlin Social Support Scale (BSSS) (http://userpage.fu-berlin.de/~health/soc_e.htm) was included in this research in order to understand the relationship, if any, to poverty, antenatal and postnatal mental health and quality of life. These multidimensional scales have been selected as they include several dimensions of social support (perceived available support, received support, need for support and support seeking) (Haga et al., 2012) and allow the participant to answer based on support from someone who is close to them, and from whom they are receiving support. This is likely to be a partner or husband in the case of research into new motherhood, but allows for single parents (for example,) to answer about a close friend, or other family member. This is in contrast to similar scales specifically for new mothers, such as the Maternal Social Support Scale (MSSS) of which a number of questions refer specifically to a husband or partner (Webster et al., 2000). These scales have been successfully previously used in a related research area (Haga et al., 2012).

The mean scores for each sub-scale are calculated and summed to arrive at the overall score for the BSSS. The differences were then used to explore the relationships between social support, quality of life scores (Haga et al., 2012) and wellbeing.

3.1.5 Data analysis procedures

3.1.5.1 Statistical Tests

The data from the antenatal and postnatal questionnaires were entered into SPSS (IBM SPSS Statistics 24).

The Shapiro-Wilks test for normality was conducted on all variables, as this is the most appropriate for sample sizes below 50 (Field, 2009). Where normality assumptions were met, the appropriate parametric test was used. Parametric tests were used with the

results from Likert scales where these have been summed into a score (Sullivan & Artino, 2013), and met normality assumptions. Non-parametric tests were employed where the data did not meet these assumptions.

Descriptive statistics have been used to provide a demographic picture of the participants.

The wellbeing scores and quality of life scores, using the WEMWBS and MGI, of the whole group, and of the poverty status groups, were calculated and reported using the mean or median as appropriate with regard to normality, as discussed above. The groups' scores were compared at each time point using an appropriate test, such as a t-test for means, or a non-parametric test such as the Mann-Whitney U test where the median and range are reported. Effect size is reported, in order to illustrate the magnitude of any difference (Sullivan & Feinn, 2012).

In the case of the MGI, the primary score was calculated, and weighted by the secondary score, where these were completed by the participant. Where these have either not been, or have been incorrectly, completed, the primary score was used.

The BSS scores was summed (Haga et al., 2012), and the point estimate for the whole group, and the poverty status groups were reported.

Repeated measures 'Analysis of Variance' tests (ANOVA) were used in order to investigate any change over time in wellbeing, quality of life, and social support scores, for both the whole group and in order to compare changes between groups according to poverty status and social support scores.

Poverty status and social support scores were used to investigate the relationship with wellbeing scores and quality of life scores in a regression analysis where appropriate and the necessary assumptions were met, in order to test for and explore predictive relationships between indicators of socio-economic position (Galobardes et al 2007), poverty and material deprivation, (Pantazis et al 2006) and quality of life and wellbeing.

3.1.5.2 Establishing the poverty threshold for the sample

The number of 'basics' that a family cannot afford, indicated on the deprivation measure, and the household income of that family, was entered into an ANOVA analysis, to 'draw' a poverty threshold within the group. This provided the criteria for the participants to be analysed as part of the 'living in poverty' or 'not living in poverty' groups. This was also confirmed using logistic regression. The threshold between groups was indicated by the maximum between group difference and minimum within group difference, "indicat[ing] that there is a significant difference between equivalised income and the deprivation score...suggesting that this is one level where material deprivation occurs" (Treanor, 2014, p. 1343). The results of these are reported below.

The income options provided for participants are bands, rather than specific income points. Therefore, the bottom of the income band was selected for each group. This is because for the highest group, only the lower band is provided, and there was a lack of additional information to justify the use of a 'middle' or 'upper' point in this group.

The household income was then equivalised, in order to account for different family size. This acknowledges that the resources used by household differs according to how many adults and children live within it (Office for National Statistics, 2015a). The methodology outlined by the Office for National Statistics in the report on Family Spending was used: (<https://www.ons.gov.uk/peoplepopulationandcommunity/personalandhouseholdfinances/incomeandwealth/compendium/familyspending/2015>). Information on participants' family composition was taken from the baseline questionnaire completed on registering for PortCo. The weighting applied is shown in

Table 4, below:

Table 4: Modified equivalence scale applied to income (taken from ONS Family Spending 2015)

Type of Household Family Member	Equivalence scale
First adult Child aged: 0-13	1.0
Additional adult	0.5
Child aged: 14 and over	0.5
Child aged: 0-13	0.3

3.2 Background to the participants

Recruitment took place between July 2016 and January 2017. Fifty-five women agreed to take part, and 47 (40% of 116) completed the antenatal survey. Of these, 39 went on to also complete the postnatal survey, indicating a 20% attrition rate from antenatal to postnatal. The group going on to complete the postnatal survey was not significantly different on the basis of poverty status: of the eight who did not complete the postnatal survey, six were in the group who could afford three or more 'basics' (not living in poverty), and two were from the group who could not ('living in poverty'). This difference was not statistically significant ($p=1.00$, Fisher's exact test). Therefore, the postnatal surveys were analysed by poverty status using the group mean for any missing values.

The age of the participants ranged from 26 – 41 years. Almost all of the women in the group were married (74%) or in a domestic partnership (23%). Less than two percent were single, which is lower than the 10% of lone parent households in Portsmouth (Hampshire County Council, 2017). 79% of the sample lived in a home they owned, 21% privately rented, and less than 1% rented through a housing association. All of the women had been educated beyond school level: 28% had attended further education, and 72% were educated to degree or postgraduate degree level. 43% of the group were first time mothers. 45 out of the 47 in the antenatal sample were of a White European background, with two participants from an Asian background. Religious attendance, belief or spirituality, and exercise have all been associated with wellbeing (Bize, Johnson, & Plotnikoff, 2007; Norman, Sherburn, Osborne, & Galea, 2010; Schieman, Bierman, &

Ellison, 2013): 72% of the sample stated that they had no religion, and 23% took no regular weekly exercise.

3.2.1 Poverty status

The ANOVA analysis of the ‘number of unaffordable items’, and using non-equivalised income as a continuous variable showed that the largest Welch F statistic (difference between groups) was reported for the group who could not afford three items or more on the scale. The Welch F statistics for each of the groups, and for those using equivalised income, are reported in Table 5, below. In order to corroborate the results, the PSE method also uses binary logistics regression models (Treanor, 2014). The Chi square, Cox and Snell R², and Nagelkerke R² from these regressions are reported in Table 6 below.

Table 5: ANOVA of number of unaffordable items and income

Deprivation score: number of unaffordable items	F statistic for the deprivation group	F statistic for the deprivation group (Equivalised income)
1 or more	4.439	5.4
2 or more	5.469	4.19
3 or more	11.189	13.075
4 or more	9.585	15.146
5 or more	5.742	8.673
6 or more	5.742	8.673
7 or more	_.1	_.1

¹ Could not be performed as the sum of case weights was less than or equal to 1

The deprivation score with the largest sum of squares, which maximises the between group differences, and minimises the within group difference (Treanor, 2014) was 4 or

more items, using equivalised income ($F = 15.146$). This was confirmed by the results of the binary regression shown in Table 6.

Table 6: Summary of binary regression results, unaffordable items and equivalised income

Deprivation score: number of unaffordable items	Model Chi square	Cox and Snell R ²	Nagelkerke R ²
1 or more	5.529	.111	.149
2 or more	4.940	.100	.140
3 or more	13.053	.242	.376
4 or more	13.692	.253	.513
5 or more	9.824	.189	.427
6 or more	9.824	.189	.427
7 or more	_.1	_.1	_.1

¹ Could not be performed as the sum of case weights was less than or equal to 1

However, the threshold of '4 items or more' produces a group of only 5 participants. Descriptive statistics show that this would underestimate the level of poverty in Portsmouth, as illustrated in Table 7, below.

Table 7: Material deprivation using PSE vs child poverty levels in Portsmouth

Group	Percentage affected by poverty
Portsmouth	22% ¹
Birth Cohort Sample, 3 items or more	21%
Birth Cohort Sample, 4 items or more	11%

¹ Child poverty levels are reported (“Tackling Poverty in Portsmouth – Needs Assessment Refresh,” 2015)

In previous research using the PSE method, a different threshold has been selected from that identified by the ANOVA analysis, where this is “statistically robust and is comparable to the contemporary proportion...living in income poverty” (Bradshaw & Finch, 2003; Treanor, 2014, p. 1343). The threshold of three or more unaffordable items more closely reflects the picture of poverty in Portsmouth and allows a larger group number for analysis purposes. In the binary regression and ANOVA, the ‘3 items’ threshold also has a large F statistic, X^2 and Cox and Snell R^2 , and therefore reflects the Bradshaw and Finch criteria outlined above (Bradshaw & Finch, 2003). It was therefore used as the primary threshold in conducting this analysis. This is a more conservative approach: where a difference might be expected between the groups according to poverty level, a lower threshold would be less likely to delineate this difference.

The groups are referred to as ‘living in poverty’ (unable to afford three or more of the basic items on the deprivation measure,) and ‘not living in poverty’ (those unable to afford two or fewer items on the measure, or not needing or wanting the items) throughout the analysis. The background characteristics of the sample by poverty status are reported in Table 8, below.

Table 8: Group characteristics by poverty status

	Living in poverty	Not living in poverty
Age ¹	32 ± 4.0	33 ± 3.4
First-time mother n/N (%)	2 / 10 (20%)	18 / 37 (49%)
Highest level of education (Higher) n/N (%)	5 / 10 (50%)	29 / 37 (78%)
Housing status (Owner-occupier) n/N (%)	6/10 (60%)	33/37 (89%)

¹ Mean ± SD

The difference in the number of first time mothers between the poverty status groups was not significant ($p=0.154$, Fishers Exact Test). There was also no significant difference between the groups in the mean age ($t(45) = 1.029$, $p=.278$), number of women who had higher education vs further education ($p =.112$, Fishers Exact Test). There was a significant difference between owner-occupiers vs. private or social renters according to poverty status ($p =.003$, Fishers Exact Test).

3.2.2 The picture of social support in the sample

The BSSS scores in pregnancy were not normally distributed in both groups (Shapiro-Wilks <0.05). Therefore, the scores from each poverty group were compared using a non-parametric test, the Mann-Whitney U test. The social support scores were higher in the 'not living in poverty' group compared with the 'living in poverty' group, (median 115 (IQR 16) vs 99 (IQR 28)). The difference in the social support scores between the two groups was significant ($U=95$, $p= .019$) Therefore, women in the 'living in poverty' group experienced significantly lower levels of social support in pregnancy than those in the 'not living in poverty' group.

The median social support scores decreased in both groups in early motherhood compared with pregnancy, but remained higher in the ‘not living in poverty’ group (median 111 (IQR 13.5) vs 92 (IQR 41.5)). The difference in the social support scores between the two groups was significant (U=95, Exact sig (2 tailed) p= .018). Therefore, women living in poverty continued to experience significantly lower levels of social support in early motherhood, although this level reduced in both groups at this time point.

These scores are reported in Table 9, below.

Table 9: BSSS score by poverty status

BSSS	Overall group (n 47)	‘Not living in poverty’ (n 37)	‘Living in poverty’ (n 10)
Antenatal	113 (IQR 19)	115 (IQR 16)	99 (IQR 28)*
Postnatal	111 (IQR 23)	111 (IQR 13.5)	92 (IQR 41.5)*

BSSS, Berlin Social Support Scale

*Difference between ‘Living in poverty’ and ‘Not living in poverty’ p< .05

A repeated measures ANOVA was conducted in order to assess whether the reduction in social support over time was significant. The social support scores assessed at time 1 (pregnancy), and time 2 (early motherhood) were entered, along with poverty status. There was a significant reduction in social support in the groups over the two time points, $F(1,45) = 9.79$, $p = .003$. However, this reduction in support was experienced by both groups, and there was not a statistically significant interaction between time and poverty ($F(1,45) = 1.174$, $p = .284$)

3.3 Quality of life in pregnancy and early motherhood

All 47 women who returned the antenatal questionnaire completed the primary MGI quality of life score. 5 participants either did not complete the secondary (weighting)

score or did not complete it correctly. Here, an equal weighting of the primary scores was assumed.

Nine women did not complete the postnatal MGI, with a further five women not completing the secondary score for the postnatal MGI. The latter scores were therefore again the primary MGI postnatal score without weighting. The former were assigned the group mean, according to poverty status, in order to carry out the postnatal quality of life analysis.

3.3.1 Quality of life scores in pregnancy and early motherhood

The mean MGI score in pregnancy for the group as a whole was 5.68 (95% CI 5.18 – 6.17). MGI scores in pregnancy were normally distributed in each group (Shapiro-Wilks >0.05), and therefore an independent samples t test was used to compare the poverty status group scores. The MGI score in pregnancy was very slightly lower in the ‘living in poverty’ group of women compared with the ‘not living in poverty’ group. This difference was not significant ($t(45) = 1.230, p > .225$). A Hedges g effect size of 0.42 was calculated, which suggests a moderate effect size. The results are presented in Table 10 below.

The mean MGI score in early motherhood for the group as a whole appeared to remain stable overall at 5.67 (95% CI 5.2 - 6.2). This score was lower in early motherhood in the ‘living in poverty’ group, when compared with the ‘not living in poverty’ group, however this difference was not significant ($t(45) = 1.807, p = 0.077$). The MGI weighted score increased slightly for the ‘not living in poverty’ group in early motherhood from pregnancy (5.9 ± 1.5). However, this score was lower in the ‘living in poverty’ group after giving birth: 5.1 ± 1.4 vs 4.9 ± 1.8 . This difference again suggests a moderate effect size (Hedges $g = 0.63$). These figures are reported in Table 10.

Table 10: Mother-Generated Index scores by poverty status

	Overall group (n 47)	'Not living in poverty' group (n 37)	'Living in poverty' group (n 10)
Antenatal MGI	5.68 (95% CI 5.18 – 6.17) ¹	5.8 ± 1.7	5.1 ± 1.4*
Postnatal MGI	5.67 (95% CI 5.2 - 6.2)	5.9 ± 1.5	4.9 ± 1.8*

¹ Mean reported

* $p > 0.05$ between 'not living in poverty' and 'living in poverty'.

In order to understand the possible effect of time and poverty on the change in MGI scores between pregnancy and early motherhood, a repeated-measures ANOVA was performed, with MGI scores at time 1 and time 2 entered as within-subjects factors, and poverty status as between-subjects factors. There was not a significant group effect of poverty: $F(1, 45) = .181, p = .672$.

The ANOVA did not show an effect of time on the MGI score change, $F(1, 45) = .057, p = .813$ or an interaction of poverty with time, $F(1, 45) = .181, p = .672$. This indicates that these do not change significantly over time, and the scores are not changing significantly due to poverty status from pregnancy to early motherhood.

3.3.2 Quality of life scores according to reported negative financial concerns

Antenatal and postnatal MGI scores were analysed according to whether or not a negative comment was made about finances or financial circumstances in the respective surveys (Symon, McGreavey, & Picken, 2003). The MGI scores were distributed normally in those with and without a negative financial comment at both time points, therefore a t test was employed to compare means.

In pregnancy there was a difference in MGI scores between the group who had a negative financial comment (n=9) and those who did not (n=38): 5.1 ± 1.1 vs. 5.8 ± 1.7 . This

difference was not statistically significant ($t(45) = 1.1730$, $p = .247$) but does suggest a moderate effect size (Hedges $g = 0.42$). However, this picture changed in early motherhood. Those who cited a negative financial comment had significantly lower MGI scores than those who did not: 4.3 ± 1.4 vs 5.9 ± 1.5 ($t(45) = -2.87$, $p = .006$). This also increased the effect size: Hedges $g = 1.06$, which suggests a large effect size.

3.3.3 Roles of poverty and social support in quality of life in pregnancy

Neither poverty status (reported above) nor social support score in pregnancy was significantly associated with antenatal MGI scores (Spearman's $\rho = .219$, $p = .138$) in pregnancy.

3.3.4 Areas of importance nominated in the MGI in pregnancy

All of the women completing the pregnancy questionnaires nominated important areas of life that had been affected by having a baby. Twenty-five different areas of life impacted by being pregnant were nominated by the mothers in this group. The areas with the most nominations are presented in Table 11 below. Areas nominated were coded together and therefore may appear more than once in a participant's response. For example, 'friends' and 'social life' may both have been nominated by one participant, and these were then counted twice in the category 'social life'.

Table 11: Antenatal themes nominated in the MGI

Important area of life affected by being pregnant	Total nominations	Positive	Negative	Equivocal
Relationship with husband/partner	35	17	3	15
Work	33	1	20	12
Social life/friendship	32	13	8	11
Physical health/energy levels	25	3	18	4
Looking to the future	22	16	1	5
Extended family	21	13	3	5
Personal appearance	20	7	9	4
Older children	19	1	9	9
Exercise/keeping fit	13	1	12	0
Mental/emotional health	13	2	2	9
Finances	13	0	9	4

3.3.5 Areas of importance nominated in the MGI in early motherhood

The areas most impacted by having a baby closely reflect those nominated in pregnancy, and are reported in Table 12 below.

Table 12: Postnatal themes nominated in the MGI

Important area of life affected by having a baby	Total nominations	Positive	Negative	Equivocal
Relationship with husband/ partner	39	11	13	15
Social life/ friendship	26	11	3	12
Work/ returning to work	23	5	9	9
Personal time/ hobbies	18	1	12	5
Extended family	18	11	-	7
Feelings towards baby	15	10	2	3
Older children	15	6	5	4
Physical appearance/ 'My body'	15	1	8	6
Finances	12	2	9	1

The three most nominated areas are again relationship, social life/ friendships and work. The character of some of these nominated areas has changed however: 'Relationships with husband or partner' garnered predominantly positive comments in the antenatal responses; in the postnatal there were slightly more negative comments. However, these referred to a lack of time with a partner, and only one comment explicitly referred to an unsupportive partner. Whereas 'work' was classified predominantly negatively in late pregnancy, in the early postnatal era these responses were more equivocal, with a fairly even split across looking forward to, or 'dreading' the return to work. Personal appearance appears in both antenatal and postnatal comments, but has become more

negative in early motherhood, than the equivocal attitude in pregnancy. And finances are considered an important area that has been affected by having a baby both in the antenatal and postnatal periods; at both stages these are considered to have a negative impact.

Other changes to the nominated areas include 'personal time/ hobbies' becoming more important in early motherhood, where time for these has become more restricted. There was some overlap in the postnatal period with this and 'exercise', which might indicate that the frustration at not being able to exercise and keep fit as much in late pregnancy is reflected in the lack of any personal or 'me time' in early motherhood.

3.4 Subjective mental wellbeing in pregnancy and early motherhood.

The WEMWBS (subjective mental well-being) scores in pregnancy were normally distributed in each poverty status group (Shapiro-Wilks >0.05). Therefore, parametric tests were used to compare the groups even though the dependant variable is ordinal rather than interval or ratio data, as described in the 'data analysis' section.

The mean wellbeing score for the group as a whole in pregnancy was 52 (95% CI 50 – 55). The score for the group as a whole in early motherhood was slightly reduced: 50 (95% CI 47 – 53).

3.4.1 Wellbeing scores and poverty status

The mean wellbeing score for the women in the 'Living in poverty' group was lower in pregnancy than for those women in the 'Not living in poverty' group: 47 ± 9 vs 54 ± 7 , and this difference was significant ($t(45) = 2.55, p=.014$). The Hedges g effect size is 0.92, which suggests a large effect size.

The mean wellbeing score for the women living in poverty was again lower in early motherhood than for those women in the 'Not living in poverty' group: 42 ± 8 vs 52 ± 8 . This difference between groups was significant ($t(45) = 3.702, p=.001$), and the Hedges g effect size was 1.22, again suggesting a large effect. However, though the score reduced further from pregnancy to early motherhood in the 'Living in poverty' group, this difference in reduction over time was not significant. These results are presented in Table 13, below.

Table 13: Questionnaire scores in pregnancy, by group (DS3)

WEMWBS	Overall group (n 47) ¹	'Not living in poverty' (n 37) ¹	'Living in poverty' group (n 10) ¹
Antenatal	52 (95% CI 50 – 55)	54 ± 7	47 ± 9*
Postnatal	50 (95% CI 47 – 53)	52 ± 8	42 ± 8*

WEMWBS, Warwick-Edinburgh mental wellbeing score, possible range 14 - 70

* Difference between 'Living in poverty' and 'Not living in poverty' $p < .05$

¹Mean reported for each group.

3.4.2 Social support and wellbeing scores

An analysis of the possible relationship between the social support and wellbeing scores was undertaken. Both scores are based on Likert scales, and do not generate interval data. Therefore a Spearman's rho test was used (Field, 2009).

In pregnancy, wellbeing scores and social support scores were moderately positively correlated, and the correlation was significant ($r_s = .449$, $p < .05$). This relationship between social support and wellbeing became stronger, and remained significant, in early motherhood, ($r_s = .609$, $p < .05$).

3.4.3 Possible confounding variables, and the relationship with wellbeing

The relationships between potentially confounding variables and wellbeing, such as age, religious belief, exercise, education level and home ownership were explored. These variables were included in a multiple regression model with wellbeing as the dependent variable. The results are presented in the Table 14 below. Age was entered into the model first, as a relationship between age and subjective wellbeing has been established through previous research (Ferraro & Wilkinson, 2013; Field, 2009).

Table 14: Relationship between potential confounding variables and antenatal wellbeing scores

	B	SE B	β
Model 1			
Constant	47.032	10.465	
Age	.158	.314	.075
Model 2			
Constant	46.725	10.925	
Age	.181	.334	.86
Regular exercise	.312	3.018	.016
Religious belief	4.246	2.885	.233
Higher education	-1.798	2.980	-.099
Home ownership	-2.559	3.184	-.128

Note: $R^2 = .006$ for step 1, $\Delta R^2 = .064$ ($p > .05$) * All variables $p > .05$

The VIF values in both models are below 10 (Model 1 = 1, Model 2 = 1.080 – 1.175), and the tolerance statistics are > 0.2 (Model 1 = 1, Model 2 = 0.851 - 1) and therefore the model meets the assumption of no collinearity within the data. The Durbin-Watson statistic is 1.690, which although greater than 1 may indicate that the assumption of independent errors has been violated, although a value of less than 1 would warrant further investigation (Field, 2009). 2% (1/47) of cases has standardised residuals outside of ± 2 , however the Cook's distance remained below 1, and therefore this model appears to an accurate model within these limits (Field, 2009). The normal distribution on the

histogram of the standardised residuals suggests the assumption of normality is met. The scatterplot of standardised residuals against standardised predicted values suggested the assumption of homoscedacity is met.

Each of the variables had a very weak relationship with the wellbeing scores in pregnancy of this sample. In the case of age, regular exercise and religious belief this was a positive relationship, whereas education level (further vs. higher) and home ownership status both had a negative relationship ($r=-.099$ and $r=-.128$ respectively). None of these relationships reached statistical significance, and therefore they were not included in the final regression model.

A similar model was run to assess for possible confounding variables in early motherhood. As in the antenatal model, none of the variables was found to have a statistically significant relationship with the postnatal wellbeing scores. The results of the postnatal regression model of potential confounding variables are presented in Table 15, below:

Table 15: Relationship between potential confounding variables and postnatal wellbeing scores

	B	SE B	β
Model 1			
Constant	49.81	11.499	
Age	.022	.345	.010
Model 2			
Constant	50.074	11.565	
Age	-.110	.353	-.048
Regular exercise	3.866	3.195	.183
Religious belief	3.298	3.054	.165
Higher education	.979	3.155	.049
Home ownership	-5.145	3.371	-.235

Note: $R^2 = .10$ for step 1, $\Delta R^2 = .000$ ($p > .05$) * All variables $p > .05$

Education has changed to a positive relationship with wellbeing scores postnatally in the sample, however the correlations between these variables and the wellbeing scores remain very weak and do not reach statistical significance.

Once again in this model the assumption of no collinearity is met (VIF Model 1 = 1, Model 2 = 1.175; Tolerance = >0.2 in both models). The assumption of independent errors holds, (Durbin-Watson 1.739) and the Cook's distance on standardised residuals remained below 1. The normal distribution on the histogram, and analysis of the scatterplots suggests both the assumptions of normality and homoscedacity have been met.

3.4.4 The roles of poverty status and social support in wellbeing

As reported above, social support scores and poverty status are both associated with wellbeing levels in pregnancy. In order to test the extent of social support or poverty status effect on wellbeing, a multiple regression analysis was undertaken. The group 'DS3' (those who could not afford 3 or more items from the list) was re-coded to a dummy variable 'Living in poverty': '0' if not in the group, '1' if a member of the group. Linear regression was run: in this first model 'poor' was entered as the independent variable, and the WEMWBS score as the dependent variable. In the second model, the social support score, BSSS, was entered into the second model at the same time as the poverty variable. The 'Enter' method was used, so as to avoid the random variation in the data influencing the model (Field, 2009).

3.4.4.1 Pregnancy

The correlation reported between being a member of the 'living in poverty' group and wellbeing score is -3.55, which indicates a moderate, and statistically significant, negative relationship ($p=.007$). Therefore if a mother is a member of the 'living in poverty' group, there is a correlation with poorer wellbeing scores. There is a statistically significant positive correlation between social support score and wellbeing score ($r=.485$, $p<.001$). Therefore there is a correlation between higher social support and higher wellbeing scores.

There is a negative correlation between membership of the poor group and social support score ($r=-.408$, $p=.002$). Therefore, there is a relationship between being poor and lower social support scores in this group.

The detailed results of the regression model in pregnancy are presented in Table 16.

Table 16: Regression model, effect of poverty status and social support level on wellbeing in pregnancy

	B	SE B	β
Model 1			
Constant	53.78	1.28	
Poverty	-7.08	2.78	-.355*
Model 2			
Constant	26.09	9.67	
Poverty	-3.77	2.82	-.189
Social support	.248	.086	.408*

Note: $R^2 = .12$ for step 1, $\Delta R^2 = .14$ ($p = .006$) * $p < .05$

In the first model, membership of the poor group predicts wellbeing score in pregnancy, and this is statistically significant ($p = .014$):

$$(\text{Model 1}) \text{ Wellbeing score} = 53.78 + (1 \times -7.084 \text{poor})$$

In this model, only membership of the 'poor' group was used as a predictor of wellbeing score. Here the R^2 is .126, showing that membership of the poor group explains only 13% of the variability in wellbeing score in this group in pregnancy. When social support scores are added into the model the R^2 is .265, showing that both poverty and levels of social support combined explain 27% of the variability in wellbeing scores. This change in R^2 in the second model is significant (F ratio = 7.93, $p = .001$).

The regression equation for Model 2 is

$$\text{Wellbeing score} = 26.095 + (1 \text{poor} \times -3.771) + (.248 \times \text{socialsupportscore}).$$

In this model, where the social support score is added, then membership of the poverty group is no longer statistically significant, suggesting that social support has a mediating effect on poverty status in predicting wellbeing score.

The VIF values in both models are below 10 (Model 1 = 1, Model 2 = 1.198), and the tolerance statistics are >0.2 (Model 1 = 1, Model 2 = 0.835) and therefore the model meets the assumption of no collinearity within the data. The Durbin-Watson statistic is 2.063, indicating that the assumption of independent errors holds (Field, 2009). 6% (3/47) of cases has standardised residuals outside of ± 2 . None of the cases have standardised residuals outside ± 2.5 , which would suggest the need for further investigation, and therefore this model appears to be an accurate model within these limits (Field, 2009). The normal distribution on the histogram of the standardised residuals suggests the assumption of normality is met. The scatterplot of standardised residuals against standardised predicted values suggested the assumption of homoscedasticity is met.

3.4.4.2 Early motherhood

The correlation between living in poverty and wellbeing score in early motherhood is -0.483 ($p < .001$). This statistically significant negative relationship has strengthened slightly in early motherhood. The strongly positively correlated relationship between social support scores and wellbeing scores continues in the early postnatal period $r = .621$, $p < .001$, as does the moderately negative relationship between social support and poverty status ($r = -.456$, $p < .001$). Therefore the relationships between poverty, social support and wellbeing remain broadly the same in early motherhood, as they were in pregnancy. The detailed results of the regression model in early motherhood are presented in Table 17, below.

Table 17: Regression model, effect of poverty status and social support on wellbeing in early motherhood

	B	SE B	B
Model 1			
Constant	52.162	1.316	
Poverty	-10.562	2.853	-.483
Model 2			
Constant	18.782	8.094	
Poverty	-5.340	2.745	-.244*
Social support	.309	.074	.524

Note: $R^2 = .23$ for step 1, $\Delta R^2 = .22$ ($p < .001$) * $p > .058$, all other results $p < .05$

In the first model in early motherhood, membership of the poor group again predicts wellbeing score in pregnancy, and this is statistically significant ($p = .001$):

$$(\text{Model 1}) \text{ Wellbeing score} = 52.162 + (1 \times -10.562\text{poor})$$

In this first model, poverty status alone predicts 23% of the variability in postnatal wellbeing scores in this sample. In the second model, where the postnatal social support scores are included, both variables predict 45% of the variability in postnatal wellbeing scores ($R^2 = .451$, change is R^2 , F ratio = 17.39, $p = .000$).

The regression equation for Model 2 is

$$\text{Wellbeing score} = 18.782 + (1\text{poor} \times -5.340) + (.309 \times \text{socialsupportscore}).$$

As in the antenatal model, where the social support score is added, then membership of the poverty group is no longer statistically significant, suggesting that in this period, social support still has a mediating effect on poverty status in predicting wellbeing score.

The model meets the assumption of no collinearity within the data: the VIF values for both models are less than 10 (Model 1 = 1, Model 2 = 1.263), with the tolerance statistics

for both models being greater than 0.2 (Model 1 = 1, Model 2 = .792). The model also meets the assumption of independent errors: Durbin-Watson = 2.43. 3/47 cases has standardised residuals above ± 2 , however none are above ± 2.5 , which suggests that the model is accurate within these parameters (Field, 2009). The assumptions of normality and homoscedacity are met, as demonstrated by the scatterplot of standardised residuals against standardised predicted values, and the histogram of standardised residuals.

3.4.5 The interaction of poverty, social support and time, and impact on maternal wellbeing

The potential impact of time on wellbeing scores was explored, using a repeated measures ANOVA.

The effect of time on wellbeing scores is significant $F(1, 45)=7.96, p=.007$. This shows that wellbeing at time 2 (early motherhood) was significantly lower than at time 1 (pregnancy). This decrease in wellbeing was not significantly different according to poverty status: $F(1, 45) = 2.13, p=.151$.

Social support scores were measured at both time 1 and time 2, and therefore could not be used to assess the relationship between these and the decrease in wellbeing over time: as described above, social support scores also decreased over time in both groups. This meant that the postnatal support score could not be used alone to explore the decrease of wellbeing scores in pregnancy to the level of those in early motherhood.

Therefore, in order to remove the potential confound of social support scores from the time series data, errors were regressed out of the wellbeing data. For each participant, a linear regression was performed: 'wellbeing' was entered as the dependent variable and 'social support score' was entered as the independent variable. The unstandardized residuals were saved from this regression. These regression residuals represent the portion of each wellbeing score that is independent of social support score. These were then entered into the ANOVA in order to ascertain the effect of social support on the longitudinal data.

In this analysis time is now not statistically significant, $(F(1, 45) = 0.78, p=.781)$. Therefore, where social support scores were controlled for, wellbeing did not decrease in the sample

from pregnancy to early motherhood. This suggests that where wellbeing scores decrease from pregnancy to early motherhood, particularly for the women in the living in poverty group, this is linked to the lower social support levels that they also experience at these time points.

3.5 Discussion

3.5.1 Statement of principal findings from the questionnaire study

This study investigated the levels of poverty, quality of life, subjective wellbeing and social support in a group of women late in pregnancy, and again when their babies were around three months old. Social support levels were also investigated with regard to poverty levels, and found to be significantly lower in mothers who were living in poverty, and to have decreased significantly in both groups from pregnancy to early motherhood.

Mother generated quality of life (MGI) score was lower in the 'living in poverty' group in both pregnancy and early motherhood, but this was not statistically significant at either stage. There was however, a moderate effect size. These scores were also found to not change from pregnancy to motherhood in either group. In early motherhood, women who made a negative comment about their finances were more likely to have lower maternal quality of life. Social support scores were not significantly associated with quality of life score. However, relationships, and social life and friendships, were the most frequently nominated areas of importance in the MGI at both time points.

Subjective wellbeing scores were significantly lower in the 'living in poverty' group both in pregnancy and early motherhood. The mean wellbeing scores for the group 'not living in poverty' were the same as the group mean in the antenatal period, suggesting that these had not been lowered by the transition to motherhood, whereas in the 'living in poverty' group these scores decreased in early motherhood. This relationship was mediated by the social support scores when these were entered into the models at both stages, meaning that where a mother who is living in poverty has good support, this will mitigate the effects of poverty on her subjective wellbeing. Conversely, if a woman who is not living in

poverty experiences low social support then she is more likely to have lower wellbeing levels.

The effect of time on wellbeing was therefore directly examined. Both groups were found to have lower wellbeing over time (from first measurement in late pregnancy, to the second in early motherhood). However, there was not a significant difference over time between the 'living in poverty', and 'not living in poverty' groups. Where social support scores were accounted for when examining the change in wellbeing scores over time, it was found that the lower social support received by women living in poverty was affecting their mental wellbeing between pregnancy and early motherhood, rather than poverty per se. This would suggest that social support provided to women when having a baby could increase wellbeing levels, regardless of poverty status.

3.5.2 Strengths of the quantitative study

This study has several strengths. As outlined in Chapter One, there is a paucity of research which centres mothers' own experiences, and which looks at the positive wellbeing of mothers when they make the transition to motherhood. Despite the importance of mental wellbeing to a range of physical and mental health conditions, (Barry, 2009; Diener & Chan, 2011) subjective wellbeing levels in the transition to motherhood has not been extensively or consistently investigated. This study has contributed to addressing this gap in knowledge.

The option to complete both surveys online was available, which meant that it was more accessible for women who were working or had small children, and therefore were able to complete this when convenient. The option of a researcher visiting with the questionnaire was available in the antenatal period to address participant preference, or lack of computer or IT access. This was taken up by one participant once the online survey was available.

The method to calculate the poverty threshold in the group accounts for both income and ability to afford the basics. This means that the 'not living in poverty group' did not include participants who may appear to have high household incomes, but still cannot afford the 'basics' as assessed by consensus methods. The reasons for not being able to

afford these were not collected, but may include high debts or housing costs. Conversely this should capture those households that appear to have low incomes, but may still not be 'living in poverty' due for example to wealth, or savings. Defining poverty in this way in this study means that there is an opportunity to consider the mechanism for how this might be impacting on the wellbeing scores of the women in the study, rather than a more vaguely defined measure of SEP.

The generalizability of some of the included measures was also a strength of the study. The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) is a scale that has been developed for use in the general population (aged 16 and above,) and has been employed in national surveys, such as the Health Survey for England (Morris & Earl, 2017). This, and the generic nature of the measure, means that these results can be compared with the population means published in these surveys, allowing a picture to be built of how maternal mental wellbeing may differ from that of a group of women of the same age, and from areas of varying deprivation levels. Diener and colleagues demonstrate that measures of wellbeing, and what is being measured, matter. For example, life satisfaction, used by many studies and by national surveys to denote wellbeing, has been found to be affected by income and health and work quality. Positive feelings are more likely to be impacted by social relationships. (Diener et al., 2017). It is therefore a strength of the study that a measure such as the WEMWBS is used, which encompasses both hedonic and eudemonic wellbeing.

The MGI, in contrast, allows pregnant women and mothers to nominate areas of pregnancy and motherhood which are important to them, and this is a strength in contrast to the generic, illness focused, quality of life measures, such as EQ5D and SF-36, which may be inappropriate for pregnancy and motherhood.

The BSSS is a suitable measure of social support, that allowed the women completing it to nominate any significant person when assessing the levels of support they receive, and this meant that it was appropriate for single mothers, and women who are receiving support from, for example, mothers or sisters, rather than a partner or husband. This measure also combined perceived and actual support, and received and need for support,

meaning that it provided a full picture of the support that women had available to them at this time.

The sample reflects the Portsmouth population in some key aspects. Principally, the percentage of women living in poverty in the group reflects the percentage of people living in poverty reported in Portsmouth (Public Health England, 2014).

The final models in pregnancy and early motherhood explained 27% and 45% of the variability in mothers' subjective wellbeing scores respectively. Attrition from the antenatal time point was low: 80% of women who completed the antenatal questionnaire went on to complete the postnatal questionnaire, a rate which compares well with other studies across this period (McBean & Montgomery-Downs, 2015).

3.5.3 Limitations of the quantitative study

The study was a small scale study, and its key limitation is in the small number of participants recruited to complete the questionnaires from the wider PortCo study. This was partly due to the lower numbers of women recruited to the Portsmouth Birth Cohort study than had been originally anticipated. This may have been in part that the women were recruited at scan appointments, where they may have felt they wanted to focus on what is a medical screening, which can be nervously anticipated. Where mothers consented to be followed up for this, and were contacted again, there were few refusals to participate. However, mobile phone numbers were the primary contact method given, and these were frequently unanswered, with voicemail messages not returned. Whilst this may represent active refusal to participate, this may also be a case of missed opportunities, and should be considered when recruiting (often) working women, women who have busy lives with caring responsibilities, or both, in the future.

The small numbers may further limit the generalisability of the findings, as the sample is not representative of the Portsmouth population in some important ways. Single mothers are underrepresented in this sample, which may have an impact on the wellbeing levels, especially as it is likely that this group would have been represented in the 'living in poverty' group (Office for National Statistics, 2015b). However, it is likely, given the links found here between wellbeing, poverty and social support, that this under-

representation would have led to an underestimate of the relationship between wellbeing and poverty.

In this group, the youngest mother was 26. This may partly explain the lack of relationship between age and wellbeing scores in this group, as this is a recognised driver of wellbeing (Ferraro & Wilkinson, 2013). Around 95% of the group was from a white, European, background whereas in Portsmouth around 16% of the population is from groups other than 'White British'. (Office for National Statistics, 2013). This may limit the generalizability of these findings beyond this group.

The MGI was completed correctly in the majority of cases. However, particularly in the postnatal surveys this was sometimes incomplete, or the scores were inserted incorrectly in the survey. As this arose in the postnatal surveys of participants who had previously completed the MGI without any difficulties then this suggests that this was not an issue with the difficulty of the MGI itself to complete or understand, but that completing a survey in very early motherhood may mean that having the time to consider the more in-depth questions and scoring systems that the MGI asks for may be more difficult at this stage.

Although attrition from the pregnancy to postnatal surveys was low, there was still some missing values in the postnatal data, particularly in the MGI secondary scores, as outlined above. Methods for accounting for these missing values were considered. The ANOVA analyses needed to assess the change in wellbeing scores both over time and between groups required data from both time points in order to be carried out, if not the case would be excluded by SPSS in the analysis. In order to avoid this the mean for the groups 'living in poverty/ not living in poverty' were calculated and applied to each missing case. This allowed for the cases to be used in the analysis, and as the number of missing cases was below 25% this was considered a reasonable course of action. However, this may have led to the overestimation or underestimation of the group means in some cases, and a reduction in the variability overall. Where only primary MGI scores were given, these were used without weighting, which again may mean these are over or underestimated in a very small number of cases, however given the small impact of the weighting on the primary scores this impact is likely to be minimal.

'Living in poverty' has been used here to term the group where three or more basics were unaffordable for that household. This uses the definition of poverty outlined earlier, that 'poverty' denotes both low income and lack of resources for basic items. However, it should be acknowledged that this may not necessarily be how the women in this group would describe themselves.

3.5.4 Comparison with the literature

The mean WEMWBS score for the whole group of participants in pregnancy was comparable to the population WEMWBS for women, at 52 (95%CI 50 – 55). This is slightly higher than that reported for women across age groups in a representative population sample (median 51, 95% CI 50-52) (Tennant et al., 2007). However, this population estimate had declined in the more recent (2015) Health Survey for England, where the average score for women was 49.6. For women in the 25 – 34 group, which is closest in age to the group of women included in this study, the score was 49 (Morris & Earl, 2017). The women not living in poverty in this group had higher scores in pregnancy therefore than the population average for a comparable age group. This is reflected again in the scores for early motherhood, although the scores have decreased for the women not living in poverty in the group, they are still higher than the population average at 52 (SD \pm 8). The scores of the women living in poverty were about the same as women living in the most deprived areas in pregnancy, as reported in the Health Survey for England, and much lower in early motherhood (47.3 average in women in the most deprived areas, vs. 42 in women in the 'living in poverty' group in early motherhood). (Morris & Earl, 2017).

A number of measures capture quality of life, or more specifically 'health-related' quality of life and a variety of these have been used with pregnant women and new mothers. Studies using the MGI have suffered some practical, conceptual and linguistic difficulties with the use of the instrument and measurement of the concept of 'quality of life' in countries such as India, Brazil, China and Poland (Symon et al., 2013). A study conducted in the UK examining both antenatal and postnatal MGI scores as part of a wider randomised controlled trial found higher mean scores than those reported here: 7.6 vs

5.68 in pregnancy, and 7.6 vs 5.67 in early motherhood, for the overall group (Symon et al., 2015). As in the Symon study, the scores for the overall group of participants in this study did not really change from pregnancy to motherhood. A more recent study in Germany found an overall mean score of 6.8 (at seven weeks after delivery,) and found that scores were statistically significantly associated with support at home (Grylka-Baeschlin, van Teijlingen, Stoll, & Gross, 2015). This is in contrast to the findings in this study, that the social support scores were not significantly correlated with the MGI scores. This could be an effect of the smaller sample size in this study. A moderate effect was found for poverty on the MGI scores here. The two studies that explicitly measured the impact of SEP upon MGI scores reported a relationship, however these were both conducted in India, and may not be comparable to the findings here for the reasons discussed above (Symon et al., 2013).

Where the small existing literature on wellbeing in new motherhood investigated any relationship with SEP, generally this relationship was found to be positive (Buttner, O'Hara, & Watson, 2012; Green & Kafetsios, 1997; Holton et al., 2010). Whilst these studies report on both educational level and living in areas of socio-economic dis/advantage, and therefore it is difficult to compare the results to the findings presented here, overall they do support the small evidence base that suggests that there is a relationship with socio-economic position and wellbeing in new motherhood. Even where studies have found an improvement in women's mental health in motherhood (Holton et al., 2010), this is not the case for women living with some form of socio-economic disadvantage.

Although the impact of living in poverty appeared to be less when measuring mother-generated quality of life, the effect size was moderate. This suggests that the lower differences as measured by the t-tests or ANOVA may be a function of the small sample size in this study. It may also reflect what is being measured: mental wellbeing is an aspect of quality of life, which is a broader measure, particularly in the case of the MGI, where this is comprised of areas of life the mother nominates herself, and may include physical wellbeing. It may be that in pregnancy and motherhood, there is a physical strain, which is not necessarily poor health, and that this relationship is more complex.

Again, the studies that have measured MGI scores and explored an indicator of SEP have found a positive relationship between these: where mothers have higher education, 'economic status' or income they also had higher quality of life scores overall (Bodhare et al., 2015; Nagpal et al., 2008; Symon et al., 2003).

The lower wellbeing and quality of life scores of the 'living in poverty' group, even when compared with those of women living in the most deprived areas, in the case of SWB, suggests that early motherhood is a particularly difficult time for women who are living in poverty, and that there are factors that arise because of the transition to motherhood, which interact with poverty, to result in a lower overall level of subjective wellbeing. The results of this study, where social support scores have been shown to mediate the effects of poverty on wellbeing scores suggest that this support that the women in this group received from a close relationship is a key aspect of this. Social support levels were found to decrease in both groups from pregnancy to early motherhood. This is supported by the areas nominated by participants in the MGI. At both time points, the three most important areas affected by pregnancy and early motherhood were relationships, friendships and social life, and work and career. Although coded differently in different studies, this is broadly similar to the mothers in the literature using the MGI, which also includes 'less time with a partner' or 'worse relationship with partner or family member' (Symon, MacDonald, & Ruta, 2002), 'work' and 'social support' as two of the most frequently mentioned categories in pregnancy (Symon & Dobb, 2008). 'Partner' and 'extended family' were the two most frequently nominated areas where this instrument was used in a recent randomised controlled trial (Symon et al., 2015).

These findings contribute to the existing literature on motherhood, wellbeing and SEP: each previous study that included this alongside a measure of SEP, found that social support had a positive relationship with wellbeing in motherhood (Athan, 2011; Emmanuel et al., 2008; Gebuza et al., 2014; Green & Kafetsios, 1997) and in quality of life (Bodhare et al., 2015; Emmanuel et al., 2012), with one exception (Hueston & Kasik-Miller, 1998). This study found that social support mediated the relationship with poverty, but also that social support was significantly lower in the 'living in poverty' group.

These latter findings are also supported by the broader literature on happiness and poverty and social circumstances. For example, a content analyses of written ‘happiness recipes’ in respondents aged from 18 – 84 years found a significant role for both social circumstances and social support. 95% of respondents named ‘social relationships’ in their recipes for happiness, with 39% mentioning employments, and 12% education (Caunt, Franklin, Brodaty, & Brodaty, 2013). Higher levels of perceived social support was a predictor of higher mental wellbeing in a longitudinal study of drivers of wellbeing in adulthood (Wilhelm, Wedgwood, Parker, Geerligs, & Hadzi-Pavlovic, 2010). A study of SWB in children and poverty, using similar measures to those employed in this study (measures of both material deprivation and low income) found that children’s SWB was lowered by poverty across all the domains measured, albeit with a different impact in different domains (Main, 2014).

More broadly, even within the discipline of Psychology, the study of SWB has moved away from a focus upon personality, or genes as the determinants of an individual’s wellbeing, to an understanding of the impact of life circumstances (Diener et al., 2017). Although the theory of adaptation has had an influence in the field for some time (the theory that people ‘adapt’ to their life circumstances, including the seriously adverse, and return to their pre-event levels of wellbeing,) more recent evidence suggests that these circumstances, such as losing a job, may continue to impact on wellbeing, even where they are resolved (Diener et al., 2017). In turn, this means there is also more scope than previously thought to develop ways to improve SWB, as it is not determined solely by genes or a predetermined ‘set point’.

So, the findings presented above contribute to, and strengthen, the evidence that subjective wellbeing and quality of life in pregnancy and early motherhood are influenced by a complex array of factors that are known as ‘social determinants of health’, which can include living and working conditions, and social and community networks (Huppert, 2005). In this study, better support from a close relationship reduces the impact of poverty. However, those living in poverty in the study reported significantly worse levels of social support, which reflects Athan’s findings with new mothers, where social support was linked to income in her sample (Athan, 2011). This fits with findings from the wider

population. The rate of 'relationship distress' was much lower in the wealthiest quintile, compared with the poorest (4% vs. 10%) in a report based on the UK Household Longitudinal Study:

(<https://www.understandingsociety.ac.uk/cache/normal/www.understandingsociety.ac.uk/documentation.html>). Relationship distress was defined here as "having a clinically significant impact on partner's wellbeing" (Sserwanja & Marjoribanks, 2016, p. 3) and characterised by being unhappy with the relationship, thinking about divorce, and arguing. A report for the Joseph Rowntree Foundation (JRF) makes a link between the stress of poverty and breakdown in relationship quality (Stock, Corlyon, Castellanos, & Gieve, 2014). Whilst parenthood is linked to poverty, this study found that even amongst parents, social support received by mothers from a close relationship was higher in the group not living in poverty. This report appears to argue that the pathway is relationship distress ensuing from poor maternal mental health induced by the stress from poverty (Stock et al., 2014). The results presented here however show that lower support from a close relationship exists prior to the baby's arrival, which in turn suggests it is not experiencing poor mental health as a result of the baby's arrival alone which may affect the relationship quality. This supports the JRF report's second assertion, that poverty "reduces relationship quality for couples including perceived relationship satisfaction and happiness and increasing relationship instability" (Stock et al., 2014, p. 30). The effect of poverty appears to be bi-directional, impacting on relationship quality, which in turn impacts upon maternal mental wellbeing.

However, it is not possible to ascertain from these findings if the concepts of 'relationship distress' and lack of 'social support' to a new mother are the same thing, per se. A recent paper examining the effect of poverty on social outcomes, found that material deprivation (similar to the measure of poverty used in this study) had a greater impact than income poverty (absolute or relative) upon these outcomes, and that the relationships between friends and family were the worst affected by this (Mood & Jonsson, 2016). The authors found that poorer people had worse primary social relationships (Mood & Jonsson, 2016) using large scale panel (longitudinal) data to suggest that there was a causal, directional relationship between poverty and poorer

social relationships. They reported that this impact was less for the closest social relationships, and particularly in times of need: “This is in line with an interpretation of such close relations being unconditional: our nearest and dearest tend to hang on to us also in times of financial troubles” (Mood & Jonsson, 2016, p.649), which appears to contradict the findings of this study, where we might then expect to see no difference in social support between the groups. This suggests that there might be something particular about the combination of poverty, social support and the transition to motherhood, which may not be captured by these quantitative results. What might be happening at this time of transition with regard to the relationship between close personal relationships, poverty, and the subjective wellbeing of women becoming mothers?

3.5.5 Summary

The findings from this survey study of women becoming mothers in Portsmouth demonstrate that both poverty, and the level of social support a new mother feels she is receiving, play crucial roles in how she then assesses her mental wellbeing. The MGI can shed useful light on what aspects of becoming a mother are important to her quality of life. In both pregnancy and new motherhood these encompassed relationships, friendships and varied and opposing concerns around work and returning to the workplace.

Whilst this is an interesting picture of wellbeing in the transition to motherhood, these results do not illustrate how these factors work to reduce wellbeing. They do not shed light on how or what aspects of social support, be they friendships or family relationships, or the balancing of working and mothering roles (important themes nominated within the MGI,) might serve to mitigate poverty or place barriers in the way of supporting mental wellbeing. A qualitative interview study was undertaken in order to explore these aspects of subjective mental wellbeing in the context of becoming a mother, and in order to deepen understanding of these quantitative results, and explore the potential to develop explanatory mechanisms. This is reported in full (including methods, findings, and a discussion of these) in the next chapter.

4 Chapter Four: Resistance and Resilience: Positive mental health and wellbeing in the context of becoming a mother

4.1 Research Design & Strategy

In order to explore the fourth research question, addressing women's experiences of mental wellbeing in the context of becoming a mother, and what might support, or undermine this, a qualitative study was undertaken.

Qualitative research allows the researcher to "focus...on the way people make sense of their experiences and the world in which they live" (Holloway & Galvin, 2016). It seeks to explore and understand, instead of quantify (Green & Thorogood, 2018). This, therefore is the appropriate approach for the exploration of women's experiences of mental health in early motherhood. Rather than imposing only the researcher's definitions and constructions of mental wellbeing upon participants, a qualitative approach allows the participants to construct their own meanings and thoughts about their experiences (DiCicco-Bloom & Crabtree, 2006). As well as providing insight into what these might be, it also provides a check: do researchers' own meanings, understanding and constructions of wellbeing reflect those of the people whose experiences we seek to measure?

This approach accepts that being studied modifies the behaviour of those being observed, and where this is not couched in ethnographic observation, refers to research being "closely tied to the everyday, routine lives of the people researched, aiming to understand their perspective...what distinguishes this enterprise from common-sense accounts of the same world is that the researcher "attempts to impose order on the social world" (Denzin, quoted in Green & Thorogood, 2018, p. 13). Therefore, the theoretical analysis of the accounts provided by mothers is key, rather than purely a description of them (Green & Thorogood, 2018; Braun & Clarke, 2006). A qualitative research approach recognises the role of the researcher in the research study and the importance of transparency around the impact of this at each stage of the research. A qualitative approach therefore can explore the way mothers might construct, and make sense of, the meaning of their mental health experiences whilst becoming mothers, and

also allow an interrogation of the assumptions and constructions within our measures of wellbeing and mental health during this time. The measurement of wellbeing and quality of life as reported in the previous chapter tells us about the impact of poverty and lack of social support upon mental wellbeing in the transition to motherhood, but it does not shed any light on how this might happen. Qualitative research can explore these relationships (Silverman, 2000).

Qualitative research therefore seeks meaning, and understanding, and may be able to shed light therefore on the reasons why people do not always behave in the ways that might be expected of them (Green & Thorogood, 2018). This links to the 'critical perspective', that qualitative researchers "seek to constantly question common-sense accounts and assumptions" (Green & Thorogood, 2018, p. 17). A qualitative exploration of mothers' experiences of mental health in the transition to motherhood will allow accounts to emerge that may contradict these 'common sense' accounts of motherhood that also emanate from the cultural narratives that were explored in Chapter 1. Questions of how mothers really respond to, absorb, or resist these can be explored, along with understanding how mothers perceive their 'happiness' at this time, either in contrast or agreement with the prevailing narratives.

4.1.1 Ensuring study rigour

Ensuring rigour in qualitative research is essential. In qualitative research approaches it is accepted that the researcher will affect the research conduct, data and analysis in particular ways (Green & Thorogood, 2018). Key steps can be taken to ensure rigour. These include reporting the analysis, and the steps undertaken in the analysis, such as coding, in a transparent manner; a reflexive analysis of the researcher's own role in the research; how participants were selected and recruited; and inclusion of cases that deviate from the themes (Green & Thorogood, 2018). A consideration of these issues, along with the procedures for carrying out the study, and data analysis, are outlined below.

4.1.2 The position of the researcher

Whilst within a qualitative approach the aim is to research people in 'natural' contexts, such as interviewing mothers in their homes, the researcher will always 'impact' in some

way upon this. The researcher is the key tool for data generation, and will also perform the analysis, therefore it is critical that the position of the researcher is analysed and understood: s/he cannot be separate from the research undertaken, the data or the analysis (Green & Thorogood, 2018). Consideration of the position of the researcher is outlined in further detail in the 'discussion' below.

4.1.3 Ethical approval for the study

All participants and potential participants were reassured of their right to leave the study at any point until the data had been anonymised and analysed. Each potential participant received a 'Participant Information Sheet' which outlined the study and its aims, benefits and risks of taking part, and which gave the telephone numbers for self-referral to health visitors, and to 'Talking Change', an NHS mental health service offering a range of services and support, to which participants could self-refer if they felt it would be useful. All participants were told that the interviews would be confidential and anonymised, but that if they shared any information that indicated that they, or another person, was at risk, that the Director of Studies would be informed. Participants were informed that their consent forms would be stored separately to their interview transcripts, which were anonymised. These are stored securely according to University of Portsmouth policies for retaining paper and electronic data: they were archived at the conclusion of the study, and retained for 10 years.

Ethical approval was sought from the University of Portsmouth's Science Faculty Ethics Committee (SFEC) for the qualitative study, and a favourable opinion was received (SFEC 2016-045; Please see Appendix G).

4.1.4 Recruitment and consent

A theoretical and purposive approach was taken to sampling and recruitment (Saunders et al., 2018). Sampling in order to be able to generalise to the theoretical aims of the research is important in qualitative research, as opposed to the population representation aimed for in quantitative research. This is to ensure that the research remained relevant to the research questions. It was important in this study to try to invite as diverse a group as possible to take part, so that the fullest possible array of responses could be included. A demographically homogenous group of mothers might

have experienced very similar barriers to mental wellbeing, and barriers arising from other experiences and backgrounds would potentially be lost.

In order to invite mothers from as wide a range of backgrounds as possible to take part in the study, an initial strategy of contacting local community support groups, such as playgroups, baby singing groups and baby yoga classes, and local nurseries, was adopted; and examples and contact details of these groups were sought from all wards of the city. Emails were sent, with the posters attached, asking group leaders to put up the posters or speak to their group members about the research, with offers to provide paper copies of the posters if required. The posters gave a short introduction to the research, how long the interview would take, and contact details for the researcher. Recruitment was aimed at mothers who had babies under two years old, in order that it would be easier for them to remember their experiences from pregnancy and early motherhood. No other inclusion or exclusion criteria was applied.

A number of groups and nurseries responded positively, and included the research advertisement on notice boards, in newsletters and on group Facebook pages. Contact was then made with Portsmouth City Council, to request permission to place the advertisement posters in Children's Centres, and to contact group leaders in order to promote the research to the groups that attended there, again with the aim of participants from as diverse groups as possible to take part in the research. Two 'new mothers' groups and two breastfeeding support groups in Children's Centres in different parts of the city were attended as a result. Finally, in a further effort to reach women with varied experiences of becoming mothers, permission was sought to attend two 'HomeStart' support groups aimed specifically at mothers who had experienced some mental health difficulties, in order to talk about the research study. One group was visited, the second was not due to low attendance from its members.

Women who were interested in taking part emailed for further information, upon which they were sent the Participant Information Sheet (PIS) and invited to arrange an interview when they had read it and were happy with the information and to consent to take part. Alternatively, interested women approached the researcher at one of the groups. They

were given the information sheet to read and a provisional time and date arranged for the interview.

Each participant was asked before the interview commenced if they were happy with the participant information sheet, and if they had any questions arising from it. They were then talked through the statements on the consent form, and given a further opportunity for questions, before being asked to sign the form.

The interviews were conducted and transcribed alongside the recruitment process. Eight interviews took place in respondents' homes, two at the University where the researcher worked, and one in a public library. Eleven interviews were arranged and conducted throughout the fieldwork process (Saunders et al., 2018). Promotion of the research and recruitment were ended when it was felt that no new codes were emerging from the interviews that had already been undertaken and transcribed (Saunders et al., 2018). All the names of the participating women were changed when transcribing the interviews.

A further two women expressed interest in taking part and later withdrew. Reasons for withdrawal were not recorded.

4.1.4.1 The participants

Nine of the participants were first time mothers, and the children ranged in age at time of interview from 8 weeks to 2 years of age.

Detailed information about the participants' own SEP was not collected. As discussed above, a deliberate sampling strategy was undertaken, in order to recruit participants from as broad a range of socio-economic backgrounds as possible. Two of the women lived in a suburban area of the city that, while mixed, has the lowest deprivation score of the three recruited from (ranging from the third to sixth least deprived England rank of Index of Multiple Deprivation (IMD)). The second area is again a mixed area in terms of IMD scores, but in one of the highest bands for income, and lowest for percentage of social housing; seven of the participants were recruited from this area. The third area, where a further three participants were recruited from, was an inner city area, with a very high percentage of social housing and child poverty. This area is in the 10% of most

deprived areas in England

(https://democracy.portsmouth.gov.uk/Data/Health%20Overview%20&%20Scrutiny%20Panel/20120322/Agenda/hosp20120322r9_appx_1.pdf).

4.1.5 Data generation

Semi-structured interviews were undertaken. This technique allows for a deeper understanding of the participants' own experiences, and is appropriate when discussing potentially sensitive issues (Green & Thorogood, 2018), which may arise when asking about mental health when becoming a mother. The participant was allowed within the interview to pursue topics that were relevant for them within the broad area of their mental wellbeing during pregnancy and motherhood. Such open-ended questioning has many advantages when exploring perceptions and experiences: unlike the structured questioning of the questionnaires, this allowed for the areas of importance to participants themselves to be raised and explored, as opposed to being imposed by the researcher (Wilkinson, Joffe, & Yardley, 2004). What is of relevance and importance to women becoming mothers may contradict what has been asked about in the questionnaires in the first study, or it may support it. The interview process may also allow for contradictory thoughts to be expressed and explored, not only between participants, but those held by individual participants themselves (Wilkinson et al., 2004). Although in-depth interviews also offer this advantage, this technique was not adopted, as it was key to the research to explore the barriers and supports to positive wellbeing, and probing questions were employed to explore these within the interview. A focus-group design was rejected: although the study was exploring the impact of the social aspect of becoming a mother on mental health, and a focus-group may have allowed further insights into this process, or collective meaning construction, the potentially sensitive nature of discussions of postnatal mental health meant that a one-to-one interview was more appropriate (Dempsey, Dowling, Larkin, & Murphy, 2016; Helitzner-Allen, Makhambera, & Wangel, 1994).

A topic guide (in Appendix J) was developed in order to conduct each of the interviews along broadly the same lines (Wilkinson et al., 2004). The topics included how each mother felt during pregnancy, early motherhood, and now, if their babies were older than

this at the time of the interview, and what had built, supported or undermined their wellbeing during the transition to motherhood

All participants were offered the interview at a location and time (during the day) that was convenient for them. This was offered to make participants feel comfortable, and at ease with the interview process. Eight of the eleven interviewees elected to hold the interview in their own homes. Two of the interviewees chose to be interviewed in a neutral location at the university, and a further interviewee selected the public library as their chosen meeting place. Where attending interviews in participants' own homes, the researcher notified a supervisor of the time this was expected to end, and arranged to contact the supervisor when finished. The supervisor was provided with details of the research location in an email only to be opened if contact was not made. This was to protect the confidentiality of the participants, and the safety of the researcher attending interviews alone.

The interviews were recorded, with the permission of the interviewee, in order to allow the researcher to listen fully to responses and form follow up questions (Green & Thorogood, 2018).

4.1.6 Data analysis

Thematic analysis was selected as the analytical approach. Although thematic analysis is itself not bound to a particular theoretical position (Braun & Clarke, 2006) it can be used with the critical realist approach adopted here, "which acknowledges the ways individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings" (Braun & Clarke, 2006).

Thematic analysis involves the identification of themes within the data collected: a theme itself "captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set" (Braun & Clarke, 2006 emphasis in text). How 'important' a theme might be is not linked to the number of times it appears in the data, instead whether this theme does in fact encapsulate a key idea or message with regard to the research questions (Braun & Clarke, 2006). The aim was to identify important themes, and to take the analysis beyond a

descriptive level to an interpretive one, in order to be able to compare the findings with, and where possible to contribute to, the relevant theories and causal mechanisms.

4.1.6.1 Thematic analysis

The process of conducting the thematic approach broadly followed the steps as outlined by Braun and Clarke: familiarisation with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report (Braun & Clarke, 2006). In using this structure to report on data analysis here, it is acknowledged that this was not a strictly neat, linear process, but one that involved ‘circling back’ on many occasions to revisit or re-do a stage that required this (Braun & Clarke, 2006), in light of subsequent progress or findings.

In contrast to many qualitative studies, but in keeping with the mixed-methods, theory-embedded approach of this study, a combination of inductive and deductive approach to data analysis was undertaken. For example, questions regarding finances and resources, and regarding social support generally, were included in the topic guide. However, themes that were identified as important, and raised by the participants and which related more broadly to the research question, were also included in the analysis, so as to provide as full a picture of wellbeing in this group of mothers as possible. It is important for findings to be able to contribute to explanatory theory, that those themes which might contradict, or appear tangential to the researcher’s own position, be included and considered, in order not to avoid reproducing the researcher’s own views and expectations.

The theoretical context of critical realism also guided the analysis. The analysis sought to go beyond individual accounts, to consider the possible impact of socio-economic structures upon the wellbeing and mental health experiences of the mothers taking part in the research (Braun & Clarke, 2006). Coding was therefore undertaken at both the semantic and latent level. The former refers to what has been explicitly expressed by the participant, and then interpreted by the researcher. The latter “involves interpretive work, and the analysis that is produced is not just description, but is already theorised” (Braun & Clarke, 2006, p. 13)

Broad, initial themes emerged during the interview process (Braun & Clarke, 2006). Notes were taken after each interview to capture these early ideas and thoughts. All eleven interviews were fully transcribed as soon as possible after they had been conducted by the researcher. The transcription removed references to children and partner's names, or identifying locations, but included pauses, colloquialisms, hesitation and laughter. This was to capture as fully as possible the intention of the interviewee and the context of what they were saying, as well as the content (Green & Thorogood, 2018). Potential initial codes that emerged during the transcription process were also noted. Each transcribed interview was read fully again at least once in order to be as familiar as possible with the data before formally coding.

Using these early codes, and having re-read the interviews in order to generate further codes, an initial list of codes was produced. Coding is the process of "organising your data into meaningful groups" (Braun & Clarke, 2006) and the codes are the labels given to these groups. These then are the building blocks of the developing themes, which are the interpretation of the data. The codes assigned at this stage, and themes they contributed to, are outlined in the coding manual, in Appendix K. Coding was undertaken manually, by writing directly onto the printed transcripts. Contradictory data was also included in the coding, in order to include these accounts in theme development, and context around codes was retained.

[4.1.6.1.1 Charting](#)

The codes were analysed and brought together under broader 'themes'. A process known as 'charting' was employed to assist with organising codes, and the data which supported them, into themes (Green & Thorogood, 2018, p. 268). Each proposed theme was added to a separate EXCEL spreadsheet, with sub-themes as rows and participants allocated a column. In this study the specific quotes used from the interview transcriptions to support a code or sub-theme was entered into the relevant cell. This process allowed comparisons of each participant's responses across codes and sub-themes, allowed the refinement of themes, and possible connections and interactions between these (Green & Thorogood, 2018). This also allowed 'deviant' cases, where the response under a theme is different to those given by others, to be identified more easily. This, along with showing

explicitly how the themes are built directly from quotes within the transcripts, helps to build the credibility and reliability of the findings from the study (Green & Thorogood, 2018). Although charting is a practical tool that can help to map and build themes directly from the data, this also aided the interpretation of the data and led to the next phase of the thematic analysis, 'reviewing themes' (Braun & Clarke, 2006).

In the course of reviewing the proposed themes, it became clear that there was overlap between themes, and that these were not clearly enough defined. The themes and supporting codes were returned to, and re-analysed, to take them from the descriptive labelling of a 'process' of transitioning to motherhood, to an attempt at interpreting and explaining this time in terms of mental health and wellbeing. New themes were created in order to achieve this.

The analysis also continued as part of producing the report, wherein it became clear at one stage of writing about the themes that two of them overlapped, and needed further consideration. The thematic map was revised again. These repeated processes are conducted to ensure that the thematic map produced both fits the data and has a story to tell. Then, the process of analysis can follow, in linking themes to both the data, and the research question. (Braun & Clarke, 2006).

At this point, the process deviated from that described by Braun and Clarke: the sub-themes were already part of the building blocks of the broader themes, rather than being identified at this later stage. Questions asked of the theme during the analyses and writing up stage included, what is the meaning of the theme, how does it relate to both the research question, and to other themes, and what is the story that the themes tell together about the research question? (Braun & Clarke, 2006).

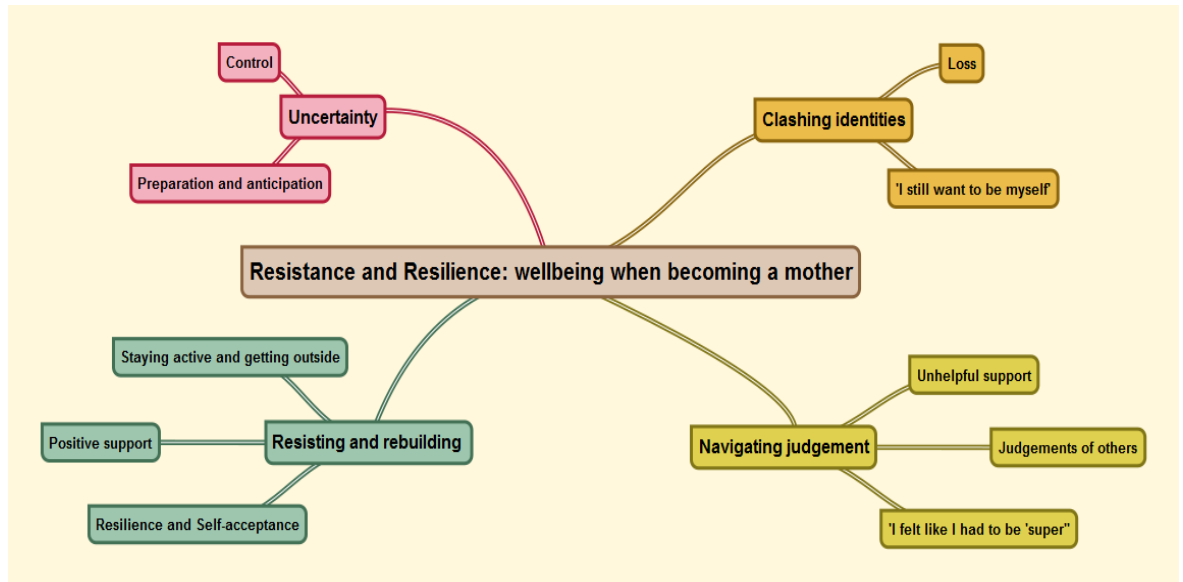
The themes and interpretation that have resulted from this analysis are presented below.

4.2 The findings

An overarching theme of 'resistance and resilience' was identified from the interviews. Four main themes emerged: Uncertainty; Clashing Identities; Navigating Judgement and

Resisting and Rebuilding. These themes and their sub-themes are displayed in Figure 2, below.

Figure 2: Resistance and Resilience: Themes and subthemes



These themes are not chronological. With the exception of ‘preparation’ as a sub-theme, which relates predominantly to pregnancy, evidence for the themes come from all stages of pregnancy and early motherhood, and are not arranged to imply a completed or linear journey through this time.

4.3 Uncertainty

This theme encompasses two sub-themes, ‘Control’ and ‘Preparation and Anticipation’.

4.3.1 Preparation and anticipation

The anticipation of pregnancy and motherhood impacted on the mothers’ wellbeing in different ways. Some had planned extensively prior to even becoming pregnant, for example, Miriam had saved money in preparation, to support her and her partner when she was not working, whereas Linda had not really been sure that she had wanted children in the past. For Chloe, who had not intended to become pregnant, this shock of being in a position quite different to the one she had planned for was detrimental to her wellbeing:

“I didn't want to be pregnant. At all, so I was, like really confused. Like, really devastated. Erm, I found out, on my own, I didn't tell my other half either, I like waited” (Chloe).

Preparation activities emerged as a key theme from the interviews. Some preparation activities were perceived by the mothers as the ‘ideal’, and therefore more crucial to wellbeing at this time. This included antenatal classes, and one of the mothers likened the anxiety she felt when she was worried she would miss the classes to ‘freaking out’:

“I was really anxious he could come early and erm I hadn't had that information given to me” (Miriam).

National Childbirth Trust (NCT) antenatal classes were also perceived as the ideal preparation for some of the women, when compared to the NHS alternative:

“Yeah, we did the NCT ones, yeah my mum was really an advocate, she was championing them saying they would be a good thing to do, cos I was planning on just doing the NHS ones, but erm I did see her point.” (Jo).

These classes were seen as a good way to meet people, but also as a more thorough preparation for motherhood than the NHS classes, which focused on labour and breastfeeding:

“the two hour sessions that we had [laughs] it was very brief...what I really wish they'd done, was not just focus on the immediate after, like the first month of the baby, because...I'm sure it's not the same for everybody, but for a lot of people, that's the time when you get the most support from your family and friends, because you've got a brand new baby that they want to come and cuddle and say hello to, and actually it's the four months plus that you're kind of on your own thinking, now what do I do with them? And they don't give you any preparation for that side of it, so I think that's the part that maybe they should have...given you more information on” (Emily).

The free, two hour sessions for preparation for birth and early motherhood offered by the NHS did not feel like adequate preparation, particularly if the pregnancy was not within

'normal' parameters. Emily felt excluded from these classes but unable to afford the NCT groups:

“So, the two classes that I went to during my pregnancy were free, the NCT classes are substantially more money, and they do offer much more, erm, information and support for you, and I think it covers a longer period of time as well, but it does cost more money, and when you're trying to buy cots and prams and all the rest of it, you kind of weigh up the physical things you can see for your child, and then the kind of, I guess it sounds awful, but you because you can't see what you're getting out of it, and there is the NHS version available, you kind of think well I'd rather spend that money on, you know, a better pushchair or something” (Emily).

Emily is not able to access what she perceives as the 'ideal' preparation because she cannot afford it – and this was reflected in other participants' accounts: Miriam also rejected NCT courses despite experiencing pressure to go, because of cost, but felt that the NHS class was 'enough',

“ a lot of people are saying to me, are you going to NCT, NCT, and I was like no, because I'm not rich like, everything costs so much money, I'd love to go, but actually these things are there for a reason, I just did that, and I felt quite happy that that was enough” (Miriam)

Working during the day also prevented attendance at many classes and courses,

“And working as well, apparently everything is in the day. Well, that's no good, because I've got work. So trying to get to do things in the evening, again, really hard [...] So, I just, I do think that if you've got the money there is a lot more available to you and if you haven't it's unfortunate” (Miriam)

Some of the mothers also felt under pressure to purchase certain brands of equipment for their babies,

“I mean sort of during pregnancy and stuff you know, you do haemorrhage cash, cos you buy all the stuff you don't need, erm and you feel like you have to [...] you

feel this sort of overwhelming pressure, you have to have everything, and everything has to be ready, [...]-'everything has to be perfect before the baby arrives'" (Harriet)

Emily perceived that preparation was taken out of her control (with the justification of a high risk pregnancy,) and she was told not to even make a birth plan. She compares this with how preparation for birth is 'supposed' to be done:

"I was told that I wasn't allowed a birth plan which was quite a shock, because when you read all the books, and you see everything on the internet it's like 'ooh, make sure you have this wonderful birth plan that's, tailored to how you'd like it', erm, and then you're told, actually, no, don't even bother writing anything, you don't get one, that was a bit of a shock, and a bit of a concern" (Emily)

Other participants showed examples of resistance to these perceived standards, and to the expectations they felt were placed on them in terms of preparation during pregnancy. They demonstrated this by not purchasing everything new for the new baby, for example,

"we're also not kind of precious about everything being brand new or anything like that, we're quite happy to have seconds stuff... erm as long as they're kind of good quality and yeah like not from a skanky place, so that saves a lot of money." (Jo)

There was also some resistance to participation in expensive ceremonies such as baby showers. Miriam felt under pressure from other pregnant friends to participate:

"they really wanted me to have a baby shower, and I really didn't want to have a baby shower cos I can't think of anything worse, like it's just embarrassing, like I don't like the idea of it, everyone makes a big fuss of it and expects presents, and I would never, I wouldn't want to put my family and friends in that position where they felt like they needed to bring me things?" (Miriam)

Linda had to live with her in-laws at the end of pregnancy and found that not being able to have and prepare her own space negatively affected how she felt in this time:

“I kind of, I never got to do that nesting thing, so my instincts were being compressed because of the situation we were in, so I never got to follow that through which I think probably damaged my mental state a little bit, cos I couldn't do those natural things that were, my brain was telling me to do” (Linda).

4.3.2 Control

The theme of control was relevant to both pregnancy and motherhood, and to mothers' sense of wellbeing. Mothers are aware that caring for babies will mean relinquishing some control and autonomy over their lives:

“I am a bit of a control freak, babies don't, that doesn't work for babies so, I knew that was going to be really difficult” (Miriam).

This anticipated loss of control in turn impacted on how they took care of themselves, and therefore their wellbeing:

“I kind of had it in my head that it would just slot in to my already existing life, and it very much doesn't [laughs], erm, so yeah, I don't think, I think that the lack of control was the thing that pulled me down, because I'm quite organized” (Linda).

A key area where loss of control, or a feeling of retaining control, made a substantial difference to mental health in the early months of motherhood, was childbirth. In Heidi's case, her labour and birth was very different from the home water birth that she had planned

[I: how was the birth?]

“Not at all to plan, but still really, really good. I was planning a home birth, had like ... but yeah, I went from planning a home birth to having erm a hospital birth where I er ended up on my back, through my own choice, but ended up lying on my back with legs in stirrups, having had an episiotomy and he was born with a ventouse, erm, but the staff were so amazing at making sure that I was the one that was making the decisions about how things went erm, which for me at least was really important. [Whispers] I'm a little bit of a control freak, I don't like giving

up, that feeling of giving up control and sort of having someone else make the decisions, erm, so whilst it didn't go to plan it was still really, really good.” (Heidi)

Heidi felt strongly that this experience had impacted on how she felt when she became a mother:

“I think so, I think because I had had the opportunity to make my own decisions if things didn't go to plan. I make my own decisions, like having to roll with the punches meant that when, I felt a bit, quite confident in the fact that I was like, okay, I managed to make all the right decisions, and everything went well, [...] I then felt that, whilst tired, I then felt that being able, to trust myself, and trust myself making decisions, erm instead of second guessing, which is a thing a lot of mums seem to do, is completely second guess themselves” (Heidi).

This experience of retaining control was in stark contrast to Emily’s experiences. She felt she had a terrible birth experience, and that her expectations were completely different from her experienced reality,

“my birth experience was awful, and I've been told by midwives that it was one of the worst that they've seen, erm and I was in hospital for 10 days with my baby, and then I ended up, when he was about maybe 2, 3 months old realising that actually what I was feeling wasn't normal, and ended up being referred to Talking Change and erm had group therapy for post-traumatic stress disorder and yeah, post-natal depression” (Emily).

4.4 Clashing identities

The theme of ‘Clashing identities’ comprises two sub-themes: ‘Loss’, ‘and ‘I still want to be myself’.

4.4.1 Loss

A feeling of being lost appeared almost universal among the mothers in the group, although it lasted for differing periods of time:

“Like it was a big haze of...boobs and nappies and not really knowing what was going on... erm, yeah not a humungous amount of actual memories, of that period of time, cos it’s just so intense...” (Heidi).

The feeling of losing a former, perhaps ‘true’ self was a key theme among participants:

“I think it was a phase where, a sort of stage I would say, probably the first five or six months that I felt a bit lost in myself, not quite, I wasn't me” (Harriet)

Harriet refers to not being herself here: in this time she doesn’t feel she has an identity.

This feeling in turn impacts on positive wellbeing in this period for Miriam:

“kind of the first four weeks were really wobbly, and I just felt like I didn't know what to do, I didn't know what I was doing, well, I did know what I was doing, didn't feel like it, didn't know what I was doing, actually, erm, and trying to figure it all out I found that was really tough, really tough” (Miriam)

Jo’s pre-pregnancy identity as someone who was active, positive, and well-prepared in pregnancy is threatened by the physical pain she experiences post- childbirth. She goes on to describe her experience as traumatic:

“I felt very different, in yeah the first couple of weeks, erm, just I knew, you know it’s going to be a shock, you know it’s going to change everything, but I don't think I really realised how emotional it would be? Erm, like erm, and yeah how much pain you'd be in as well ...I felt quite traumatised for the first few weeks...I just felt a bit of an invalid, like, and that's not like me at all, because I'm used to being so independent, erm, so active and everything, suddenly having all that removed, was quite a shock.” (Jo)

Feeling physically lost, as well as emotionally, featured in Linda’s experience of not having her own home at the time, and having to live with her in-laws:

“so I was completely lost for the first few months...I was just in such a bubble, and then the end of January it got worse...so I'd been in hospital for a week, we'd been

at [Husband's] mums for a week, cos we were still there at that point, and then I, I just wanted to go home" (Linda).

Michelle started her maternity leave late, around her due date, because she felt well enough to keep working, but also because of the fear of "losing herself":

"I guess, kind of - the fear I suppose as well, I think when you're, if you're you know the fear of losing yourself, the fear of er...not knowing what's coming and I think I was particularly naive about it all, it was just something I was aware of, ooh these are the last few, everything's gonna change, which of course it does."
(Michelle)

This feeling of loss was also related to the feeling that the baby might subsume the mother's identity, that they are not separate:

"sometimes I feel like I lose myself and, there is no me and her, we're just the same thing" (Chloe).

4.4.2 'I still want to be myself'

Most of the women in the sample had worked full time before becoming mothers; and the work or career identity they had previously held was referred to often in the interviews. This identity appeared to be severely disrupted, and often substantially changed, when women become mothers:

"in the first six months I was like, I wanted to go back, I felt like I needed to go back, to work I was really [gasps] I don't know if I'm comfortable doing this"
(Harriet).

The mothers held concurrent conflicting feelings about work and about 'staying at home' to care for children. For example, Michelle speaks about feeling "mourning for my career" but also goes on to say that,

"I always think, I'm four days a week, I'd rather be three days a week and [my husband's] like yeah but we kind of have a mortgage to pay, and then I figured out the other week that I'd only had it would only make 15 pounds a week difference?"

And then I'm like, why didn't I go three days a week, argh, but anyway, too late now" (Michelle).

The rejection of traditional gender roles was alluded to, however this in general had not resulted in fathers taking over the primary caring role:

"I don't agree with the traditional er role that the mother has to stay at home, look after the kids, keep the house clean and tidy and cook the dinner, I don't agree with that, I think that's er, it should be 50-50 effort from both parents, and both parents should contribute to the housework...I think it doesn't matter whether it's a female or male parent doing, who's bringing home the money and who's doing the housework erm, or whether both do it, both do both things in equal share, erm...I think...other than the whole being pregnant, and breastfeeding afterwards if you choose to, there's no...It's not that a mother has to be that different from a father, do you see what I mean?" (Susan)

The women experienced an ongoing tension between being at work and 'missing out' on their child's key development milestones,

"I'm enjoying being back at work, but I do miss kind of the day to day stuff, and he's also going through the stage of milestones so I'm waiting for my mum to go oh, he's walking! And I'll have missed it, but it's okay. I'm sure she'll video it, or take a photo [laughs] but yeah" (Emily).

And, where the women had been in work prior to having children, this 'working' identity strongly clashed with the mothering identity in early motherhood,

"I kind of like to think of myself as quite *strong* and, erm...I work in quite a high-pressured job, it had taken a lot of my time, and a lot of my brain power, and then suddenly ..." (Harriet)

However, there is still a tension and conflict over returning to work. A core pressure here was financial:

“I'm the breadwinner which is a whole other thing, cos I find that really annoying, the pressure of being the breadwinner is rubbish when you want to be a mum, because I have to go out to work” (Miriam)

However, this frustration at having this decision made for her because of financial pressures contrasted with Miriam's thoughts about giving up work:

“I always thought I would hate being stuck at home as a stay at home mum anyway, I can just imagine that it wouldn't be something that I would be satisfied with, erm, just stimulation wise, and like having my own, like my job is very much how I define myself so when I got pregnant I was like, shit, I don't know if I'm going to be any good at this mum stuff, like ooh, I just do my job, it's what I do and I put so much into it” (Miriam)

The clash between a valued work identity, and its subsequent impact on wellbeing, is to an extent mitigated by supportive bosses and workplaces, with regard to part time and flexible working arrangements:

“I was lucky that my boss let me go from full time to part time, so that was there was no real stress there, my boss was quite supportive. Erm, which really helped actually, it took the worry out of it really.” (Elizabeth)

However a stigma around part-time working persists,

“You do feel, feel a bit of stress with that, because you feel almost that you have to do your full time work in part time hours there is, and there is a bit of a stigma about part time working I think erm, and you know, there is, you get the jokes about oh you're only part time, that sort of thing, which is you know you have to laugh too, but really I think I do more now than I did when I was full time, you just have to squash it in basically, so there is the stigma but I don't think and stereotypes, but I don't think they are really true.” (Elizabeth).

There were mothers among the interviewees who did not experience a clash between a working identity and a mothering one. Heidi was happy to give up her job and had only

recently gone back to it (her child was a toddler). This has allowed her to pursue other challenges that she has found rewarding, and therefore maintain her wellbeing:

“I was very lucky to be in a position where I didn't have to work, I do now, erm, but I didn't have to work, or go back to work early, it was sort of open ended as and when I wanted to go, and I do think that was a massively positive thing, without that I would have, I probably wouldn't still be breastfeeding, I probably wouldn't be able to volunteer, erm at, for breastfeeding support, which is something I feel incredibly strongly about erm and I think that probably led me to be much more er, secluded in my parenting?” (Heidi).

The fear of not being able to return to the valued previous identity was expressed and, contrasted with this, motherhood appears to hold a lower status,

“when I'm feeling logical I just think well I can go back to it, but then there's other times where I think argh you know, panic, am I wast-have I ruined my career and that's it now and I'm just gonna be on the rubbish heap” (Harriet).

Participants referred to 'old selves' to indicate a 'true me', or something they wanted to return to, reflecting Harriet's assertion earlier that in early motherhood 'I wasn't me'.

They felt better, happier, when this is possible:

“for me part of it, and this probably sounds massively selfish, is being able to keep yourself as well. That's one of the things, I think it's so easy to just be like completely sucked up and only becoming just a mother, and losing all your other identities, and whilst it's probably my most important one, it's the one that's most important to me now, I still want to still be myself?” (Michelle)

4.5 Navigating judgement

Friends, family and health professionals, and the mothers themselves, were all sources of criticism and judgment for new mothers to navigate. Under this theme there are three sub-themes: 'unhelpful support', 'Judgements of others' and 'I felt like I had to be super'.

4.5.1 Unhelpful support

In pregnancy and childbirth the mother's own knowledge and understanding can be undermined at an early stage, in this case by health professionals caring for Jo in labour:

“yeah, so that was the scariest thing, because we just didn't, I couldn't understand why no-one was getting back to us, or what we were supposed to do, and just didn't know whether I was in labour, whether I wasn't in labour, having not been in labour before, and because I've been told oh no you're not in labour part of me was thinking oh well maybe this isn't it, maybe there's more to come like worse to come?” (Jo)

Heidi told a similar story of her early labour. Both women were made to disbelieve their own knowledge of their experience. This dismissal of new mother's knowledge of themselves or their children was reflected in Emily's experience of trying to convince the staff on the postnatal ward that her child was ill. When staff finally accepted that he was, it had become an emergency:

“I kept saying to them, my baby doesn't seem right, he's really quiet, and they said, oh are you a first time mum, and I was like, yes, but I do have baby experience, and they said oh no, he's fine, he's fine, and I said, okay, so put it off and put it off, and then it got to the evening and I said to them, well he hasn't fed in seven hours, and he's not mov, like he's really lifeless, and they were like, no, no he's fine, you've got to stop worrying about it, you know, just make the most of it that he's quiet, get some sleep” (Emily).

Problems for maternal mental health also appear to arise when the needed support from a partner, or close family is restricted or prevented in some way in the context of hospital or health care. As Linda indicates below, her partner had to leave at 9pm when she had the baby, because of visiting hours being enforced, but this had a detrimental effect on her mental wellbeing at the time:

“I needed to go home [from hospital] for my mental health, for my partner to be there to help me, cos just every time he left at 9 o'clock every night I just sobbed

and sobbed and sobbed, but I needed to be in hospital because I wasn't very well” (Linda).

Emily also found that her partner was not allowed to stay, and so she was told that her baby was seriously ill when she was by herself, and was then left alone. She talks about the difference her partner being allowed to stay would have made to her:

“I was in my own room, so it wouldn't have imposed on anybody else, but they were restricted to come and visit between 2 and 9, so for the whole morning, and lunchtime, you're on your own, I just think it is quite an alien thing to ask somebody to do” (Emily).

Many of the examples for this theme arose from the participants' interactions with health professionals around feeding, and babies gaining weight. The majority of the mothers in this group tried breastfeeding, and experienced different levels of 'success'.

One of the participants did raise the lack of information on feeding equipment for mothers who bottle fed as an issue:

“No one told me try a different bottle. So for weeks and weeks she wasn't eating properly erm so she's become, the health visitor calls it a snacker? ... Cos it was for a good few weeks... but no bugger said oh why don't you try changing bottles” (Chloe).

Among many of the mothers, breastfeeding was perceived as another aspect of the 'ideal' way to mother, something they 'should' do, and the problems they experienced were couched in this context:

“I'd failed, in some way, because I wasn't able to do something that I was supposed to be so natural, and it felt so unnatural, erm, but again I felt this overwhelming need to do it” (Harriet).

This impact on wellbeing of not being able to do what feels 'right' for the child, as judged by health professionals, was substantial for Elizabeth:

“I only breastfed for the first sort of couple of months, erm, and I do think sometimes that women have, you're chastised for that almost, and its, you know, sometimes you have to make these decisions and you know they're fine now, but you almost have to defend yourself to health visitors and all of those people, and sometimes I think it's not a good environment sometimes, cos you're desperate to do what's right for your child, absolutely desperate to, and sometimes you can't and that makes it worse almost?” (Elizabeth)

There is additional pressure felt, not only to breastfeed, but to breastfeed 'properly', in a certain way:

“the breastfeeding, I found it really hard, and the only way we've been able to breastfeed is with using nipple shields which was something I never even knew about before I had him...I was using them because he wouldn't latch on any other way, so I kind of felt like a bit like 'this isn't proper breastfeeding'” (Miriam)

Participants felt the reactions of health professionals to mothers who may be struggling with breastfeeding, particularly where babies are not gaining the amount of weight that midwives want to see in the early postnatal period, impacted on wellbeing. Mothers wanted to work with midwives, and valued and trusted health professionals. However, this trust was sometimes undermined in the early days and weeks:

“I had a really varied experience with midwives? Where it, I think the trouble is, they're all well-meaning, but they're all different? ...you hear one piece of advice and you take that, and particularly me, cos I, I trust medical professionals, I value medical professionals, so I took what they were saying to be the truth,” (Michelle)

The effect of feeling criticised by health professionals at this time was substantial:

“yeah they were much more pre-occupied with her weight, I think, which I know they have to be, because they want to make sure she's growing, but erm, yeah think there are ways of doing it, and some of them were spot on, some of them made you feel really reassured, and really supported, whereas others just made you feel like yeah you were useless, and purposefully making your child not grow.

Erm, just coming away and just being broken, really just feeling completely broken..." (Jo)

Some participants also experienced a lack of support from health professionals for their own decision making where this contravened the 'ideal' of breastfeeding, for example where adding a bottle:

"If they'd have just let me get on with it, with some support, I would have been fine...and I, you know, I tried really really hard and I felt like they were telling me I'd done it wrong?" (Michelle).

The effect of inconsistent messages and strategies from staff and of the undermining of a mother's confidence in her own capabilities and knowledge, on wellbeing and identity building in the early stages of motherhood is profound:

"I couldn't even eat my dinner, just sobbing hysterically, I just couldn't stop...I just couldn't, I could, I couldn't bring myself to do anything, couldn't bring myself to have a conversation....I just felt like I was a complete failure, I felt like I'd already failed" (Michelle).

The trust in health professionals held by first time mothers is threatened by these experiences, as mothers repeatedly mentioned planning on not fully communicating with them in the future, or with a second baby.

"A second time I'd be like 'how's the feeding going? FINE! What you doing? Feeding her. Feeding her. Go away' I just wouldn't even...I wouldn't engage" (Michelle).

4.5.2 Judgements of others

Extended families' judgments that the mothers were not parenting correctly, or not as they have done, are also keenly felt. Families do not always represent a source of positive support. The participants' own mothers were often referred to as a source of criticism or judgment,

“she said 'well, it wasn't like that when I had you, and this didn't happen, and you didn't do that and, but her memory's obviously...you know, it was a long time ago...” (Linda)

The judgments of friends, or other mothers, can also be painful to deal with. Harriet begins motherhood by avoiding going out (a popular coping strategy) because of how she feels she may be judged:

“I think I was *scared* in the beginning, I was constantly scared that he was going to kick off, he was going to start crying, or screaming” (Harriet)

And Miriam also talks about comparison of babies' development and milestones, and judgment this can precipitate among friends:

“really interesting how easy it is to fall into this, my baby does this, what does yours do, and thinking there is something wrong, because yours is different and like he had a really bad night last night, he doesn't let us put him down you know, you kind of get caught up in all of that, and it's really hard to not, kind of feel annoyed, or like something's not quite right for you” (Miriam)

Michelle, for example, does not go to many baby groups as she has received explicit judgment from a group facilitator for the snacks she gives her daughter, and in the early days she feared judgment for bottle feeding:

“I felt erm like I couldn't really go to the breastfeeding groups cos I was also bottle feeding and I felt like I would be judged for that erm even though they told me I wouldn't be, I just really feel like I would erm, so I didn't go to a huge amount” (Michelle)

However, as Chloe's comment shows, there is an element of resistance to many of the responses to the criticism from others. The criticism, implied or explicit, is not always passively received or responded to. It may be dismissed:

“She's still got the dummy, the shame [amused]...people look at you like... with a dummy, I think shut up, nothing to do with you. She will spit it out soon” (Chloe)

Or it may be actively fought against, requiring energy and strength which may be hard to find in difficult circumstances:

“I was thinking, I'm really not okay with this, so put my foot down and said no actually I want to see a doctor, and they said oh well, if you insist, making me feel like I was kicking off so, 24 hours after, the paediatric doctor came in, took one look at him and said I'm really sorry, I'm going to have to take him, and ran him to neo-natal, his infection levels were so high that they told me they didn't think he'd make it through the night” (Emily, after resisting being told that she was incorrect about her child being ill.)

Harriet summarises this mix of external, cultural pressure to live up to certain ideals, and the difficulties of resisting this, and the impact on wellbeing:

“I think it's a general kind of social pressure, this idea that you have to be this kind of ...'perfect mother' and it's like the whole going back to work thing, I feel very much like people look at me and think... I feel like I'm some kind of failure in that I can't do the whole working and being a mother thing, but I always feel like people are judging, and I'm sort of erm...going against my 'feminist rights' by not going to work and trying to juggle everything, erm, but, actually, I think well feminism is about having a choice, and so you should be able to have a choice about what you ch-, you know what you choose to do and for our family, it works” (Harriet)

4.5.3 'I felt like I had to be super'

The participants themselves were sometimes a source of criticism and guilt. This leads to self-regulation:

“everything was plagued with anxiety, anytime we went anywhere, what if he got upset, what if I can't get him to stop crying, that all normal mums, all new mums have but they were magnified a billion kind of thing because of the depression and the anxiety that went with that” (Linda)

The pressure of this self-criticism then has the effect of reducing wellbeing,

“so I kind of went through like a period of just really beating myself up, just feeling like not good enough for him really, and just feeling quite low, and anxious and just not myself at all, and that, that was a really tough few weeks” (Miriam)

Many of the women experienced their partner’s attempts to take a full child-caring role as a form of criticism: that their partner might be ‘good’ at nappy changing or soothing the baby was not always welcomed, but sometimes received as criticism of their own skills, which it was expected ‘should’ have been higher. Again, although some expressed explicitly support for non-gendered parenting or childcare roles, mothers still expected that they, as the childbearer, should have some ‘natural’ skills:

“it’s all irrational, as well, like with my partner, he’s really laid back, and I was watching him do it all, and thinking why is he so good at this, it’s really annoying and being really pleased, because at least he’s like keeping his stuff together, and I just felt kind of really like, just not good enough” (Miriam)

The women also related some self-critical feelings to other ‘ideal’ standards imposed in the wider culture:

“I felt really guilty after he was born, erm it was like, is it weird that we didn’t cry? Like when he was born we didn’t cry and I was, I thought that was a bit strange, I thought I’d be really emotional and I think I was so relieved to have him out that I didn’t get really emotional about it and like, our friends were like, you didn’t cry that’s a bit harsh” (Miriam).

As breastfeeding was not, for some of the mothers, the only the only and ‘right’ approach to feeding to take, the pressure to do so lead to an impact on their wellbeing:

“we had issues feeding as well, so a lot of those things kind of gave us a bit of a rocky start” (Miriam)

And conversely could support wellbeing when a success,

“[In response to being asked what was good for wellbeing at the time] I think it was the feeding, when feeding was going okay” (Jo).

Linda found that the pressure to live up to the demands of an idealised motherhood meant that taking care of mental wellbeing was not prioritised by her in the same way as other healthy behaviours such as diet and avoiding alcohol, for example, during this time:

“all the way through my pregnancy I felt like I had to be 'super', had to be performing at the same level I did normally, to prove I could still do it, so I didn't look after myself as much as I should, as I should in reflection should have done”
(Linda)

This is reflected where mothers have felt able to maintain a certain amount of control of their image of ‘perfectionism’ through a career or work identity before having children:

“I think... before him, in my job, I've, in everything I was such a perfectionist everything had to be perfect, and I had to give everything 100%, and if it wasn't perfect ...I'd be able to do something to try and make it perfect. And then suddenly, you have this little person, you can't do that anymore because they're their own little person” (Harriet)

4.6 Resisting and Rebuilding

This theme encompasses the sub-themes of ‘staying active and getting outside’, ‘positive support’ and ‘resilience and self-acceptance’.

4.6.1 Staying active and getting outside

Staying active and getting outside were key to happy, or happier, days and memories for all but one of the participants (who did not actively raise it). Even in the early difficult days, getting outside of the house, in whatever form, was crucial:

“generally going out, cos we both get bored in the house, and we've only got one room downstairs that she can go into cos the kitchen's really cold... so generally we'll, like get up and have breakfast, and maybe go to a group, or go to a friend's house where she can get out and wander around, or sometimes going to my mums...just going out really, getting out of the house, and so she's not stuck in the pram the whole time, so yeah, that's the best days, getting out, going out” (Chloe)

Getting outside appears essential for good wellbeing at all stages of early motherhood, from babyhood to roaming toddlers. This can be especially useful in those earlier days when mothers are most likely to be on their own:

“the worst thing was shutting myself away, cos I'd just feel even worse and more lonely and isolated and that's, that was the worst thing to do, erm getting out by far helped on those days” (Harriet).

And in some cases motherhood lead to improved opportunities for getting out of the house, socializing, and therefore improved wellbeing:

“so I went to lots of playgroups, erm, and which is where I've met lots of other mums, and so, I think I've got a much better social life than I ever had really, before he was born which, which is nice, erm, and [baby] enjoys socialising with other kids so... I think him being happy rubs off on me, makes me happy” (Susan).

Getting outside can bring a feeling of achievement, helping that feeling of ‘getting back to normal’:

“once I'm out I feel *instantly* [sounds of relief] oh, okay, I'm out and that's almost like I've succeeded in some way, I've done something, I've got out the house so therefore its fine, um, yeah, I think that's probably the most important thing for me” (Harriet).

Getting outside to meet others in similar situations was near universal in leading to improved wellbeing in the group:

“the fact that we're able to go off to groups and things erm it does, it's really empowering, cos I feel like it's good for me to get out and know that I can go and meet other mums and things and make links, ...I didn't know that many people, but I sort of built up a sort of a network of people that I know now, ...yeah, so it makes me feel good.” (Jo)

And returning to ‘normal’ is a continuous thread emerging from the interviews, supported in some cases by attending ‘mother and baby’ groups

“it wasn't until I felt brave enough to go to the groups...that I really started to kind of figure it out, and get a bit more confidence and just feel like a normal human being” (Miriam)

Whilst simply getting out of the house is usually free, there are many activities (that the mothers in the group explicitly associated with increased wellbeing; groups such as swimming, baby signing, and going to cafes with friends) that can be costly. And the mothers themselves raised this as a possible barrier to wellbeing, if they struggled to afford access to these activities,

“they say to you to try and get out to baby groups and see other mums, but there aren't any free ones [in the area] that you can go to from a very young age[...] they do cost money, and when you kind of add it all up, it does become, well especially when you are on maternity pay which is so low that you're kind of struggling anyway...” (Emily).

Or even where groups are free, access issues such as lack of public transport were raised:

“If you've got a car, or a bike or something, absolutely fantastic erm...and there are loads, there's loads of space to go, but getting from one place to the other isn't necessarily all that easy [...] a lot of his very young life was spent trying to negotiate buses and stuff, which is fine, but if you want to go to things which is specific group times and stuff, it can be erm, that can be a real challenge, [...] if you don't have access to reliable form of transport then it's a bit of a nightmare” (Heidi).

For some of the mothers, exercise and trying to stay active was another coping strategy they employed. This was most commonly in pregnancy, where perhaps there was more time to be able to focus on this strategy. For several mothers, an explicit link between exercise and wellbeing was made:

“I did pregnancy yoga throughout, and remained active, but I didn't do any physical exercise as such, apart from the yoga...I just walked and stuff like that, which I enjoyed, you know, I really enjoyed pregnancy yoga that was really good,

and that I think really helped me through my pregnancy, erm emotionally,”
(Miriam).

And sport could provide an important link to valued pre-pregnancy identities:

“I think I’m quite a healthy sort of person anyway, did lots of, like, physical activity before, lots of cycling, played netball and so I think that definitely helped” (Jo).

The participants raised the difficulties with limited access to chosen coping strategies:

“there's other things that I would have done, exercise classes for pregnant people, I would have done more, but it’s so expensive, like literally, everything was so expensive the one I went to was the cheapest I could find it’s a lot of money”
(Miriam).

4.6.2 Positive support

Where the women in the group had partners, or lived with their children’s fathers, their support was seen by the women themselves as crucial to their wellbeing in pregnancy and early motherhood. For example, for Elizabeth, consistent support from her husband for her decisions around feeding helped her to feel confident that these were correct.

And this is reflected in accounts from the other women:

“I really, really like having my partner around, erm, he was amazing in those first couple of weeks, I don't know how anybody does this on their own. Yeah, just to have somebody, I almost learned more from him really, in terms of watching him do stuff, especially with like nappy changes and bathing her and stuff like that erm, so I really enjoyed those, and it brought us closer I think as well, being able to do all those things together” (Jo).

Close, supportive relationships were beneficial in increasing confidence in parenting decisions that may have not received broader support from health professionals, or transgress cultural ideals,

“erm I think my husband helped, he supported me all the way through, he, in the end he said, look, it doesn't matter, you know, if you end, if she's bottle fed it

doesn't matter, and sort of put it into perspective, and my mum as well said that you know, it doesn't matter, you're doing what's best, you know" (Elizabeth).

By helping to alleviate the potentially gruelling task of prolonged night feeding, a supportive partner enabled one of the participants to continue breastfeeding, one of her 'aims' as a mother,

"He liked being able to help and be part of it. And he was brilliant, so the whole time that I breastfed and bottle fed he would get up, even when he was at work, make the feed, make the bottle up, bring me the bottle, check on me, bring me a glass of water, check if I needed anything else, and then go back to bed. Every feed, bless him. So, in that sense I was really lucky, and he made that possible really" (Michelle).

In this group positive support from close family is also key to good mental health:

"I was quite lucky cos erm my family still all live kind of within the... area so I had a lot of support from my family to kind of get through the pregnancy and that wasn't so much of an issue" (Emily).

Many of the women interviewed, including those who had difficult experiences during and shortly after labour, told stories of help and support from individual health professionals:

"I had a really good birth, erm at the hospital, erm...the midwives were fantastic and the lady who came round took me for breastfeeding support was fantastic" (Susan)

"I mean the staff and everybody there were brilliant, the midwives, the support workers, the students, the doctors, literally hands down, and I know people complain about the NHS, but I've never really had to use the NHS before" (Miriam)

Miriam talks about her partner being allowed to stay the as she has a private room, and how beneficial this was:

“[Baby] was poorly and I couldn't physically look after him very well on my own, so I had a lot of help from them, and they let my partner stay at the hospital as well on a couple of the nights, which is really rare, so I was quite lucky when my partner got, they said did you want to stay? The staff had literally all took turns coming in to support and see to us” (Miriam)

Heidi speaks of appreciated support from her mother-in-law, who placed no expectations on Heidi at this time:

“she stayed at a hotel just round the corner, which meant that she was on hand, but not like to, every evening she'd be like right, I'm going home, I'm going now, and so we had plenty of time where it was just us, she came over and would put the Hoover round, and do the washing up and cook us meals and stuff whilst we just relaxed and got to know our little one” (Heidi)

This practical help from family appears to be particularly valued and useful:

“I think, I think another thing, reason why I'm happy, is cos, [baby's] dad, his family, are they live nearby and they help out with him a lot, so they, they're always coming over, giving him lots of cuddles, spending lots of time with him and that gives me a break, or sometimes they'll drive us to the supermarket, cos I don't drive, and things like that, they really help us out a lot” (Susan)

Susan's family provided this support by supporting her desire to introduce solid food via 'baby-led weaning' (a method of weaning onto solid foods that introduces solid foods immediately, without using pureed food as an interim step,) for example:

“yeah, I started off doing baby lead weaning with him erm, and they, even though they'd never heard of it and thought it was 'mmm, can they choke?' and all that sort of thing, but no they were really supportive and they were like, okay, if that's what you're doing we'll go, we'll help you with that, it's been really nice having them be really supportive” (Susan)

This positive, practical support from family can support mothers' mental wellbeing in particularly difficult circumstances:

“she's never gone without and we've never not been able to, we've never not had gas and electric and what not, but I think that was one of the reasons I used to spend a lot of time round my mums, cos I knew there was food there, and things like that” (Chloe)

Positive support from friends, where this is available, also played a substantial role in supporting good mental health, although making and maintain friendships at this time can be difficult. The value of positive friendship support in maternal mental health, even where a supportive partner may be present, is acknowledged by the participants:

“I had a couple of key friends that, if it hadn't been for them through the really anxious times of pregnancy, I'd have really struggled, just because I needed to be able to say those things out loud and not be judged, and just get it out of my system and have somebody to talk to.” (Miriam).

Support may be particularly useful from peers experiencing difficulties:

“we met up every week, erm, because I think we'd all, we all struggled in some way, every single one, so there were six of us, and every single one there was some issue, yeah, everybody had their own sort of specific thing that they found really difficult in the end, and I think we all kind of just...stuck together, which helps in the beginning, definitely” (Harriet).

In fact, admitting and bringing out into the open these feelings can be a way to connect with other mothers:

“I sort of find as well if you open up about certain things you are struggling with, its more often than not people go oh yeah I'm actually struggling with that too. And sometimes I feel more guilty if I go somewhere saying that I'm not struggling with anything cos then you're like, become one of those mums that everyone hates [laughs]” (Jo).

Joining the National Childbirth Trust (NCT) surfaced repeatedly in interviews, and provokes conflicting emotions among participants. Michelle refers to it as something mothers are ‘supposed to do’, she joins in response to others’ expectations, but finds a

good friend and source of support from doing so. The NCT, classes, or spending time in cafes is frequently referred to by respondents as key activities which supported or improved their wellbeing in early motherhood.

“the NCT girls, we would arrange to meet at least once a week, so that was kind of a good focus, I mean, we haven't got family nearby, I think that would have made a huge difference on, just you know, getting out and about, having, having somebody who I could phone and have a bit of a break” (Harriet)

“we found a nice cafe on the seafront, it was really breastfeeding friendly, a really good kids menu when they were eating, finger food and all that kind of you know homemade hummus with no salt in it and lots of kids around, no one blinks an eye lid if you are breastfeeding, and that was a really nice place and we felt like we could go there for a treat.” (Michelle).

Being part of groups and attending activities with her daughter contributes to Jo's wellbeing, but each of these is demanding on financial resources,

“the fact that we're able to go off to groups and things erm it does, it's really empowering, cos I feel like it's good for me to get out and know that I can go and meet other mums and things and make links...so I know that I'm giving her nice things to do like swimming and just going and interacting with other little ones and ...yeah, so it makes me feel good” (Jo).

Children's Centres, another source of both health professional and social support, have undergone re-organisations, and closures in the local area, proving worrying for mothers who may not have the resources to join paid for groups:

“I was really really sad to hear actually that ... my Sure Start clinic has shut, and to me, in the early days, that was my lifeline, and I feel a bit, ooh [noise of trepidation] about the idea of having a second knowing its shut, the idea of it not being there, I think is really sad, and erm...it seems like a real shame to me, real loss” (Michelle).

4.6.3 Resilience and Self –acceptance

All of the mothers, (with one exception) said they ‘felt like’ mothers. This feeling had arrived at very different times and stages of motherhood. However, all of the mothers have exhibited resilience in resisting the regulatory effects of judgment and criticism, or the potentially overwhelming experience of feeling the loss of previously cherished identities. For example, Fay is resilient, coping, and actively trying to improve her wellbeing, in the face of a difficult relationship break-up. She still takes her children out, and socializes with friends, is returning to education and holds a volunteer role:

“sometimes there were problems when he sort of would disappear and wouldn't come back home when I was meant to see him and help out with the children, so there was emotional times, but I kind of still got on with everything and still took the [children] out every day” (Fay).

Despite many of the difficult times they have been through, a number of the mothers talk about having a second baby. Michelle, for example, refers to this several times throughout the interview. She discusses this in terms of overcoming problems and using the solutions with a second baby, but also about how she would avoid the judgments and inconsistent advice of health professionals a second time around.

Some of the women also refer to how much they have already changed, particularly with reference to their priorities:

“I mean I do feel like I'm very different now, my priorities are completely different, I was very career driven before having him, I never thought I wouldn't go back to work” (Harriet).

Resilience has also meant standing up for mothering in the way that the women want to, in the face of external pressure,

“she took that as I didn't want to talk to her, and then it all kind of just, you know, went mad, and that in itself was a bit of a healing ...thing, because I stepped away from that, and I stepped out of those, kind of...expectations and I was like, no, actually, this is what I want to do, and he's my child, and this is, these

are my thoughts on parenting, and yeah, and that was a big therapy, and once I started on that, and didn't feel frightened of the fact that we co-slept and you know, all those things that we do, and didn't feel frightened to tell people, you know what's their reactions" (Linda, on her mother's expectations and her response to those).

The sense that becoming a mother is an ongoing process, begun at least in pregnancy, if not before, and spanning well beyond the days and weeks after childbirth, is reinforced by the mothers, who attribute feeling 'better' or 'like a mum' to the passage of time rather than any particular event. As Emily says, the learning process is 'constant':

"you're constantly learning, erm, as he gets older, it changes again every week changes, and I think you just constantly learn new things about what your role is as a mum, and I think you spend every day going, 'am I doing this enough', 'am I doing the right thing?' and I think you just, it is just a learning process that I guess will go on until he's however old, I'm sure it will go beyond 18, [laughs]" (Emily).

Each of the mothers holds conflicting emotions, and has come to a degree of self-acceptance, and it was thought of as positive to now be seen to be doing things 'their way', and this no longer has to be 'perfect':

"just *finally*, I've reached a realisation that I can't make everything perfect anymore so let's just accept the way it is, try my best, to do the best job that I can do but I can't control him" (Harriet).

Alongside this, some of the mothers also referred to a sense of self-fulfilment, however, this was not universally expressed:

"from when I had her I guess I felt everything was complete, and I felt complete, and I feel that now. It was just the time in between...but I kind of feel more happy now than I felt since having her, I think, even though I was really happy when I had her, there was the bit in between, and now I'm building back up and feeling happy again, yeah" (Fay).

4.7 Discussion

A qualitative interview study was undertaken, in order to explore wellbeing broadly, and positive emotions and experiences more specifically, when becoming a mother. Eleven mothers were interviewed about how they felt, and what supported or disrupted their mental wellbeing during this time. The findings and interpretation, and strengths and limitations, of this study are discussed below.

4.7.1 Interpretation and Comparison with the literature

4.7.1.1 *Summary of the findings*

An overarching theme of ‘resistance and resilience’ emerged from the interviews. Six main themes were identified: ‘Uncertainty’ encompassed the feelings of loss of previously felt control over their lives and the careful preparation that was undertaken to regain some of that feeling of control. ‘Clashing Identities’ explored how the women all seemed to undergo a feeling of having ‘lost’ their ‘true’ selves, however briefly, and the desire to, (and difficulty of,) regain or retain some element of that true self, even where now this needs to accommodate the new identity of ‘mother’. The women found that they were continually ‘Navigating Judgement’ and this impacted significantly on their wellbeing. Finally, the positive support of family and friends, active strategies such as getting outside and staying active, and self-acceptance were the foundations of the theme of ‘Resisting and Rebuilding’.

Underpinning all of the themes were the women’s feelings of being compared to, or comparing themselves to, what they feel was the ‘right’, ‘normal’ or ‘natural’ way for things to be done, and their concomitant ability to achieve this. For example, within the theme of ‘preparation’, women wanted to take part in antenatal classes and staying active to look after themselves and their baby during the pregnancy. This appeared to be important for wellbeing and being unable to attend, or having to navigate barriers brought stress and anxiety. Many of the mothers also raised the costs of such activities. Membership and attendance at NCT classes in the UK was seen as the ‘ideal’ preparation by some mothers, however for many the costs of their classes was prohibitive. The ability to purchase what are seen as the ‘essential’ expensive items of equipment, such as certain prams, weighed on the minds of some of the mothers; however an equal number

of mothers stated that they were very happy to purchase or accept second hand equipment and clothes for their children.

Along with financial concerns, the ability to mobilise the practical support of partner, family, and friends impacted on the women's sense of wellbeing at this time. The support women received from partners for key parenting decisions appeared to be crucial to their sense of themselves as mothers, and their confidence in making and keeping to their decisions, to their sense of resilience in the face of difficult times. This was particularly apparent in the clash between health professionals and mothers over issues such as breastfeeding, and baby weight gain. Breastfeeding emerged as an important locus of tension in the transition to motherhood, usually as perceived criticism appeared to strike at the core of a mother's identity where she has chosen to feed in this way. She wants very much to 'succeed', and is often made to feel, by health professionals, that she is not managing. It felt to the mothers in this group as if feeding was at the core of what they could do for their children, and this was where their sense of wellbeing is at its most vulnerable.

The findings showed overall that building a strong identity as a mother, that encompasses as much of the valued pre-motherhood identities that the mother had as possible, is key to wellbeing, and that whilst new mothers experience many difficulties and barriers to wellbeing, they also employ strategies to overcome these, and to maintain as much as what they perceive of as their 'true selves', and to bolster their wellbeing as mothers. Well-supported resistance to idealised notions of motherhood, and to those critiquing women's choices and decisions in this role, can lead to a greater sense of self as a mother, alongside those cherished pre-motherhood identities and roles.

4.7.1.2 Uncertainty

Preparation activities were linked to wellbeing, and formed a key part of pregnancy for the participants in the study. However, this is also associated with feelings of pressure from perceived ideal ways to prepare, and perfectionism, and to the ability to access this perfectionism. 'Nesting' in mothers' own home and space was mentioned on several occasions, and is termed by Linda as 'natural', which implies that she felt it is the ideal,

what all mothers should be able to do, as part of their preparation. Barriers to being able to prepare adequately included working in the day, when courses were available, and financial barriers such as being able to afford the recommended classes or baby equipment, and being able to 'nest'.

The findings presented here show that preparation facilitates the transition to motherhood, and this is similar for the women in Afflerback and colleagues' study (Afflerback et al., 2014). The authors found that spending and consumption are important in order to support the new mothering identity, and being able to take part in rituals felt like 'succeeding' in the transition (Afflerback et al., 2014). 'Nesting' and 'gifting' were key elements of this, both of which emerge in this study: one participant has come under pressure to take part in baby showers with other pregnant friends, and resists in order not to cause embarrassment for her family. 'Nesting' is seen as 'natural' for women during pregnancy, bringing anxiety to two participants who were not able to have their own homes and space when they were pregnant. The theme of 'preparation' is in the only one in this study that relates to pregnancy alone, and pregnancy appears to be a key time for this to be undertaken, reflecting the experiences of the women in the research by Bailey (Bailey, 1999), who saw this period as a useful time for 'psychological self-adjustment'.

However, not all of the mothers in this study felt that they had to take part in these activities, and some actively resisted them. For example, Miriam felt pressure from other pregnant friends, to participate in the 'baby shower' but she resists this as she also wishes to protect her family from having to bring her presents, when they are not in the financial position to do so, in public and in front of friends who are financially 'better off'.

Although the participants were aware that some control over their lives will be relinquished, they try hard to retain it. Feeling in control, particularly in childbirth, is important and impacts on wellbeing in early motherhood. A key locus of control/ loss of control in the transition to motherhood is in childbirth. The contrasting experiences of Emily and Heidi showed that where mothers felt that they retained control over childbirth, they felt empowered and confident in themselves when beginning

motherhood. Although Heidi experienced a high level of unplanned intervention in the birth, she felt that she remained in control of decisions, and this made a substantial difference to her feelings about herself as a mother in the early weeks. She had felt able to make her own decisions, supporting her self-confidence and her ability to trust herself with future mothering decisions. Emily directly links her poor mental wellbeing, and diagnosis of PTSD in the months after the birth, to her experience of antenatal care, labour and subsequent care. These findings are supported by the wider literature (Cook & Loomis, 2012; De Schepper et al., 2016; Green & Baston, 2003; Green, Coupland, & Kitzinger, 1990). In their study of women's choices in childbirth, Cook and Loomis found that the effect of changes to birth plans were mitigated by the mother feeling she retained some control over these changes: "negative experiences were related to the degree of change and amount of control over the changes" (Cook & Loomis, 2012, p. 165). Conversely, positive wellbeing has been found to be related to feeling in control and informed in labour, (Green & Baston, 2003; Green & Kafetsios, 1997) and control in childbirth emerged as a "protective factor" against postnatal PTSD (De Schepper et al., 2016, p. 87).

4.7.1.3 Clashing identities

The early period of motherhood (lasting from a few weeks to a few months for the participants here) is characterized by a broad feeling of being lost that was linked to loss of previous identities by the women in the study. For example, Jo experiences a threat to her identity as someone active and positive from the unexpected post-birth pain she experiences. This feeling of 'loss' was nearly universal, although to different degrees, among the participants, and did not appear to have any link to financial or social resources.

The women mostly expressed their desire to retain their former/ 'true' selves, but concurrently worry that this is 'selfish'. They strongly felt the loss of former, cherished, identities or the clash of these alongside the new status of 'mother'. These identity tensions influence wellbeing. There is a strong sense that this leads to being unable to

'do' either work or motherhood well, and this is sharpened by the discussions around feelings of needing to be perfect, and loss of control in early motherhood. Mothers therefore may feel guilt and anxiety about wanting to return to work, feeling that they might 'miss out' on their children's milestones. Conflicting feelings were held over whether mothers welcomed the return to the working identity that gave them some space, some adult conversation, and a step back into their 'old me', and the resultant feeling that a mother 'should' be with the baby.

The ability to retain valued elements of an 'old' self appears to support wellbeing such as a work identity that balances with the new mothering identity. For the women in this group the key to this appeared to be supportive workplaces, or the kind of jobs or skills that lend themselves to flexibility. Workplace inflexibility, or insecure employment, is a barrier to a smooth transition and therefore to wellbeing. Flexibility on the part of the employer, or financial flexibility, was supportive of participants' mothering identities: Heidi had able to pursue her chosen parenting style because of this, and volunteer, and this had also supported her wellbeing.

Even where strong beliefs were held and expressed over gendered roles in relation to childcare and housework, these had not resulted in the father remaining at home to undertake childcare in a full time capacity, (although one couple had plans for this to happen part-time in the future). It appears that despite the strong conflict between working and mothering identities, the women in the sample still either gave up work, or returned on a part-time basis with some childcare in place when their children were older, with their partners remaining in their careers, mainly full time. Stigma around part time working and adds to the impact on the wellbeing of women trying to manage motherhood and working.

In research discussed in Arendell (Arendell, 2000) on work and women's identities, women experienced more tension between their roles of mother/ parent and worker than do men. Abrams and Curran find that employment and work held contradictory

meanings for the low income mothers in their study: “employment and breadwinning was, paradoxically, both an essential component of a positive maternal identity and, for some, an additional threat to their sense of maternal competence” (Abrams & Curran, 2011, p. 378). This ‘clash’ therefore, for the women in both this, and Abrams and Curran’s study, stems from the dominance of the cultural discourse of ‘intensive mothering’ which suggests that mothers should be there all the time for their children, despite their need to retain or accommodate their ‘true’ identities into their new mothering identity. For some women this includes an identity built around their paid employment. Whilst loss was mentioned by all of the participants in this study, the ‘clash’ between mothering and working identities was not universal. Interestingly, the mothers who did not experience this had found volunteering positions which were embedded in their new mothering roles.

Bailey’s study with pregnant women (Bailey, 1999) explored work, and thoughts about work both when pregnant and about to return. Both work and motherhood were viewed by the women in Bailey’s study as moral projects, linked to the number of participants in her study working in caring professions. This also reflects the sample in this study: the majority of those that worked prior to motherhood worked in caring professions and roles. It could be argued in this case therefore that this might help these women overcome the clash of identities because these are more congruent with a mothering identity, (and with those characteristics associated with being a ‘woman’) to continue with caring roles (the valued ‘self-sacrifice’ involved with both motherhood and caring professions here maybe even includes the sacrifice of time with the baby).

4.7.1.4 Navigating Judgement

Health professional’s perceived judgemental attitudes towards feeding difficulties, or insufficient weight gain, had a negative impact on many of the participants’ mental health. The contrasting stories of partners allowed to stay or asked to leave hospital in the very early days of motherhood demonstrate the inconsistency of these gatekeepers in ‘allowing’ new mothers access to the positive support they need, and how damaging or supportive this can be to their mental health. The mothers’ requests for support with breastfeeding (support for the mother herself, and therefore for the mothering identity

she is trying to build) are relegated beside the concern over the baby's weight gain, elevating concerns about the baby over those of the mother's wellbeing. This in turn diminishes the mother's own knowledge and expertise about her baby, undermining the building of the new mothering identity, and impacting again on wellbeing.

These judgments proved to be a very powerful force in new mother's lives. For example, receiving negative feedback on mothering in public can be enough to cut off mothers from potential sources of positive support or positive coping strategies in the future. Michelle rejected the baby group, and many mothers had decided not to fully engage with health professionals if they had children in the future. Barimani and colleagues found that a perceived negative judgement from health professionals, particularly around feeding choices hindered a smooth transition to parenthood (Barimani, Vikström, Rosander, Forslund Frykedal, & Berlin, 2017). This was also the case for the mothers interviewed by Haga and colleagues: "staff failed to acknowledge the uniqueness of the individual, and they failed to remember that although painful and stressful experiences are normal in the postpartum period, they can nevertheless be extremely difficult for a new mother" (Haga et al., 2012, p. 463).

Breastfeeding is perceived by many of the mothers to be the ideal, and not only this, but there are also ideal ways to breastfeed. This appears to go right to the heart of any identity as a mother, and experienced as a failure, if unable to breastfeed, or if exclusive breastfeeding does not lead to a healthy infant weight. There was also a lack of information and support available to the mother who did not breastfeed, leading to problems for her child's feeding in the future.

Women did not always passively accept the stigma they felt from health professionals, or critical extended family. They were in some cases able to resist this stigma, and furthermore incorporate it into a positive mothering identity. This may suggest growing self-confidence but could also conversely suggest a fragility to the identity that they wish to protect in the future. This sometimes took the form of actively deciding not to engage with health professionals around certain issues, particularly feeding, in the future. This is reflected by the findings of the McLeish study, a theme of which is mothers 'unwilling to

be open with health professionals' (McLeish & Redshaw, 2017). Although in the McLeish study this was regarding mental health difficulties, it was similarly in response to the belief that midwives had a "professional agenda" which excluded the concerns of the mothers themselves (McLeish & Redshaw, 2017).

In this study, mothers were able to reject the perceived stigmatising of health professionals by prioritising alternative explanations from supportive partners, who offered reassurance that the mother was doing her best, or what was right for their child. This in turn appeared to strengthen both the new identity, and the relationship in that time of early motherhood. Not all mothers had close partnerships to help them resist the stigmatising, but this was still possible with the help of supportive extended family for example. Where this was not available, the impact on wellbeing appeared to be substantial.

4.7.1.5 Resisting and Rebuilding

Getting outside, and staying active are clear facilitators of good mental health in new mothers. These allow a feeling of contact with the 'old me' and continuation from that time before the baby arrived. And, for those participants whose pre-motherhood identity included career related markers of success, getting out of the house can bring a needed sense of achievement. Even in the earliest days of motherhood, leaving the confines of the house was important to the happiness and wellbeing of most of the participants. Staying active was both a source of relieving stress, and a further connection to pre-motherhood identities and groups. Despite the importance of these activities, there are also barriers to these raised by the participants, such as access to transport, or the costs of attending groups.

The coping strategies employed by new mothers are a focus of Currie's recent work on wellness in motherhood (Currie, 2018). She found that leisure and exercise were crucial aspects of mothers' coping strategies, as these can have the effect of helping a mother to feel like she is meeting her own needs, of finding space as well as improving body image and physical fitness. These themes were reflected in a study of free exercise classes provided to new mothers (Currie, 2007), and both physical fitness and reduced isolation

were benefits. While these classes were free of charge, lack of access to childcare was a challenge for those wishing to participate, and in the former study, a lack of personal financial resources was a further barrier to accessing leisure time (Currie, 2018).

The transition to motherhood, while seeming to be alleviated by attending mothers' groups for many of the women in the sample, also provided opportunities for socialising (in some cases leading to a 'better' social life than before the baby). Positive social support helped the mothers to build resilience to the pressures of early motherhood, and confidence in their decisions as mothers. 'Positive' support is termed as such because of how it is received by participants: 'support' offered by others, such as health professionals, as discussed earlier, will not always have the effect of raising wellbeing. A more complicated effect is seen where 'support', from midwives or health visitors is received as criticism or undermines a mother's knowledge, for example. Positive, practical, support from wider family members (where it meets the mother's needs, whatever these may be,) is of real value in supporting maternal mental health. This kind of support provides the space and ability for the mother to develop her parenting identity. By its nature it places minimal demands on the mother's emotional or financial resources and may even be particularly beneficial where these resources are low. For example, Emily's parents taking her and the baby out for the day, or where Chloe goes to her mother's to get the basics, such as food and a warmer place to be with her baby. Positive social support, from partners, extended family, and from health professionals, emerged as key to support the building of the new mother's identity, and therefore her wellbeing, in the findings of this study. Support from partners which helped to bolster difficult mothering decisions which may have gone against the grain of the dominant cultural ideals of mothering, such as introducing bottles to help continue with breastfeeding, supported the mother's new identity and belief in herself and her decisions, and concurrently supported the relationship. Social support across family, friends and health professionals was crucial to mothers' wellbeing in the study by Haga and colleagues and these transcended the different approaches to motherhood identified in this research (Haga et al., 2012). This kind of support was vital in raising and

maintaining wellbeing in difficult circumstances, such as where this felt to be under attack from health professionals. Positive support from health professionals during labour and birth, to specifically support the mother's choices also led to increased confidence in her decision making, and subsequently her identity as a mother and wellbeing. Women's need for midwives to give practical informational and emotional support, was highlighted in the study by Seefat-van Teeffelen and colleagues (Seefat-van Teeffelen, Nieuwenhuijze, & Korstjens, 2011). The experiences of the participants in the current study who did not have the support of a close partner or husband are relevant here.

Luthar and colleagues found that strong partnerships are protective against the tyranny of dominant ideals of motherhood, however close friendships were able to perform a similar function (Luthar & Ciciolla, 2015). This study was conducted with 'upper middle class women' (Luthar & Ciciolla, 2015) and therefore the findings may not shed light on the barriers to mobilising strong relationships with fewer financial resources. The theme of relationships again emerged in Bailey's study with pregnant women, where again women are "let into a club, become part of this other world." (Bailey, 1999, p. 344). However, the potential isolation for those who do not fit into this 'club' is acknowledged.

This type of support was in some cases provided by friends who were pregnant at the same time as the mothers in the study, but more usually these groups were found either in antenatal classes, or baby groups such as Sure Start groups, or groups set up around activities such as swimming, singing or massage. These groups appeared to have a dual impact on identity building in new mothers: they both provided a source of potentially like-minded peers, preferably who might also be facing various struggles in the transition to motherhood; and also the feeling that the mothers were doing the 'right' thing in spending that time with their children, engaging in these types of activities. Joining new groups and activities also held importance for the pregnant women in Bailey's study: they used the period of time afforded by pregnancy to join groups compatible with their new identity (Bailey, 1999). Here, the ability to maximise the opportunities to smooth the social identity transition is facilitated by access to social and personal resources.

Pregnancy is an opportunity to start shaping this change in identity (rather than a new identity) but the financial resources and power the participants in the Bailey study have

enable them to do this in a positive way (Bailey, 1999). McLeish and Redshaw found that organised peer support for new mothers resulted in their increased confidence, feelings of value and self-worth and reduction in stress. Overall these activities improved their mental wellbeing (McLeish & Redshaw, 2017); this is reflected in the findings that local groups, facilitated by mothers, improved subjective wellbeing (Strange, Bremner, Fisher, Howat, & Wood, 2016).

Making new, mutually supportive, 'mum friends' appears crucial to mental wellbeing for many of the mothers, to support and help to put problems into perspective, to not feel alone with struggles. Forming a group of mothers to be part of, even where not perfect, and not being perfect is part of that group identity. However, again, this may be problematic for some as access to other mums is often mediated through groups, classes, or other organisations such as the NCT, which, as the mothers raise, are in themselves costly. Mothers are both advised to join groups, and appear to derive real benefits to wellbeing from these. However, there are issues with affordability and access to these benefits. Miriam does not join the NCT, despite expectations, because "I'm not rich". Those women who had lower financial resources in the group tended to be more reliant on family support, or the free groups such as the Children's Centres. Across the literature, as in this study, participation in peer support was also threatened by financial restrictions, the demands of work, and accessibility issues, such as the location of activities, and public transport (Cronin, 2015).

Many of the women experienced a substantial, sometimes distressing, clash of identities and difficulties with expectations and judgments of others. The participants related experiences that some described as traumatic, that in some cases lead to depression, or a diagnosis of post-traumatic stress. Even where there was not a diagnosis of mental ill-health, participants described some incidents of overwhelming anxiety where they found that they felt lost, or out of control whilst juggling clashing identities. Some have also experienced relationship challenges or break-ups. It is important to note that not all mothers experienced these feelings; some recounted feeling like 'naturals', or 'empowered'. However, all of the participants demonstrated resilience to some extent. For example, continuing to breastfeed under some of the challenges faced by many of the

mothers, and the commitment to the mothering identity they wish to build. Laney and colleagues also found that after a period of identity 'loss', women reported "coming back to themselves" (Laney, Hall, Anderson, & Willingham, 2015, p. 132). For the women in this study, this is likely to renew, grow and waver over time (as each expresses a version of it, and all have children at slightly different ages and stages). Identifying as a mother, for these women, appears to involve resilience, conflicting emotions, and self-acceptance. These do not appear to be an 'end-product', but an ongoing process of negotiation. The women in Laney and colleagues' study "maintained continuity with their identities," but, as in the findings here, this is not a linear journey, rather an expansion of identity (Duggan, 2012; Laney et al., 2015, p. 139). In some of the literature exploring the transition to motherhood, as discussed in Chapter One, this emerges as a 'transformational' experience in terms of identity (for example, Barclay et al., 1997; Hanna, 2001; Sethi, 1995). Whilst the mothers in this study discussed their changed priorities in many cases, here the findings appear more aligned with those of Abrams and Curran, and Sheeran and colleagues', whereby they have experienced profound change to their identities, coupled with conflicting emotions, and self-acceptance (Abrams & Curran, 2011; Sheeran et al., 2015).

4.7.1.6 The relevance of poverty to the findings

Whilst each of the themes touch on the difficulties of transitioning to motherhood under difficult financial circumstances, there are key ways in which the wellbeing of participants was affected by inequalities in financial resources, suggesting that living in poverty impacts severely upon wellbeing in this transition.

The first of these is in the negative impact of 'clashing identities', for example with a working identity. Women who are poor are more likely to work in occupations with lower agency and autonomy, and higher levels of job strain (Williams, Blair-Loy and Berdahl 2013) or live with partners who work in a less flexible occupation. The flexibility of employers with regard to reduced or changed hours, so valued by the women in this study, is less available to poor women. Research suggests that a "flexibility stigma" exists, wherein workplace flexibility is more easily accessed by those occupying professional positions (Williams et al., 2013). Women in lower-paying, and less secure, roles are likely

to be penalised for flexibility requests, with fewer working hours offered, or loss of their jobs (Williams et al., 2013; Dodson, 2013). Around 50% of child poverty is found in working households (Kenway, 2008) and therefore this issue remains pertinent to the lives of poor women. They are likely to experience reduced and restricted choices in decision making around work continuation and childcare, which as can be seen from the findings above, will have consequences for building the maternal identity, and the mother's wellbeing (Abrams & Curran, 2009).

Poor women are also more likely to experience the 'unhelpful support' outlined above, that appears to impact fundamentally upon wellbeing in the transition to motherhood. Whilst nurses have been found, in previous research, to agree that poverty is due to structural, rather than personal, causes, they have also been found to agree with stigmatising statements around poverty, and deficits in training around structural causes of poverty have been found in both nursing and medical education (Loignon, Gottin, Dupéré, & Bedos, 2018; Wittenauer, Ludwick, Baughman, & Fishbein, 2015). Poor mothers not only experience stigmatising attitudes from health professionals involved in their care (Lindquist, Kurinczuk, Redshaw, & Knight, 2010) but these are further compounded by "barriers of confidence" (McLeish & Redshaw, 2019) meaning that poorer women may have fewer resources to engage in resistance to these attitudes, and their effects. This may lead to the disengagement from services described by the women in this study, and is more widely described among poorer women in the UK (Lindquist et al., 2010).

As discussed above, poverty in the UK is defined as a household income below 60% of median outcome after taxes and benefits. With approximately 25 % of households across Portsmouth living in poverty (rising to 50% in some inner-city wards) this suggests that around a quarter of new mothers will not be able to afford to participate in activities that they perceive as central to supporting new mothers' mental health. Many of the methods used by the participants, such as meeting peers through organised classes, informally in cafes, or through sports participation, implied a financial cost. Active social participation is central to maintaining good mental health for new mothers, as it is in the general population, (Fancourt & Steptoe, 2018; Strange et al., 2016) and participation in many of

the activities available to new mothers, and mentioned by those in this study, has been shown to have some benefit in addressing postnatal mental illness (Perkins, Yorke, & Fancourt, 2018).

The positive support needed is defined by accessing supportive relationships with family, friends and health professionals, accessing flexible working arrangements and community resources. These help new mothers to resist potentially oppressive dominant cultural ideals of motherhood. Women living in poverty face an intersecting array of challenges to their wellbeing in the transition to motherhood but lack the financial means to mobilise these resources or to participate in their communities in ways that would support their mental health. The relationship between poverty and wellbeing in the transition to motherhood, via the inability to call upon these in the same way as mothers not living in poverty, is clearly illustrated in the findings here.

4.7.2 Strengths and limitations of the qualitative study

This qualitative interview study had some key strengths. Women who have themselves become mothers recently (within the last two years) were asked to identify and discuss their experiences of their wellbeing during the transition to motherhood. This has allowed the key elements that are important to the participants to emerge, and be understood.

In-person interviews were the appropriate method for exploration of this subject; these are useful for examining potentially sensitive issues (Dempsey et al., 2016). In order to allow mothers to talk about the full range of their experiences, and to discuss aspects that had helped them to feel happy or well at this time, broad, open questions were employed. This inevitably meant that some difficult experiences were raised and explored, and a one-to-one interview allowed this to happen. An alternative such as focus groups, for example, would have allowed a larger number of women to take part in the study but would have potentially hindered the exploration of these more sensitive issues. All mothers were given the contact details for local organisations offering support, and for the telephone number where they could contact the health visiting service, in the event that the interview raised issues they felt they needed further help or support with.

A further strength of this study is that the research was undertaken with women with a variety of mental health experiences during pregnancy and after birth. The majority of research in this field has focussed solely upon postnatal depression. This work builds on this existing research by expanding the scope of researched experiences, and therefore identified new findings. For example, 'loss of control' or identity is associated with postnatal depression in a large body of research (Abrams & Curran, 2011): this study demonstrates this sensation is near universal in a group where many have not experienced mental ill health.

A limitation of the study is the lack of other types of diversity within the group. Although the mothers were not all from white British backgrounds, the majority were, and a broader representation of the different groups living in the area may have allowed a richer picture to emerge of the ways women negotiate motherhood, and try to support their own wellbeing at this time. The same is true, to an extent, for the socio-economic position of the mothers taking part. It is a common criticism across different types of research that there is a social gradient to participation, and therefore the picture is skewed to over-represent the experiences of certain groups (Abrams & Curran, 2009, 2011). This research did include several women who experienced financial difficulties and restrictions of varying degrees, and some for whom this was not a concern. This may be as a result of the efforts outlined above in encouraging participation from diverse wards of the city. However, the majority (but not all) of the women were in partnerships, and either had jobs, or partners who were working. The study was strengthened by the participation of women who were not in this position, and would have been further so by the inclusion of more, if this had been possible. Different barriers to wellbeing, or coping strategies may have emerged if there had been more voices from marginalised groups in the study. However, the extent to which financial considerations did emerge in a group of women many of whom stated they were not struggling from a financial perspective, is in itself, an interesting finding.

4.7.3 Reflexivity and rigour

The researcher carrying out this study was a similar age and socio-economic position to many (but not all) of the participants, and a mother, albeit of older, school-age children.

Some of the motivation for researching the transition to motherhood and its impact upon mental health, and identity at this time emerges from this personal background, not solely a professional context.

This personal context may have led to a position as an “insider” (Berger, 2015, p. 223) within the qualitative study. This may have resulted in three advantages as outlined by Berger: improved access to participants and the field, an improved perception of the topic, and therefore of the experiences being explored (Berger, 2015). Potential participants were invited to the study via personal introduction to the study and its aims, and therefore met the researcher/ interviewer before deciding whether to take part. Although the information that the researcher was a mother was not volunteered as this point, it was shared if asked directly.

This status will also have assisted potentially with the interviewing. Although the topic guide questions emerged from an understanding of the paucity of literature in this area, and in aiming to explore topics that had not been exhaustively covered by other qualitative research in this field, these will have inevitably been guided by and further shaped and phrased by the researcher’s own knowledge and experience of early motherhood. This additional knowledge will also have shaped the wording and use of probing and follow up questions (Berger, 2015).

These similarities in key characteristics may also have affected what the participants were willing to discuss and share within the interviews. It is possible that the shared demographic characteristics, in some cases, may have led to greater comfort in sharing more personal or sensitive information and stories than with a different researcher (Berger, 2015). However, it is important to continue to acknowledge the impact of prevailing cultural narratives around motherhood, and how these impact upon how mothers may present themselves to others, including other mothers.

This ‘insider’ status is likely to have assisted in establishing a rapport with the participants. It was important therefore to be aware ahead of the interview not to let it become a conversation between mothers as opposed to a research interview. Sometimes this was particularly challenging: when the participants became upset over an aspect of

parenting, or a child's behaviours or habits. In addition, it was necessary to avoid over emphasising shared experience, in case this led to participants excluding information that they felt would be implicitly understood, or became instead about the researcher's experience being imposed upon the participants own. However, not to say anything where directly asked felt challenging and unethical: the participants were sharing potentially sensitive stories, and their time for the research study (Green & Thorogood, 2018). This was overcome by waiting until the interview was concluded, and the tape recorder switched off, to have a brief, informal, chat about the children, or shared experiences.

There were participants who took part who had had difficult experiences with their mental health before, and during, becoming mothers. It was particularly important to manage these interviews with sensitivity and understanding, and where participants became upset, discontinuation of the interview was offered. In all cases the participant chose to continue. It should be made transparent that these especially difficult scenarios were not deeply probed within the interview, out of an acceptance that the researcher did not have the skills to do this safely, and that a research interview is not the appropriate place for this to happen.

The quantitative and qualitative studies have separately considered wellbeing, its drivers, supports and barriers in the transition to motherhood. The next chapter will consider the overall contribution of the studies to the empirical and theoretical literature, implications for policy and practice, and future research.

5 Chapter Five: Implications and future work

5.1 The study aims

This study aimed to contribute to the gap in the research literature regarding the mental health of women in the transition to motherhood: to understand the levels of positive wellbeing in new mothers, and how these might compare to subjective wellbeing in the wider population, whether these levels are impacted by social circumstances such as poverty and ability to access support from partner and peers, and what women's experiences of wellbeing and good mental health are when becoming mothers. A further aim of this study was to contribute to developing explanations of how poverty and social support might affect positive wellbeing in this transition.

5.2 Insights from the critical realist, mixed methods approach

When viewed together, the findings from both studies suggest that where mothers are living with poverty, that they will have lower subjective wellbeing when becoming new mothers. The overall study not only expands our understanding of maternal mental wellbeing, by demonstrating that this is also driven in part by poverty, in the way that poor maternal mental health is, but it can offer some explanation as to why this might be the case. The study shows that poorer women also have lower levels of social support. When levels of social support are held constant, then the significant effect of poverty is removed. It appears from these results that it is social support that is really driving a large part of the mental wellbeing levels of pregnant women and new mothers.

Wellbeing appears to decrease for all mothers regardless of poverty status in the early months of being a new parent. However, for those mothers who feel well supported, by close relationships, extended family, and in their relationships with the health professionals who care for them, this will offset some of the problems with wellbeing that might have been partly explained by poor financial circumstances.

Poverty, or restricted resources, appears to impact access to social support, and therefore wellbeing, in this transition in various ways. It further restricts the ability of mothers to prepare in the ways that enhance wellbeing, by allowing them to feel as if they are meeting perceived standards of 'ideal' or 'natural' motherhood, such as 'nesting' or

accessing antenatal education. Limited financial resources may limit the ability to build a new mothering identity. For example, choices over returning to work or being able to stay at home as a mother may be shaped by the financial resources that can be mobilised in support of these decisions. A mother without a partner, or extended family support may need to provide 'breadwinning' support where this may not be the case for her peers. Mothers with fewer resources, and lacking in social support may be less able to engage in the behaviours that support rebuilding identity after the identity 'crisis', characterised here by a sense of loss, that appears to be nearly universal among new mothers, regardless of financial circumstances. This latter sense of 'crisis' may to an extent explain the drop in mental wellbeing levels across the groups in early motherhood. Positive coping strategies, such as being able to stay active, and actively seek and nurture the types of relationships which provide emotional support, such as joining groups to develop and maintain supportive friendships with like-minded mothers, are all affected by access to financial resources, and supportive relationships and networks. Therefore, a mother's ability to 'resist and rebuild'; to maintain her own wellbeing will be shaped by all of these factors: the findings suggest that mothers living in poverty will be less likely to have the type of social support, from a close other, that supports key decisions, even where these might contradict advice or directives from health professionals, or run counter to powerful cultural ideals; or judgements from family or allows mothers to resist the deleterious effects of self-criticism.

This study has been carried out from a critical realist perspective, as outlined in Chapter 2. This accepts a realist ontology, that there is a reality 'out there', combined with a constructivist epistemology: that our responses to reality will be partial, and subjective, and shaped by complex factors. Research undertaken from this perspective seeks underlying explanations and mechanisms rather than causality per se (Maxwell & Mittapalli, 2010). Researching mothers' own experiences of wellbeing in early motherhood can deepen understanding of the relationships between poverty and social support, and mental health in the transition to motherhood. These insights into the possible mechanisms at work, which emerged from combining quantitative and qualitative approaches, is a key strength of the study.

The shape of this field is beginning to change: the study of subjective wellbeing is an emerging science (Diener et al., 2017) and more recently publications in the field of maternal mental health are embracing this from the perspective of wellbeing (Currie, 2018). As explored in Chapter 1 however, there is much less known about the holistic picture of maternal mental health (Alderdice et al., 2013). This means that understanding of what happens to women in this transition is restricted to focussing on pathology and disorder, equally therefore, our understanding of how to promote mental wellbeing, and the drivers of this in this group is limited. This study contributes to this understanding, by adding to our knowledge of the levels of wellbeing, some of the possible drivers of these, and some of the possible mechanisms at work between the two. It also contributes further to our understanding of the steps mothers take to protect and bolster their wellbeing at this time, and why this may be more difficult for women who are 'economically marginalised' (Abrams & Curran, 2011).

5.3 Theoretical implications of the study findings

5.3.1 The determinants of mental wellbeing

The socio-economic position of participants is often included as a variable in the study of maternal mental health, particularly in the literature exploring the determinants of postnatal depression, but this is rarely accompanied by a consideration of the concomitant relationships to power of those participants, or the mechanisms by which these might reduce mental health and wellbeing. Despite the use of varied indicators of socio-economic position within the literature (education, employment or sometimes an under-described 'socio-economic status',) without a theoretical basis for this relationship the extent to which the evidence can provide a basis for action is limited.

The findings reported here clearly support a 'social determinants' (Barry, 2009) approach to the consideration of maternal mental health and wellbeing. This contrasts with the traditional approach of the discipline of 'positive psychology', which focuses upon the personal resources of individuals to cope with adversity and build resilience, rather than the influences of social or macro structures, although there is a central role for the importance of personal relationships upon wellbeing, within this approach. Traits such as 'optimism' and 'hope' are important for achieving and maintaining happiness (Seligman & Csikszentmihalyi, 2000) but within this discipline there is less accommodation for the

complex ways wider social circumstances may proscribe the development or preservation of these traits. The findings of this study support the existence of a complex relationship between personal resources and how these might be mobilised differently in different social and economic circumstances.

The theoretical framework of the social determinants of health allows consideration of the various characteristics or positions a person might hold in society, and the way in which these might affect health. As Benzeval and colleagues argue, and outlined in Chapter 1, three models of the relationships of these characteristics to health are posited: behavioural, which suggest for example that poor people are more inclined to indulge in unhealthy behaviours, psycho-social, which suggests that the circumstances of being poor for example will lead to stress and therefore ill health, and materialist, which suggests that the material circumstances of being poor will lead directly to ill health, such as being unable to buy access to “health-promoting goods and the ability to engage in a social life in ways that enable people to be healthy” (Benzeval et al., 2014, p. 1). The findings lend some support to materialist explanations: the quantitative study shows that poorer women contend with lower social support levels, and lower wellbeing than women living in households which can afford to provide ‘the basics’, whilst the qualitative study shows that these lead directly to being unable to afford participation in certain group activities such as staying active, which would in turn be health promoting. They also suggest some support for the psycho-social model, whereby the circumstances of poverty cause stress and anxiety to women becoming mothers, producing a mechanism of social shame and stigma which impacts when we have restricted financial resources to navigate a transition (Bartley, 2004; Friedli, 2009). The results of the qualitative study imply the ways in which anxiety is caused in this specific instance of the transition to motherhood: via being unable to sustain a particular type of identity, one which matches both cultural and personal expectations. The findings of the study suggest that developing and maintaining an identity which matches, or is as close as possible to, some of these expectations, will lead to higher wellbeing levels, and that some of this ability is facilitated by access to financial and social resources. This moves the explanatory model beyond the materialist level, to the psycho-social stress of not being able to meet cultural narratives about how mothering ‘should’ be done.

5.3.2 The implications for theories of 'transition to motherhood'

It has been argued that 'Transition to Motherhood' (TTM) theories, such as 'maternal role attainment' (MRA) and 'Becoming a Mother' (BAM), are essentialist, and minimise differences between women in the way that they become mothers (Parratt & Fahy, 2011). The results from the quantitative study clearly show that poverty and social support have a relationship with women's wellbeing in this period, and that there are structural differences in how women experience the transition. Rubin's MRA theory in particular does not account for how the different social structures within which women become mothers within may impact on that process, and how in turn this may impact on wellbeing. The implication is that mothers who struggle, or who have postnatal depression have not made a successful transition, but women who have postnatal mental ill health to whatever degree are still 'mothering', with this illness. Theories are necessarily simplifications of the 'realities' they seek to explain, and these TTM theories were first developed over 50 years ago, however they are still employed as frameworks for much health research in the nursing and midwifery literature (Parratt & Fahy, 2011). The results of the study presented here support some aspects of these theoretical models, for example, a key facet of the early stages of the 'transition to motherhood' paradigm is that of 'attachment, preparation and commitment'. The conclusions presented here make clear that different levels of preparation are considered necessary by different women, and this is likely to be affected by the social context in which women become mothers, and the various rituals and requirements they feel beholden to. Crucially, the women interviewed discussed housing, work commitments, transport difficulties and financial constraints as issues they needed to navigate while trying to prepare for new motherhood in the ways they wanted to. Additionally, the ways they wanted to prepare varied. The women in the study were all aware of the perceived 'ideal' way to prepare, and had differing relationships with that. In some cases, an inability to prepare in this way was deleterious to wellbeing. In others, an active rebellion against these and decision not to, for example, buy the latest or recommended equipment was a part of building an identity that they were comfortable with, despite the external pressure. The women in the study conveyed differing levels of feelings of attachment and commitment during the pregnancy, and were honest about their differing feelings towards their babies in the early days after their arrival. The implications of the findings

for the TTM theories are that women have very different relationships with the process of becoming mothers, which are mediated by the cultural ideals within which they become mothers, and both their ability and desire to meet or be governed by these, with differing effects on wellbeing.

The idea of a time-constrained process of becoming a mother has persisted throughout the evolution of the theory from 'maternal role attainment' to 'becoming a mother'. The findings of this study contradict the idea that there is a linear process through which all women travel to become mothers, and which is broadly 'complete' at around four months after the birth. With the exception of the theme 'preparation', each of the themes presented in this study was derived from codes referring to all time points of pregnancy and motherhood across the first two years. All of the mothers were asked when they 'felt like' mothers, and the responses ranged from during pregnancy, to not really feeling like that yet, around 18 months after the birth. The 'physical restoration' expected within this four month time frame by the TTM theories of transition would also not have resonated with many women in the study.

BAM theory does not explicitly account for difficulties with health professionals, whereas the preceding theory of 'transition to motherhood' refers to achieving 'role congruence' with their help (Parratt & Fahy, 2011, p. 446). The findings presented in the study here suggest that help from health professionals is experienced in complex ways by the mother's themselves, with subsequent impact for identity negotiation and wellbeing. The positive support of health professionals can have a profound effect on mothers' confidence in the role, and conversely (perceived) unfounded criticism and the undermining of decisions women have made in support of their own wellbeing, but not thought to be in the direct interests of the child (such as stopping exclusive breastfeeding) can impact in deeply negative ways on women's wellbeing and sense of self as a mother. There is an ongoing tension between the 'best' interests of the child and those of the mother, and who is able to identify what these are. The mother therefore feels as if she is sometimes asked to choose between her mental health, and her ability to be a 'good mother'. Furthermore, BAM does not account for the feelings of resistance some women experience on their journey to become mothers. This approach does allow for the way women might use the example of other women to decide what not to do, but

not the cultural and social context. The resistance in particular to health professionals' judgements as expressed by some of the mothers in the study had a specific role in shaping the mothers' identity, and had implications for any future relationship if the mother had a second or third baby.

The findings from this study however do support some aspects of Rubin and Mercer's theoretical frameworks. The 'new normal' to which Mercer refers (Mercer, 2004) resonates with the 'self-acceptance' of which many of the mothers in the qualitative study expressed a version. This was characterised by a mother's newer standards, or 'priorities' which no longer included having to make everything 'perfect'. However, in contrast to the BAM paradigm, there is no suggestion that this is the completion of a journey, but another stage as part of it, which is also entered and exited according to the social circumstances the mother may find herself in.

The MRA/BAM paradigm is framed as an internal journey, one which is insular to the mother, and produced as a result of the mother and baby relationship (Mercer, 2004; Parratt & Fahy, 2011; Rubin, 1967). Whilst there is an element of copying and internalising practices which are observed in others, there is not the sense, which emerged from these studies, that the processes in becoming a mother are strongly shaped by the interactions within relationships with family, partners and new and old friends, but also the wider dominant cultural norms and narratives, and in consequence the social circumstances and therefore the power wielded within to resist or actively shape them, in protecting or bolstering wellbeing.

5.3.3 The Social Identity Model of Identity Change (SIMIC)

The 'Social Identity Model of Identity Change' offers insights into identity and wellbeing at a time of identity transition. Social identity theory contends that individuals can hold multiple social identities, which are similar to group memberships (Jetten & Pachana, 2012). Under this model, identity transition is likely to be smooth where the individual is willing to embrace the new identity (group), and the new identity is congruent with the (possibly several) other identities that she holds, so some or all of these can also be maintained on joining the new group (Jetten & Pachana, 2012). Although this theory is not specifically concerned with the identity transition taking place in motherhood, it may offer valuable insights about the role of group identity in this transition, and subsequent

impact on wellbeing. It would suggest, for example, that multiple group identities pre-motherhood are useful for smooth identity transition to motherhood. This is supported by the findings of this study: women found that 'staying active', particularly where this fit in with their lifestyles before having babies, such as where they had played sport before becoming mothers, supported their wellbeing in the transition.

Most of the women in this study wanted to breastfeed, and some not only found this possible, but also empowering; however, these findings suggest that being able to breastfeed successfully is congruent with the 'ideal mother' narratives that eulogise breastfeeding as natural, and something that all women should do, and find easy. This might in turn suggest that some of the enhanced wellbeing that derives from successful breastfeeding is the fulfilment of this 'good mother' identity being achieved. For those mothers who found breastfeeding difficult, or that their babies were not meeting the required weight goals of health professionals, this cut right to the heart of the mothering identities that they were trying to build. They were unable to do something that they perceived as natural, they were 'failures' and that the least they should be able to do would be to feed their child.

The mothers that employed 'staying active' could call upon previous identities into their new lives, and this helped with retaining a feeling of a 'true self', referred to by many of the women in the study. This further supports the argument of SIMIC which suggests that the more congruent the already held identities are with the new one, the smoother the transition will be: where women are able to remain active, for example, this supports and sustains them as they try to develop and maintain feelings of coping and wellbeing in early motherhood. However, the findings of the studies discussed here make clear that this is easier where there are both the financial resources to purchase and access the facilities or classes or equipment, but also the positive support of perhaps childcare from a partner or extended family. In this way, the findings can help to build upon the model to show that there are personal circumstances which may affect individuals' ability to move between groups beyond the congruence of the groups with each other.

As discussed above, support from a partner or close relationship emerges as key for wellbeing in both the questionnaire and interview studies. There are multiple ways this supports identity transition and positive mental health. These include reinforcing the

decisions made by the new mother, and support for joining and maintaining the membership of new groups. The social support offering of the group is a key aspect of the positive effects of group membership in SIMIC (Jetten, Haslam, Iyer, & Haslam, 2009; Jetten & Pachana, 2012), and the women in the current study particularly found that groups where other mothers could provide importantly, but not only, company, and also reassurance that they were also finding an aspect of motherhood difficult, particularly helpful for wellbeing.

Proponents of SIMIC suggest that the social identity might be the best way to smooth the transition. Other members of the social group are “the best potential resource they have for coping with major life-changes: fellow group members” (Jetten et al., 2009, p. 141). There are clear benefits to being able to join social groups of mothers to wellbeing in this study. The groups such as Sure Start or NCT groups are often the key to this, but also includes the groups organised around activities for the children, or going for coffee together. Mothers often try to form and join groups, and many of the participants here are keen to stress how other mothers have helped them through to the new identity. But again, there are potential barriers to joining these kinds of groups also outlined in the study, which suggests it may be harder for women who have stigmatised status such as poverty, or even fewer resources such as access to a car, or live near public transport links. Abrams and Curran found that the low-income women in their study resisted joining groups (Abrams & Curran, 2009), which may stem from being unable to perceive oneself as a member, for example, of an NCT group.

SIMIC also suggests that the transition will be smoother where multiple pre-transition identities are held, and the pre transition identities are close to the post transition group that the individual joins. “Membership of alternative groups can be a source of support in times of change” in one identity group (Jetten et al., 2009, p. 150). They argue that it is because of the possibility of social support from those groups that this helps to mediate the impact of social identity change. And the multiple identities offer a stronger sense of “self-continuity” (Jetten et al., 2009, p. 151). The findings may contradict the first aspect of this theoretical framework as where mothers have other identities, such as working mother, this appeared to clash with the new identity, and was not a buffer of the stress experienced. However, the latter aspect is supported to an extent by the findings here:

where mothers did not particularly appear to value their pre-transition work identity for example, the clash of identities did not emerge to a great degree. For example some participants were pursuing voluntary work as breastfeeding counsellors, either instead of, or alongside returning to work, and there is evidence that volunteering is also associated with enhanced mental wellbeing (Thoits & Hewitt, 2001). However, for some of the women, the clash between their working identity and their new mothering identity was substantial, with concomitant impact on wellbeing. As Jetten and Pachana argue: “ given that our self-definition is bound up with these social identities, it is hardly surprising that breaking with groups or joining new groups can affect us deeply” (Jetten & Pachana, 2012, p. 99).

Whilst this might suggest that women who have cherished working identities will struggle with new motherhood the findings here do not suggest that this is inevitable: supportive employers who allow for a degree of flexibility in both the timing of any return to work, the nature of employment such as tasks and hours, and work where childcare is subsidised or where the earning potential is high enough to afford good childcare after the baby is born appear to mitigate some of the effects of the transition to a combined working and mothering identity, and some of the tensions that arise therein. Whilst this is positive in the way it supports wellbeing in mothers who have access to these conditions, mothers with lower financial resources again found this harder. Mothers who cherished their working identities but had to relinquish these due to financial circumstances, the cost of childcare or problems with employer flexibility appeared to sustain substantial impact to their wellbeing. Similarly, mothers who wished to stay at home but were unable to do so due to lack of money, experienced negative impact on their wellbeing due to being unable to fulfil their ideal mothering identity, such as being present for important milestones. It is important to note however, that the relationship between working outside the home and staying at home as a mother was very complex, and rarely as easily categorised as the examples outlined here. To whatever extent a mother enjoyed her job before having children, or felt that this was a crucial part of their identity, the cultural ideals regarding mothers and working are complex and difficult to navigate for women. There is a dual and contradictory pressure exerted around cultural narratives to be both working, and within the ‘intensive mothering’ paradigm to be at home to care

for children (Budds et al., 2017), and encompassing all of this, to be enjoying it all. Inevitably, how this is navigated this will impact on wellbeing, and the findings of the study show this to be to an extent linked to the resources, both financial and social, that can be mobilised.

Joining a new social group is stressful, and this study supports the SIMIC model in that the old identities and possible clash between the two are important and have implications for wellbeing in the transition period. This may explain why some of the participants found a second or third baby 'easier': they have already joined the group 'mother'. But these findings also offer an opportunity for the SIMIC model to be expanded, by considering further the social circumstances of both those joining the group, for example women living in poverty, or in restricted financial circumstances, how these hinder joining new groups, being able to access the groups, and how the broader cultural norms of the groups that are being moved into and joined, and are operating within. How do these factors facilitate and hinder people moving between social groups and social identities, and in turn, how does this impact on their personal identity and wellbeing?

SIMIC tells us that the more identities an individual holds, the more these will provide a buffer against change during a transition in one area of life. However, this may represent the limits of its applicability to the transition to motherhood: the totality of this identity transition means that it changes a woman's relationship to perhaps all of her group identities held prior to becoming a mother. This totality of impact on identity change might, along with the ways our relationships to social structures and circumstances prescribe our ability to move between groups, may be an interesting area for future exploration.

5.3.4 Dominant cultural narratives of motherhood

As outlined in Chapter 1, the perception of 'motherhood' in western societies is dominated by 'cultural ideals': systems of ideas and representations of motherhood as it 'should' be, which are pervasive. Research has shown that women do not even need to subscribe to these ideals themselves in order to be affected by them when becoming mothers, and to feel subsequent impact on their mental wellbeing (Henderson et al., 2016). The predominant cultural narrative of motherhood in societies such as the UK and USA is 'intensive mothering' characterised by being focussed upon the child, to the

exclusion of other activities, undertaken with deference to expert opinion, and requiring a high level of emotional and financial investments (Budds et al., 2017; Henderson et al., 2016). This financial investment can relate to the outlay needed in order to maintain the appearance of 'ideal motherhood' (Henderson et al., 2016). Using this lens, the role of the socio-economic position of mothers in shaping their identities can be further understood (Kehily, 2014). For example, Kehily found that the teenage mothers in her study felt the need to purchase items to demonstrate, "privileging the needs of their child over their own, and displaying this to potentially judgemental others" (Kehily, 2014, p. 236).

Cultural narratives and maternal identity may offer further explanation for the consequences of being poor to maternal mental wellbeing. It is clear that there is felt to be a need among the new mothers in the study to mobilise resources to build social contacts. This may be to maintain current social groups where these already include mothers, such as attending baby showers and affording the gifts, paying for entrance to activities with children, often at prohibitive prices, or affording or being able to access public transport for these. Abrams and Curran found that lower financial resources make women who have postnatal depression feel worse, that they are unable to provide what their children 'need' and therefore questioned whether they were 'good' mothers (Abrams & Curran, 2011).

Work adds another layer to this relationship: having to return to work before other new mums in the social group may have the effect of cutting mothers off from these groups in turn, perhaps before membership is fully established. Whilst the link between poor social support from a close relationship and poverty was not explained by the findings from the qualitative study, it was clear from those women who did not have this kind of support that it was detrimental to their wellbeing, and led to explicitly expressed anxiety and stress. Good support from partners did not only mean obvious benefits, such as being less tired if partners attended to children in the night, for example. It also meant that they supported key decisions, and therefore the new mothering identity, and the ideal of 'doing your best' for the child.

The findings from both studies also demonstrate that it is not only very poor women who cannot afford the basics that are struggling with reduced wellbeing levels, there is a need to also understand the ways in which these narratives impinge on women who can afford

to purchase what is necessary to support and bolster her parenting identity, and feel the results of the consequent social approval. Clearly, women who are poor and cannot afford food will feel a very real and imminent sense of threat to their wellbeing which is not solely attributable to their not achieving a 'good mother' identity, although it could be argued that this will add another layer to this stress beyond being unable to meet basic physical needs. But the quantitative study demonstrates that wellbeing decreases significantly over the transition from being pregnant to early motherhood, and whilst this decrease is greater in women who are poor, it does not reach statistical significance. The findings from the qualitative study suggest that this is not as simple as there being something other than social circumstances at play here. Women who were apparently financially comfortable in terms of the 'basics' still expressed worry at missing out on certain preparation activities, equipment or baby activities due to expense. This may relate to the tenets of intensive mothering which suggest 'success' is measured by children reaching developmental and academic milestones. The tensions around work and childcare as outlined above are also keenly felt, as they may be perceived as in contravention of the ideals of self-sacrifice and child at the centre. Working identities may be felt to be at such odds, and therefore incompatible with the 'intensive mothering' dominant discourse that the transition itself becomes problematic. The findings from the qualitative study indicate that the working or career identity was synonymous with the 'true self' for some of the women in the study. This tension is therefore very difficult to resolve without some impact on the mother's mental wellbeing: she can give up what she feels to be entwined with her 'true self' or she can be a 'good' mother. It cannot be wondered at, therefore, that these impossible models of what mothers 'should' do, can impact considerably upon their wellbeing.

Intensive mothering is also characterised as involving deference to expert advice and explanations (Budds et al., 2017). This also has interesting implications when compared with the findings from the study, and may explain to some extent why the dissonance sometimes experienced by new mothers between themselves and health professionals is so damaging to wellbeing. One of the mothers in the study explicitly stated her 'trust' in medical and health professionals prior to becoming a mother, this was a widely held belief, and women who then felt that they were being criticised by health professionals

felt this keenly. It not only potentially damages the new identity and nascent confidence in it, but also contravenes the ideals of dearly held expert backing for decision making. The wider literature demonstrates that mothers often work to manage their relationships with health professionals, so that they will be regarded as “the perfect patient” (Eri, Bondas, Gross, Janssen, & Green, 2015, p. e63; Thorstensson, Andersson, Israelsson, Ekström, & Hertfelt Wahn, 2016) and that adherence to weight gain charts and critical attitudes of health professionals weakened mothers’ confidence (Harrison, Hepworth, & Brodribb, 2018). Interestingly, in the Harrison study, women were best placed to resist judgement when they were able to instead accept the opinions of someone else offering support (Harrison et al., 2018), such as a partner.

5.4 Conclusions and recommendations for further research

The findings from both of the studies presented here therefore suggest that a problematic transition to motherhood, with the resultant impact on wellbeing, may be related to a mother’s ability to mobilise resources to support her new identity. These may not necessarily be financial, instead social resources such as supportive partnerships, peers, and relationships with health professionals can assuage a lack of financial resources, equally scarce social resources are in turn related to poverty and financial restrictions. Being able to access resources such as having enough money to afford the basics, or in the form of support from a partner or close relationship allows for the building and maintenance of positive mental wellbeing in the transition to motherhood.

5.4.1 Implications of these findings for policy and practice

The profound combined effect of a lack of social support and poverty on new mothers’ mental wellbeing clearly indicates that broadly, policies are needed to address the substantial and growing inequality in the UK. 25% of children are growing up in poverty in the UK, and a long term economic policy of ‘austerity’ (reduced spending on public services) is exacerbating and amplifying its effects on the poorest people (Hastings, Bailey, Bramley, Gannon, & Watkins, 2015; Office for National Statistics, 2015b). Within this broader political context, however, there may be local actions that can be taken to mitigate some of these effects, and to facilitate mental wellbeing in women who are poor, or who struggle with low levels of personal social support.

5.4.1.1 Personal social support

The findings reported here indicate that social support from a close person that is expected to provide support through difficult times can mitigate the effects of poverty on mental wellbeing. This is supported by the qualitative findings, which showed that support from, for example, husbands could bolster confidence in a new mother's identity. Policies which promote personal relationships may include those which bolster flexible working patterns for partners of women in early motherhood, allowing them to attend crucial appointments to offer support, for example. This may serve to have a more significant impact on poorer women, whose partners may not be in the kinds of jobs that traditionally offer this flexibility.

Services which support relationships specifically in times of transition such as the transition to parenthood could be useful, particularly where these are developed with concern for women who might have restricted time and financial resources, to avoid the risk of further compounding inequalities in this area. Further to this, closer and more intensive support from health care professionals or services for women becoming mothers who do not have partners, or a close person supporting them may also be beneficial. This may need to go beyond practical support to advocating for women's choices and decisions around their children to be effective in bolstering mental wellbeing, as this appears from the findings of the study to be closely linked.

5.4.1.2 Health professionals and interaction with women becoming mothers

There are several implications from the findings of these studies with women becoming mothers that may be of interest to those who organise and deliver health services to them.

Health professionals may feel frustration in the face of the structural issues, such as poverty, the women they care for face but there may be ways in which health policies around the delivery of care, and the practice which emanates from this, can offset some of the effects of poverty. The results of the quantitative study suggest that support (albeit here from a close relationship) can mitigate some of these effects, and the qualitative study supports this with evidence from the effects of wider social support from peer networks, and the effects of health professionals. The findings here show that there was a large value placed on continuity of care and a case load approach to antenatal care by the

women in the qualitative study. The care that they received in labour had a profound impact on how they felt about themselves as mothers, and therefore their mental wellbeing in the early weeks of motherhood. Even where a carefully considered birth plan could not be adhered to, and technological intervention was unavoidable, excellent, supportive care, which involved the mother in decision-making served to increase her confidence in herself and her wellbeing. Conversely, a mother who felt as if she was not involved in decisions or listened to described her birth experience and the impact of it as traumatic.

Health professionals also play a pivotal role in how mothers feel about their developing identity through feeding support, advice, and weighing clinics. As outlined above this is a locus of fundamental tension within the development of the mother's identity, and her confidence in her role. There is an opportunity here to place the needs of the mother nearer the centre of this care. The mothers in this study felt strongly that their own knowledge of their babies was subjugated to that of 'objective' measures of baby weight gain, and the quantitative targets therein. The minimising of their knowledge and expertise had implications not only for their wellbeing, but also for their intentions to engage with health professionals in the future. This should be taken into consideration in designing the delivery of these services to women who may be lost in the future with regards to public health intervention opportunities with themselves and their children.

5.4.1.3 Community support

Positive social support from friends has a vital role in supporting maternal mental health but at a time of profound identity transition loss of friendships associated with 'old' identities may occur. If social support can mediate the relationship between poverty and mental wellbeing, and is of such fundamental importance for the smooth transition to motherhood and mental wellbeing at the time, then these are clearly findings with implications for services, and how mothers can access the types of support they need.

Children's Centres are part of the 'Sure Start' initiative, introduced in 1999 in the United Kingdom, by the then New Labour Government. The intention was to concentrate government spending into services aimed at 'early intervention': to support facilities and services for families with children under five years of age. Furthermore, whilst the services, such as outreach and childcare, were intended to be universal in access, the

siting of the facilities was deliberately in poorer areas, in these 'Children's Centres' (Glass, 1999).

More recently, cuts in local government spending have resulted in the 're-organisation' of the Children's Centres in Portsmouth, which brought about the closure of three within the city (Puffett & Woods, 2016). These centres were heavily used by the mothers in this study, regardless of social circumstances. Many mentioned the trepidation they felt for themselves and others in the wake of funding cuts that had led to these closures in the Portsmouth area. This concern may be heightened for poor women, who may not be able to instead afford the paid for activities that are seen as part of the ideal of provision for new babies. Swimming, singing, massage, or even regular attendance at cafes is costly; therefore, accessing the social networks that are fundamental for wellbeing at this time requires considerable financial resources. The Children's centres offered free groups, and the health visitor clinics were also often located at these. Where these have been re-organised, they are now run from fewer locations, and are clearly more difficult for some women to reach. An evident implication for policy and practice from these findings is the need for much more widely accessible, free, provision of mother, or parent, and baby groups and opportunities to meet and socialise across the city. The reduction of the availability of these kinds of services represents a threat to the mental wellbeing of mothers in Portsmouth, with disproportionate effects for those mothers with difficult financial circumstances. These activities are fundamental to the wellbeing and wider health of new mothers, and should not be perceived as trivial. This will include women who do not live in poverty, but that also may struggle with finding additional money or transport for these activities, and services should be designed with this in mind.

Working mothers may be disproportionately affected by the inability to access services that are provided for women and babies, and to maintain fledgling but supportive relationships. This may then represent a 'double' identity challenge for women who are required to pause work while in early motherhood, then return to work before they have fully developed the support networks they need for this role. They then often face discrimination in the workplace, particularly if returning part-time. Services to support all mothers would include the possibility of some groups and services being offered at the weekends, or early evenings to accommodate this.

5.4.1.4 Fitness, health and recommendations to pregnant women

Staying active and getting outside were key elements that facilitated and maintained wellbeing among the women in the qualitative study. This would also link with the SIMIC model: that being able to maintain key elements of pre transition identity are crucial for a smoother transition. Many women in the study valued being able to be active in both pregnancy and early motherhood, but the barriers to doing so emerge across issues such as paying for and gaining access to such activities, and practical social support from a partner or extended family with issues such as childcare. There may also be health professional support needs here, to support women's understanding that in low risk pregnancy there are not safety risks associated with physical activity. There are clearly health benefits beyond mental wellbeing for taking up and maintaining participation in physical activity. Policies and services should be designed to encourage and support women to be able to do this regardless of their ability to pay.

5.4.2 Suggestions for future research

The quantitative questionnaire study reported here was a small study. It would be useful for measurement of new mother's wellbeing to be repeated in a larger, more representative study sample, to ascertain if the relationships between poverty, social support, and positive mental health still hold.

As personal social support resulting from partnerships or other close relationships emerged as key from both of the empirical studies, it is important to understand why women living in poverty felt themselves to receive lower levels of social support from this source, when becoming mothers. As outlined above, there is evidence of a link between poverty and poorer relationship quality, but perceived social support levels within a relationship are of particular importance to the transition to motherhood. Related to this may be the reasons why social support decreased across both groups from pregnancy to early motherhood, and these should be investigated further.

The Social Identity Model of Identity Change, supported by the findings of these studies, also suggests that there is benefit in being able to maintain as much of any pre-transition social identity/ies as possible. It has been discussed above that becoming a mother is a total experience, which appears to impact on any or all social identities already held, it

would be beneficial therefore to design groups and services which might support friendships and networks formed in pregnancy across to early motherhood, which then may be easier to sustain in the face of further children or returning to work. This would suggest that instead of separate, possibly disjointed, antenatal groups and postnatal groups, that women could join a group in early to mid-pregnancy which would then perhaps be supported by a midwife or health visitor to keep meeting as one group into the early motherhood (and beyond) of all the members. This might help to mitigate the fractured feeling of losing touch with peers when they have their babies earlier or later, or return to work at differing times.

6 Appendix A: NHS Ethical Opinion



Health Research Authority

London - Hampstead Research Ethics Committee

Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Tel: 0207 104 8009

25 May 2016

Ms Louise Baxter
[REDACTED]
[REDACTED]
[REDACTED]

Dear Ms Baxter

Study title: Quality of life and mental wellbeing in pregnant women and new mothers in Portsmouth: the effect of poverty.
REC reference: 15/LO/1629
Amendment number: 3: 11/04/2016
Amendment date: 13 April 2016
IRAS project ID: 181157

The above amendment was reviewed at the meeting of the Sub-Committee held on 02 May 2016 by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

There were no ethical issues raised.

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

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

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

15/LO/1629:	Please quote this number on all correspondence
--------------------	---

Yours sincerely



Signed on behalf of Miss Stephanie Ellis Chair

E-mail: nrescommittee.london-hampstead@nhs.net

Enclosures: List of names and professions of members who took part in the review

Copy to: Ms Kate Greenwood, Portsmouth Hospitals NHS Trust

Denise Teasdale

London - Hampstead Research Ethics Committee

**Attendance at Sub-Committee of the REC meeting on 02 May
2016**

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Miss Stephanie Ellis	Former Civil Servant	Yes	
Mrs Wendy Spicer	Pharmacist	Yes	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Miss Amber Ecclestone	REC Assistant

7 Appendix B: HRA Approval Letter



Health Research Authority

Ms Louise Baxter
[REDACTED]
[REDACTED]
[REDACTED]

Email: hra.approval@nhs.net

10 October 2016

Dear Ms Baxter

Letter of HRA Approval for a study processed through pre-HRA Approval systems

Study title: **Quality of life and mental wellbeing in pregnant women and new mothers in Portsmouth: the effect of poverty.**

IRAS project ID: 181157

Thank you for your request for HRA Approval to be issued for the above referenced study.

I am pleased to confirm that the study has been given **HRA Approval**. This has been issued on the basis of an existing assessment of regulatory compliance, which has confirmed that the study is compliant with the UK wide standards for research in the NHS.

The extension of HRA Approval to this study on this basis allows the sponsor and participating NHS organisations in England to set-up the study in accordance with HRA Approval processes, with decisions on study set-up being taken on the basis of capacity and capability alone.

If you have submitted an amendment to the HRA between 23 March 2016 and the date of this letter, this letter incorporates the HRA Approval for that amendment, which may be implemented in accordance with the amendment categorisation email (e.g. not prior to REC Favourable Opinion, MHRA Clinical Trial Authorisation etc., as applicable). If the submitted amendment included the addition of a new NHS organisation in England, the addition of the new NHS organisation is also approved and should be set up in accordance with HRA Approval processes (e.g. the organisation should be invited to assess and arrange its capacity and capability to deliver the study and confirm once it is ready to do so).

Participation of NHS Organisations in England

Please note that full information to enable set up of participating NHS organisations in England is not provided in this letter, on the basis that activities to set up these NHS organisations is likely to be underway already.

Page 1 of 3

The sponsor should provide a copy of this letter, together with the local document package and a list of the documents provided, to participating NHS organisations in England that are being set up in accordance with [HRA Approval Processes](#). It is for the sponsor to ensure that any documents provided to participating organisations are the current, approved documents.

For non-commercial studies the local document package should include an appropriate [Statement of Activities and HRA Schedule of Events](#). The sponsor should also provide the template agreement to be used in the study, where the sponsor is using an agreement in addition to the Statement of Activities. Participating NHS organisations in England should be aware that the Statement of Activities and HRA Schedule of Events for this study have not been assessed and validated by the HRA. Any changes that are appropriate to the content of the Statement of Activities and HRA Schedule of Events should be agreed in a pragmatic fashion as part of the process of assessing, arranging and confirming capacity and capability to deliver the study. If subsequent NHS organisations in England are added, an amendment should be submitted to the HRA..

For commercial studies the local document package should include a validated industry costing template and the template agreement to be used with participating NHS organisations in England.

It is critical that you involve both the research management function (e.g. R&D office and, if the study is on the NIHR portfolio, the LCRN) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

After HRA Approval

In addition to the document, “*After Ethical Review – guidance for sponsors and investigators*”, issued with your REC Favourable Opinion, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the [HRA website](#), and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the [HRA website](#).

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at <http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/>.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please email the HRA at hra.approval@nhs.net. Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>.

If you have any queries about the issue of this letter please, in the first instance, see the further information provided in the question and answer document on the [HRA website](#).

Your IRAS project ID is **181157**. Please quote this on all correspondence.

Yours sincerely

Mark O'Toole

HRA Approval Team

Email: hra.approval@nhs.net

Copy to: *Denise Teasdale*
Ms Kate Greenwood, Portsmouth Hospitals NHS Trust

8 Appendix C: Participant Information Sheet (Birth Cohort Study)



Wellbeing and quality of life in pregnant women and mothers in Portsmouth

Participant Information Sheet

We would like to invite you to take part in our research study, looking at well-being and quality of life for women during pregnancy and after the baby has been born. Before you decide we would like you to understand why the research is being done and what it would involve for you. Please talk to others about the study if you wish, and ask us if there is anything that is not clear.

Researcher contact details:

Louise Baxter

02392844479

Louise.Baxter@port.ac.uk

Supervisor contact details:

Dr Isobel Ryder

Isobel.Ryder@port.ac.uk

What is this project all about?

We are interested in finding out what the quality of life and wellbeing is of pregnant women and new mothers in Portsmouth. We would like to know if this changes from pregnancy to motherhood, and if there are any reasons for low or high levels of wellbeing or quality of life, such as having lots of social support, or not having enough money to take part in certain activities.

Who is organising the study?

This is an independent research study carried out as part of a Doctorate studentship sponsored by the School of Health Sciences and Social Work at the University of Portsmouth. The study is part of the Portsmouth Birth Cohort, which has ethical approval from the NHS.

Why have I been invited to take part?

You have been invited to take part as you are pregnant and/or due to give birth in the study recruitment period 2015 – 2016.

Do I have to take part?

It is completely **up to you** to decide whether to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form.

If you decide not to take part this won't have any affect at all on your care.

If you decide to take part and later change your mind, you can withdraw any time. However, we will include the data we would have collected from

you up until then.

What will happen if I take part?

You will be asked to complete two questionnaires: one when you are about 30 weeks pregnant, and the next about four months after the birth of your baby.

A researcher will arrange to meet you at a place and time that is convenient for you, to explain a bit more about the research, and ask you the questions in the first questionnaire. It is also possible to complete this questionnaire online. The second questionnaire will be available online.

In the first questionnaire you will be asked questions about the support you have received in pregnancy and about how you have been feeling in pregnancy, looking at both positive and negative. In this questionnaire you will also be asked about the things and activities you don't have or do, either because you don't want, or can't afford them. You will also be asked to fill out a 'quality of life' form, which will ask you about the areas of your life most affected by the pregnancy, positive and negative, and how important each of these are.

In the second questionnaire (3 - 4 months after the birth of your baby,) you will be asked the same questions on support, how you are feeling and also to complete the 'quality of life' form a second time. This is so we can see if and how any of these things may have changed over time.

Will my taking part in the study be kept confidential?

Your responses to the questionnaires will be stored securely, and will only be seen by researchers working on the study. You will have a unique number in

the study, which will be used to link your questionnaires instead of your name.

Your responses to the questionnaires will be anonymous, and your name will not be used in any reports or publications to come from the research.

Your responses are confidential and anonymous. However, if a researcher finds out during the questionnaires that you or someone else is being harmed or exploited, or you are at risk of harming yourself, it is their duty to pass on this information to a relevant agency in confidence.

You will have the right to check the accuracy of data held about you, and correct any errors.

If you join the study, it is possible that some of the data collected may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant.

What are the benefits of taking part?

The aim of this project is to understand the experience of having a baby for women in the Portsmouth area, the good and bad aspects of this. At the end of the research study the results will be written up in a report (thesis) and articles may be written for journals and magazines. Talks may also be given about the research findings. We hope that this will help other researchers, health professionals and policy makers come up with new ideas and interventions to support pregnant women and mothers.

Researchers will provide information on services or support groups available for pregnant women or new mothers.

Are there any disadvantages to taking part?

You will need to give up some time to complete the questionnaires.

It is possible you may find some topics upsetting, and if you do, researchers will have contact numbers to support groups and services that may be useful to you.

You can call any of the following directly to book an appointment:

Talking Change Direct: 02392 892 920

First steps to Talking Change: Milton Children's Centre: 02392 827392

Highbury Children's Centre: 02392 377610

The contact number for the Health Visitors is 02392 684545. You can phone this number directly if you would like to book an appointment.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher or their supervisor, who will do their best to answer your questions

1. Louise Baxter 023 928 444 79, louise.baxter@port.ac.uk
2. Dr Isobel Ryder Isobel.Ryder@port.ac.uk

If you remain unhappy and wish to complain formally, you can do this by contacting: Dr Chris Markham, Interim Head of School, Health Sciences and Social Work, University of Portsmouth, PO1 2FR

Thank you for taking the time to read this information sheet. If you decide to participate in the study you will be given a copy of the information sheet to keep, and you will be asked to read and sign a consent form.

9 Appendix D: Consent Form (Birth Cohort Study)



Wellbeing and quality of life in pregnant women and new mothers in Portsmouth

Consent Form

Please initial box

1. I confirm that I have read and understand the information sheet dated April 2016 (version 8) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time from completing the surveys without giving any reason.

3. I understand that the data collected during the study will only be shared within the research team.

4. I understand that the data from the study will be stored securely, and retained for 10 years, after which they will be destroyed.

5. I give permission for the researchers to use my text/ email contact to send me reminders to complete the surveys (these won't be given to anyone outside the research team, or used for any other reason)

6. I agree to my anonymised data being used in scientific publications and presentations

7. I agree to take part in the above study.

Name of Participant:

Date:

Signature:

Name of Person taking consent:

Date:

Signature:

10 Appendix E: Pregnancy Questionnaire



Quality of life and well-being of pregnant women and mothers in Portsmouth

Pregnancy Questionnaire (30 weeks)

Louise Baxter

Researcher contact details:

Louise Baxter

02392844479

Louise.Baxter@port.ac.uk

Supervisor contact details:

Dr Isobel Ryder

Isobel.Ryder@port.ac.uk

Wellbeing and quality of life of pregnant women and mothers in Portsmouth

Thank you for agreeing to take part in this study of the quality of life and well-being of pregnant women and mothers in Portsmouth.

The purpose of the study is to look at the following questions:

- 1) What are the quality of life and wellbeing levels in pregnant women and mothers in Portsmouth? Does this change from pregnancy to motherhood, and how?
- 2) What are some of the reasons for low or high wellbeing and quality of life, such as being poor or having lots of social support?

In this questionnaire there are questions on topics such as how much support you receive, how you are feeling in yourself, and what aspects of life as a pregnant woman are important to you or having the most impact on you. There are also questions on the types of things and activities you can afford.

If you have any questions about the research then please ask the interviewer, or please feel free to contact the co-ordinating researcher: Louise Baxter (tel: 02392844479 or email: louise.baxter@port.ac.uk)

Q1. Wellbeing in pregnancy

We'd like to start by asking some questions about positive mental health in pregnancy:

Below are some statements about feelings and thoughts

Please tick the box that best describes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

Warwick-Edinburgh Mental Well-being Scale (WEMWBS) © NHS Health Scotland, University of Warwick and University of Edinburgh, 2006, all rights reserved.

Q2. The Mother- Generated Index

On the following page is an exercise to measure your 'quality of life'. In the **first** step, please write down eight areas of your life that have been affected by being pregnant. If this isn't the first time you have been pregnant, please answer with this current experience in mind.

These experiences/ areas of your life can be **positive** or **negative**, or perhaps **both** or **neither** one or the other.

Some examples other mothers have given: How they feel about themselves, how they feel about their baby, how they feel about their relationship with their partner or other family members, physical or emotional issues (good or bad), how they feel about going back to work, how they feel about their social life.

These are only examples – we want you to say what **you** feel.

In Step 2, please score each area for how you have been affected by this over the **past MONTH**, **with 0 being the worst** (you couldn't feel any worse than this) and **10 being the best** (you couldn't feel any better than this).

In Step 3 – please think about how important these areas are to your quality of life. You have 20 points to allocate. You don't have to allocate points to an item if you don't want to. **Give more points to the areas you think are most important.**

THE MOTHER-GENERATED INDEX ©

A QUALITY OF LIFE ASSESSMENT

Step 1:

Identifying areas

We would like you to think of the most important areas of your life that have been affected by having a baby. These can be **POSITIVE** or **NEGATIVE**, or perhaps **BOTH**, or **Neither** really one nor the other. Please write up to eight areas in the boxes below, and indicate if you think the area is positive, negative, or neither of these.

- Examples other mothers have given are:
- How they feel about themselves
 - How they feel about their baby
 - How their feel about their relationship with their partner or other family members
 - Physical or emotional issues (good or bad)
 - How they feel about going back to work
 - How they feel about their social life
- These are only examples.
We want you to say what **you** feel.

Please circle whether you think this point is Positive, Negative, or Both / Neither

Step 2:

Allocating points

Now please score the areas you mentioned in Step 1. This score should reflect how you have been affected by this area over the past MONTH.

Please place a cross along the line in each case:
0 is the worst - you couldn't feel any worse than this
10 is the best - you couldn't feel any better than this

Worst

Best

Please think how important these areas are to you quality of life. You have **20 points** to allocate. You don't have to allocate points to an item if you don't want to. **Give more points to the areas you think are most important.** Write the points in the boxes below.

	Positive Negative Both / Neither	0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10	
	Positive Negative Both / Neither	0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10	
	Positive Negative Both / Neither	0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10	
	Positive Negative Both / Neither	0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10	
	Positive Negative Both / Neither	0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10	
	Positive Negative Both / Neither	0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10	
	Positive Negative Both / Neither	0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10	

Remember: points in Step 3 must add up to 20

Next, we would like to ask you some questions on the type of support you receive. Please tick the box that most closely describes your experience:

Q3. Social Support

	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree
Perceived available support				
There are some people who truly like me	1	2	3	4
Whenever I am not feeling well, other people show me that they are fond of me	1	2	3	4
Whenever I am sad there are people that cheer me up	1	2	3	4
There is always someone there for me when I need comforting	1	2	3	4
I know some people upon whom I can always rely	1	2	3	4
When I am worried, there is someone who helps me	1	2	3	4
There are people who offer me help when I need it	1	2	3	4
When everything becomes too much for me to handle, others are there to help me	1	2	3	4
Need for support				
When I am down, I need someone who boosts my spirits	1	2	3	4
It is important for me always to have someone who listens to me	1	2	3	4
Before making any important decisions, I absolutely need a second opinion	1	2	3	4
I get along best without any outside help	4	3	2	1
Support seeking				
In critical situations, I prefer to ask others for their advice	1	2	3	4
Whenever I am down, I look for someone to cheer me up again	1	2	3	4

When I am worried, I reach out to someone to talk to	1	2	3	4
	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree
If I do not know how to handle a situation, I ask others what they would do	1	2	3	4
Whenever I need help, I ask for it	1	2	3	4
Actually received support				
Think about the person who is closest to you such as your spouse, partner, friend and so on. How did this person react to you during the last week?				
This person showed me that he/she loves and accepts me	1	2	3	4
This person was there when I needed him/ her	1	2	3	4
This person comforted me when I was feeling bad	1	2	3	4
This person left me alone	4	3	2	1
This person did not show much empathy for my situation	4	3	2	1
This person complained about me	4	3	2	1
This person took care of many things for me	1	2	3	4
This person made me feel valued and important	1	2	3	4
This person expressed concern about my condition	1	2	3	4
This person assured me that I can rely completely on him/ her	1	2	3	4
This person helped me find something positive in my situation	1	2	3	4
This person suggested activities that might distract me	1	2	3	4
This person encouraged me not to give up	1	2	3	4

This person took care of things I could not manage on my own	1	2	3	4
In general I am very satisfied with the way this person behaved	1	2	3	4

Q1 Standards of living

We are interested in whether your standard of living affects how you feel during pregnancy and motherhood. For each following statement please choose EITHER 1) Yes, I have this 2) We would like to have this but cannot afford it at the moment 3) We don't want or need this at the moment

		Yes, we have this	We would like to have this but cannot afford it at the moment	We don't want or need this at the moment
A	Keep your home adequately warm	1	2	3
B	Two pairs of all-weather shoes for each adult	1	2	3
C	Enough money to keep your home in a decent state of repair	1	2	3
D	A holiday away from home for one week a year, not staying with relatives	1	2	3
E	Replace any worn out furniture	1	2	3
F	A small amount of money to spend each week on yourself not on your family	1	2	3
G	Regular savings (of £10 a month) for rainy days or retirement	1	2	3
H	Insurance of contents of dwelling	1	2	3
I	Have friends or family for drink or meal at least once a month	1	2	3
J	A hobby or leisure activity	1	2	3

K	Replace or repair broken electrical goods such as refrigerator or washing machine	1	2	3
----------	--	----------	----------	----------

Q4b Household income: Please could you look at the bands below and tell me which group represents your households total income from all these sources before deductions for income tax, National Insurance etc.

Group	WEEKLY	MONTHLY	ANNUAL
A	Up to £49	Up to £216	Up to £2,599
B	£50 up to £99	£217 up to £432	£2,600 up to £5,199
C	£100 up to £199	£433 up to £866	£5,200 up to £10,399
D	£200 up to £299	£867 up to £1,299	£10,400 up to £15,599
E	£300 up to £399	£1,300 up to £1,732	£15,600 up to £20,799
F	£400 up to £499	£1,733 up to £2,166	£20,800 up to £25,999
G	£500 up to £599	£2,167 up to £2,599	£26,000 up to £31,199
H	£600 up to £699	£2,600 up to £3,032	£31,200 up to £36,399
I	£700 up to £799	£3,033 up to £3,466	£36,400 up to £41,599
J	£800 up to £899	£3,467 up to £3,899	£41,600 up to £46,799
K	£900 up to £999	£3,900 up to £4,332	£46,800 up to £51,999
L	£1000 or more	£4,333 or more	£52,000 or more

Thank you very much for taking part in this study, and answering the questions in this survey.

If you have any other questions, please don't hesitate to call or email us:

Louise Baxter:

TEL: 02392844479

EMAIL: Louise.baxter@port.ac.uk

11 Appendix F: Postnatal Questionnaire



Wellbeing and quality of life of pregnant women and mothers in Portsmouth

Postnatal questionnaire – 3-4 months

Louise Baxter

Researcher contact details:

Louise Baxter

02392844479

Louise.Baxter@port.ac.uk

Supervisor contact details:

Dr Isobel Ryder

Isobel.Ryder@port.ac.uk

Wellbeing and quality of life of pregnant women and mothers in Portsmouth

Thank you for agreeing to take part in this study of the quality of life and well-being of pregnant women and mothers in Portsmouth.

The purpose of the study is to look at the following questions:

- 3) What are the quality of life and wellbeing levels in pregnant women and mothers in Portsmouth? Does this change from pregnancy to motherhood, and how?
- 4) What are some of the reasons for low or high quality of life or wellbeing, such as being poor or having lots of social support?

In this questionnaire there are questions on topics such as how much support you receive, what aspects of life as a mother are important to you or having the most impact on you, and positive mental health.

If you have any questions about the research then please ask the interviewer, or please feel free to contact the co-ordinating researcher: Louise Baxter (tel: 02392844479 or email: louise.baxter@port.ac.uk)

Q1. Wellbeing in pregnancy

We'd like to start by asking some questions about positive mental health in pregnancy:

Below are some statements about feelings and thoughts

Please tick the box that best describes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

Warwick-Edinburgh Mental Well-being Scale (WEMWBS) © NHS Health Scotland, University of Warwick and University of Edinburgh, 2006, all rights reserved.

Q2. The Mother- Generated Index

On the following page is an exercise to measure your 'quality of life'. In the **first** step, please write down eight areas of your life that have been affected by having a baby. If this isn't the first time you have had a baby, please answer with this current experience in mind.

These experiences/ areas of your life can be **positive** or **negative**, or perhaps **both** or **neither** one or the other.

Some examples other mothers have given: How they feel about themselves, how they feel about their baby, how they feel about their relationship with their partner or other family members, physical or emotional issues (good or bad), how they feel about going back to work, how they feel about their social life.

These are only examples – we want you to say what **you** feel.

In Step 2, please score each area for how you have been affected by this over the **past MONTH**, **with 0 being the worst** (you couldn't feel any worse than this) and **10 being the best** (you couldn't feel any better than this).

In Step 3 – please think about how important these areas are to your quality of life. You have 20 points to allocate. You don't have to allocate points to an item if you don't want to. **Give more points to the areas you think are most important.**

THE MOTHER-GENERATED INDEX ©

A QUALITY OF LIFE ASSESSMENT

Step 1:

Identifying areas

Step 2:

Scoring each area

Step 3:

Allocating points

<p>We would like you to think of the most important areas of your life that have been affected by having a baby. These can be POSITIVE or NEGATIVE, or perhaps BOTH, or Neither really one nor the other. Please write up to eight areas in the boxes below, and indicate if you think the area is positive, negative, or neither of these.</p>	<p>Now please score the areas you mentioned in Step 1. This score should reflect how you have been affected by this area over the past MONTH.</p> <p>Please place a cross along the line in each case: 0 is the worst - you couldn't feel any worse than this 10 is the best - you couldn't feel any better than this</p> <p>Worst Best</p>	<p>Please think how important these areas are to you quality of life. You have 20 points to allocate. You don't have to allocate points to an item if you don't want to. Give more points to the areas you think are most important. Write the points in the boxes below.</p>
<p>Examples other mothers have given are:</p> <ul style="list-style-type: none"> • How they feel about themselves • How they feel about their baby • How their feel about their relationship with their partner or other family members • Physical or emotional issues (good or bad) • How they feel about going back to work • How they feel about their social life <p>These are only examples. We want you to say what you feel.</p>	<p>Please circle whether you think this point is Positive, Negative, or Both / Neither</p>	
<p>Positive Negative Both / Neither</p>	<p>0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10</p>	
<p>Positive Negative Both / Neither</p>	<p>0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10</p>	
<p>Positive Negative Both / Neither</p>	<p>0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10</p>	
<p>Positive Negative Both / Neither</p>	<p>0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10</p>	
<p>Positive Negative Both / Neither</p>	<p>0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10</p>	
<p>Positive Negative Both / Neither</p>	<p>0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10</p>	
<p>Positive Negative Both / Neither</p>	<p>0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10</p>	
<p>Positive Negative Both / Neither</p>	<p>0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10</p>	

Remember: points in Step 3 must add up to 20

Next, we would like to ask you some questions on the type of support you receive. Please tick the box that most closely describes your experience:

Q3. Social Support

	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree
Perceived available support				
There are some people who truly like me	1	2	3	4
Whenever I am not feeling well, other people show me that they are fond of me	1	2	3	4
Whenever I am sad there are people that cheer me up	1	2	3	4
There is always someone there for me when I need comforting	1	2	3	4
I know some people upon whom I can always rely	1	2	3	4
When I am worried, there is someone who helps me	1	2	3	4
There are people who offer me help when I need it	1	2	3	4
When everything becomes too much for me to handle, others are there to help me	1	2	3	4
Need for support				
When I am down, I need someone who boosts my spirits	1	2	3	4
It is important for me always to have someone who listens to me	1	2	3	4
Before making any important decisions, I absolutely need a second opinion	1	2	3	4
I get along best without any outside help	4	3	2	1
Support seeking				
In critical situations, I prefer to ask others for their advice	1	2	3	4
Whenever I am down, I look for someone to cheer me up again	1	2	3	4
When I am worried, I reach out to someone to talk to	1	2	3	4

	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree
If I do not know how to handle a situation, I ask others what they would do	1	2	3	4
Whenever I need help, I ask for it	1	2	3	4
Actually received support				
Think about the person who is closest to you such as your spouse, partner, friend and so on How did this person react to you during the last week?				
This person showed me that he/she loves and accepts me	1	2	3	4
This person was there when I needed him/ her	1	2	3	4
This person comforted me when I was feeling bad	1	2	3	4
This person left me alone	4	3	2	1
This person did not show much empathy for my situation	4	3	2	1
This person complained about me	4	3	2	1
This person took care of many things for me	1	2	3	4
This person made me feel valued and important	1	2	3	4
This person expressed concern about my condition	1	2	3	4
This person assured me that I can rely completely on him/ her	1	2	3	4
This person helped me find something positive in my situation	1	2	3	4
This person suggested activities that might distract me	1	2	3	4
This person encouraged me not to give up	1	2	3	4
This person took care of things I could not manage on my own	1	2	3	4
In general I am very satisfied with the way this person behaved	1	2	3	4

Thank you very much for taking part in this study, and answering the questions in this survey.

If you have any other questions, please don't hesitate to call or email us.

Louise Baxter:

TEL: 02392844479

EMAIL: louise.baxter@port.ac.uk

12 Appendix G: Science Faculty Ethics Approval (Qualitative Study)



White Swan Road

Science Faculty Ethics Committee

Science Faculty Office
University of Portsmouth

St Michael's Building

PORTSMOUTH

PO1 2DT

Louise Baxter
School of Health Sciences and Social
Work
University of Portsmouth

T: 023 9284 3379
ethics-sci@port.ac.uk

Date 13th May 2016

Louise.baxter@port.ac.uk

FAVOURABLE ETHICAL OPINION WITH MINOR CONDITIONS

Study Title: Subjective wellbeing and quality of life in pregnant women and new mothers in Portsmouth: the effect of poverty and material deprivation

Reference Number: **SFEC 2016-045** (Please quote this in any correspondence)

Thank you for **submitting your application to the Science Faculty Ethics Committee (SFEC) dated 9th May 2016** in accordance with current procedures³.

I am pleased to inform you that SFEC was content to grant a favourable ethical opinion of the above research on the basis described in the submitted documents listed at Annex A, and subject to standard general conditions⁴ and the following minor conditions/recommendations:

1. The PI should alter the PIS to state that the interviews themselves are not anonymous however the data collected will be anonymised (if the change doesn't affect the NHS REC)

³ Procedures for Ethical Review, Science Faculty Ethics Committee, University of Portsmouth, October 2012 (to be updated).

⁴ After ethical review – Guidance for researchers (Please read).

There is **no requirement** for you to confirm these conditions have been met in writing to the committee.

Please note that the favourable opinion of SFEC does not grant permission or approval to undertake the research. Management permission or approval must be obtained from any host organisation, including the University of Portsmouth or supervisor, prior to the start of the study.

Wishing you every success in your research

Yours sincerely,



1

Dr Simon Kolstoe
Vice-Chair Science Faculty Ethics Committee

Information:

Isobel Ryder - First Supervisor

Holly Shawyer - Faculty Administrator

Statement of compliance

SFEC is constituted in accordance with the Governance Arrangements set out by the University of Portsmouth

After Ethical Review

If unfamiliar, please consult the advice After Ethical Review² which gives detailed guidance on reporting requirements for studies with a favourable opinion, including, notifying substantial amendments, notification of serious breaches of the protocol, progress reports and notifying SFEC of the end of the study.

Feedback

You are invited to give your view of the service that you have received from the Faculty Ethics Committee. If you wish to make your views known please contact the administrator at ethics-sci@port.ac.uk

ANNEX A Documents reviewed

The documents ethically reviewed for this application (SFEC 2016-045)

<i>Document</i>	<i>Version</i>	<i>Date</i>
A - Signed_LB_Compiled Science Faculty Ethics Review Form	1	09/05/2016

ANNEX B - After ethical review - Guidance for researchers Guidance for researchers

1. This document sets out important guidance for researchers with a favourable opinion from a University of Portsmouth Ethics Committee. Please read the guidance carefully. A failure to follow the guidance could lead to the committee reviewing and possibly revoking its opinion on the research.
2. It is assumed that the research will commence within 1 year of the date of the favourable ethical opinion or the start date stated in the application, whichever is the latest.
3. The research must not commence until the researcher has obtained any necessary management permissions or approvals – this is particularly pertinent in cases of research hosted by external organisations. The appropriate head of department should be aware of a member of staff’s research plans.
4. If it is proposed to extend the duration of the study beyond that stated in the application, the Ethics Committee must be informed.
5. If the research extends beyond a year then an annual progress report must be submitted to the Ethics Committee.
6. When the study has been completed the Ethics Committee must be notified.
7. Any proposed substantial amendments must be submitted to the Ethics Committee for review. A substantial amendment is any amendment to the terms of the application for ethical review, or to the protocol or other supporting documentation approved by the Committee that is likely to affect to a significant degree:
 - (a) the safety or physical or mental integrity of participants
 - (b) the scientific value of the study
 - (c) the conduct or management of the study.
- 7.1 A substantial amendment should not be implemented until a favourable ethical opinion has been given by the Committee.
8. Researchers are reminded of the University’s commitments as stated in the [Concordat to Support Research Integrity](#) viz:

- maintaining the highest standards of rigour and integrity in all aspects of research
 - ensuring that research is conducted according to appropriate ethical, legal and professional frameworks, obligations and standards
 - supporting a research environment that is underpinned by a culture of integrity and based on good governance, best practice and support for the development of researchers
 - using transparent, robust and fair processes to deal with allegations of research misconduct should they arise
 - working together to strengthen the integrity of research and to reviewing progress regularly and openly
9. In ensuring that it meets these commitments the University has adopted the [UKRIO Code of Practice for Research](#). Any breach of this code may be considered as misconduct and may be investigated following the University [Procedure for the Investigation of Allegations of Misconduct in Research](#). Researchers are advised to use the [UKRIO checklist](#) as a simple guide to integrity.

13 Appendix H: Participant Information Sheet (Qualitative Study)



Wellbeing and quality of life in mothers in Portsmouth

Participant Information Sheet

We would like to invite you to take part in our research study, looking at well-being and quality of life for women during pregnancy and after the baby has been born. Before you decide we would like you to understand why the research is being done and what it would involve for you. Please talk to others about the study if you wish, and ask us if there is anything that is not clear.

Researcher contact details:

Louise Baxter

02392844479

Louise.Baxter@port.ac.uk

Supervisor contact details:

Dr Isobel Ryder

Isobel.Ryder@port.ac.uk

What is this project all about?

We are interested in finding out what the quality of life and wellbeing is of new mothers in Portsmouth, during both pregnancy and early motherhood. We would like to know if this changes from pregnancy to motherhood, and if there are any reasons for low or high levels of wellbeing or quality of life, such as having lots of social support, or not having enough money to take part in certain activities.

Who is organising the study?

This is an independent research study carried out as part of a Doctorate studentship sponsored by the School of Health Sciences and Social Work at the University of Portsmouth.

Why have I been invited to take part?

You have been invited to take part as you are the mother of a baby aged 2 or under.

Do I have to take part?

It is completely **up to you** to decide whether to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form.

If you decide to take part and later change your mind, you can withdraw any time. However, we will include the data we would have collected from you up until then.

What will happen if I take part?

You will be asked to take part in one interview with a researcher. This will probably last up to about an hour. In the interview the researcher will ask about your experience of becoming a mother, and your wellbeing during pregnancy and motherhood, looking at both the positive and the negative.

A researcher will arrange to meet you at a place and time that is convenient for you, to explain a bit more about the research, and conduct the interview.

Will my taking part in the study be kept confidential?

The interview will be tape-recorded, with your permission, and will then be typed out by the researcher. The recording and the written version will only be seen by researchers working on the study.

Your responses in the interview will be anonymised, and your name will not be used in any reports or publications to come from the research. Quotes from your comments in the interview may be used in the research report, but this will have a pseudonym (a 'made up' name) beside them, never your real name. People you know may be able to recognise you from the quotes used.

Your responses are confidential and will be anonymised. However, if a researcher finds out during the interviews that you or someone else is being harmed or exploited, or you are at risk of harming yourself, it is their duty to pass on this information to a relevant agency in confidence.

You will have the right to check the accuracy of data held about you, and correct any errors.

If you join the study, it is possible that some of the data collected may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant.

What are the benefits of taking part?

The aim of this project is to understand the experience of having a baby and becoming a mother for women in the Portsmouth area, the good and bad aspects of this. At the end of the research study the results will be written up in a report (thesis) and articles may be written for journals and magazines. Talks may also be given about the research findings. We hope that this will help other researchers, health professionals and policy makers come up with new ideas and interventions to support pregnant women and mothers.

Researchers will provide information on services or support groups available for pregnant women or new mothers.

Are there any disadvantages to taking part?

You will need to give up some time to take part in the interviews.

It is possible you may find some topics upsetting, and if you do, researchers will have contact numbers to support groups and services that may be useful to you.

You can call any of the following directly to book an appointment:

Talking Change Direct: 02392 892 928

First steps to Talking Change: Milton Children's Centre: 02392 827392 (Face to face, Weds am, crèche available)

Met Centre at St Mary's: 02392 680135 (Monday pm).

The contact number for the Health Visitors is 02392 684545. You can phone this number directly if you would like to book an appointment.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher or their supervisor, who will do their best to answer your questions

Louise Baxter 023 928 444 79, louise.baxter@port.ac.uk

Dr Isobel Ryder Isobel.Ryder@port.ac.uk

If you remain unhappy and wish to complain formally, you can do this by contacting: Dr Chris Markham, Head of School, Health Sciences and Social Work, University of Portsmouth, PO1 2FR

Thank you for taking the time to read this information sheet. If you decide to participate in the study you will be given a copy of the information sheet to keep, and you will be asked to read and sign a consent form.

14 Appendix I: Consent Form (Qualitative Study)



Wellbeing and quality of life in pregnant women and new mothers in Portsmouth

Consent Form

Please initial box

8. I confirm that I have read and understand the information sheet dated July 2015 (version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
9. I understand that my participation is voluntary and that I am free to withdraw at any time from completing the surveys, forum, or entire study, without giving any reason.
10. I understand that the data collected during the study will only be shared within the research team.
11. I understand that the data from the study will be stored securely, and retained for 10 years, after which they will be destroyed.
12. I give permission for the researchers to use my text/ email contact to send me reminders to complete the surveys/ blog (these won't be given to anyone outside the research team, or used for any other reason)
13. I understand that any quotes used in reports or presentations will be anonymised. People that I know may recognise me from the quotes used.
14. I agree to my anonymised data being used in scientific publications and presentations
15. I agree to take part in the above study.

Name of Participant:

Date:

Signature:

Name of Person taking consent:

Date:

Signature:

15 Appendix J: Interview Topic Guide

- How did you feel overall in pregnancy?
 - How was your pregnancy different or similar to how you expected it to be?
 - Do you think any of these differences/ similarities affected early motherhood for you?
- How did you feel overall in early motherhood?
 - (if appropriate given earlier response) What were 'good' days or periods of time in early motherhood like?
 - What contributed to 'good' days or periods of time, what made you 'happy' at this point?
 - (if appropriate given earlier response) What were 'bad' days or periods of time in early motherhood like?
 - What contributed to 'good' days or periods of time, what made you feel this way at this point?
- Has this/ how has this changed as your baby has got older?
[Depending on age of the child]
- How are you feeling overall now your baby is older?
 - (if appropriate given earlier response) What are 'good' days or periods of time now like?
 - What contributes to 'good' days or periods of time, what makes you 'happy' at this point?
 - (if appropriate given earlier response) What are 'bad' days or periods of time in early motherhood like?
 - What contributes to 'good' days or periods of time, what makes you feel this way at this point?
- I'm really interested in the relationship between financial circumstances and how you felt during pregnancy and early motherhood. I know that this might be a sensitive area, but all that you say will be confidential and I will not judge anything you say.
 - I was just wondering whether you could explore with me the whether your financial circumstances ever had an impact on how you felt during pregnancy? (And then in early motherhood).
- Please could you describe what you think 'being a mother' is?

- Do you feel like a 'mother' yet?
 - [if yes] when did you start to feel that way?
 - What makes you feel the way you do?

16 Appendix K: Coding Manual

UNCERTAINTY

Preparation and anticipation: Preparatory tasks for motherhood, including practical tasks such as classes or purchases, but also those preparing for a change of life/ identity

- Preparing for labour, preparing for motherhood, being unable to prepare, lack of warnings/ preparation by other people, consumption/ purchases ahead of/ in support of motherhood, financial preparation/ saving, antenatal classes, excitement, nerves, fear, anticipation, 'ideal' preparation
 - "I was surprised at how much I was affected by his arrival, in terms of, I don't think anyone can prepare you, can they?"
 - "I was very realistic, and a little bit, like my other half would say that I was quite negative and think the worst all the time but for me it was about being prepared"
 - "I think the fact that I was already positive helped a lot, I mean, don't get me wrong, it's still very, very, difficult, and a humungous adjustment, but very, erm, I was very lucky that I started off feeling healthy as opposed to going n already feeling exhausted"

Control: Being in control, preferring to have control, threat to control over life from impending motherhood, control over labour/ decision making

- Being a 'control freak', perfectionism/ perfectionist, removal of control (babies, health professionals)
 - "I am a bit of a control freak, babies don't, that doesn't work for babies, so I knew that was going to be really difficult"
 - "I think, before him, in my job, I've, in everything, I was such a perfectionist, everything had to be perfect"

- “I kind of had it in my head that it would just slot into my already existing life, and it very much doesn’t [laughs] erm, so yeah, I think that the lack of control was the thing that pulled me down”

CLASHING IDENTITIES

Loss: Defined as feeling lost, uncertain of who you are, losing a ‘true’ self.

- Loss, lost (emotional/ physical), haze/ hazy.
 - “So I was completely lost for the first few months...I was just in such a bubble”
 - “Like it was a big haze of boobs and nappies, and not really knowing what was going on”
 - “Like a complete daze”

‘I still want to be myself’: Defined as either trying to recover some of the disrupted pre-motherhood identity, often work or career related, or working out which aspects of this to try and retain; some of the struggle to retain aspects of a ‘true self’, and to work out what that might be.

- Work, working identity, choices over whether to return to work, conflict with work identity, (un)supportive work bosses, (un)supportive work environment, financial pressures over returning to work, work/ gender roles, working mother stigma, ‘old’ me, ‘true’ me, volunteering role.
 - “I’m the breadwinner which is a whole other thing, cos I find that really annoying, the pressure of being the breadwinner is rubbish when you want to be a mum, because I have to go out to work”
 - “I was very lucky to be in a position where I didn’t have to work. I do now, erm, but I didn’t have to work, or go back to work early, it was sort of open

ended as and when I wanted to go, and I do think that was a massively positive thing”

- “When I’m feeling logical I just think, well I can go back to it, but then there’s other times where I think, argh, you know, panic, am I wast- have I ruined my career and that’s it now and I’m just gonna be on the rubbish heap”

NAVIGATING JUDGEMENT

Unhelpful support: defined as support received, but not perceived by the mothers as helpful support, the type that they needed or met their needs at the time. For example, the support from health professionals was not always felt to be benign or beneficial, despite how it might have been intended.

- Negative support from health professionals, undermined knowledge, undermined experience, restricted support, lack of/ poor information/ advice, disengagement from/ resistance to health professionals, lack of trust/ undermined trust (health professionals), breastfeeding/ feeding criticism, baby weight concerns
 - “I only breastfed for the first sort of couple of months, erm, and I do think that sometimes women have, you’re chastised for that, almost, and its...you almost have to defend yourself to health visitors and all of these people, and...you’re desperate to do what’s right for your child, absolutely desperate to”
 - “The judgemental side I’m not keen on with some health visitors, not all health visitors, but some do come across as very, if you’re not doing it this exact way, then you’re wrong, and they almost make out you’re harming your child”

Judgements of others: defined as the critical and negative judgements and opinions,

perceived or received, from extended family, friends, partners or peers, where these groups conclude the mothers are not doing things 'right' or to a 'recognised' standard

- Negative support/ criticism, expectations, judgements (mothers, partners, peers), resistance to judgement, unhelpful mothers/ fathers/ partners/ friends, living up to ideals.
 - "I think it comes down to the sleep thing with him really and un, I would you know I might speak to my mum, and but she was always saying you, we used to do controlled crying, and you all slept"
 - "The older women...they're like, oh, we were in hospital for 5 days after our babies, it was the done thing, we didn't go back to work, you stayed at home and I was like I don't have that luxury, I have bills to pay"
 - "I felt erm like I couldn't really go to the breastfeeding groups cos I was also bottle feeding and I felt like I wouldn't be, I just really feel like I would erm, so I didn't go a huge amount"

'I felt like I had to be super': defined as self-judgement and self-criticism felt by the mothers

- Self-judgement, self-criticism, shame, self-stigma, guilt, competent partners
 - "So I kind of went through like a period of just really beating myself up, just feeling like not good enough for him really, and feeling quite low, and anxious and just not myself at all"
 - "I think...it's the constant feeling of...it should be like this all the time, why is it that I'm not able, why am I having a good day today, why was yesterday so awful?"
 - "Like with my partner, he's really laid back, and I was watching him do it all, and thinking, why is he so good at this, its really annoying"

RESISTING AND REBUILDING

Staying active and getting outside: defined as the coping strategies and activities that mothers undertook in order to support their own wellbeing in the transition to motherhood

- Getting outside/ getting out of the house, Gym, yoga, Groups (encompassing postnatal, singing, signing, swimming), baby massage, cafes, exercise as important for wellbeing
 - “We do go to groups, which I quite enjoy, not stay and plays, they’re too loud, little churchy groups”
 - “getting out, I think actually, even on those days where I was feeling horrendous in the morning, and had had no sleep erm, felt just awful, just getting out the house made all the difference”
 - “so I went to lots of playgroups, erm, and which is where I've met lots of other mums, and so, I think I've got a much better social life than I ever had really, before he was born which, which is nice, erm, and [baby] enjoys socialising with other kids so, he has fun, and enjoys himself at these playgroups, get to play with different toys and stuff, I think him being happy rubs off on me, makes me happy”

Positive support: Defined as the support for mothers that met their needs for support and help in the transition, the support that helped them to construct maintain or increase feelings of wellbeing and happiness

- Helpful mothers/ fathers, supportive partners, supportive siblings, supportive health professionals, support from friends, shared experiences, supportive work cultures/ employers

- “my midwife was a stern but kind lady, which is kind of what you want from a midwife who was always very, always had enough time to answer my questions, of which I had many”
- “I had a couple of key friends that, if it hadn't been for them through the really anxious times of pregnancy, I'd have really struggled, just because I needed to be able to say those things out loud and not be judged”
- “And my husband was given the time off work that he's entitled to come to the classes, to come to the scans, erm there's certain things they have to let Dad's come to and he was allowed to do all of that which was really nice, and we shared the experiences together”

Resilience and self-acceptance: Defined as the many ways in which the mothers had coped with and ‘bounced back’ from and actively resisted the difficulties and pressures and dominant cultural pressures felt upon their identities and wellbeing that came as part of becoming mothers. Not an ‘end state’; more of a ‘work-in-progress’.

- Motherhood as an identity, future self, contentment, love, future children, feeling happy, complete, gratitude, resilience, ‘can’t imagine life without’
 - “I can’t imagine life without her now”
 - “I feel like more of a mum than I am anything else. I feel like mum becomes everything, and [I am] someone else. I think you, the kind of loss of my own identity is really significant?”
 - “I did have emotional times, but kind of didn't let the children see that, sort of thing, I just carried on erm, but yeah sometimes I felt erm, this is hard but I've got to get on with it, then another time, I never kind of gave up or anything...yeah”

17 Appendix L: Research Ethics Review Checklist UPR16



FORM UPR16

Postgraduate Research Student (PGRS) Information		Student ID	UP758642	
PGRS Name:	Louise Baxter			
Department:	SHSSW	First Supervisor:	Dr Isobel Ryder	
Start Date: (or progression date for Prof Doc students)	October 2014			
Study Mode and Route:	Part-time <input checked="" type="checkbox"/>	MPhil <input type="checkbox"/>	MD <input type="checkbox"/>	
	Full-time <input type="checkbox"/>	PhD <input checked="" type="checkbox"/>	Professional Doctorate <input type="checkbox"/>	

Title of Thesis:	Positive mental wellbeing in the transition to motherhood: the impact of poverty and social support
Thesis Word Count: (excluding ancillary data)	68,856

If you are unsure about any of the following, please contact the local representative on your Faculty Ethics Committee for advice. Please note that it is your responsibility to follow the University's Ethics Policy and any relevant University, academic or professional guidelines in the conduct of your study

Although the Ethics Committee may have given your study a favourable opinion, the final responsibility for the ethical conduct of this work lies with the researcher(s).

UKRIO Finished Research Checklist:

(If you would like to know more about the checklist, please see your Faculty or Departmental Ethics Committee rep or see the online version of the full checklist at: <http://www.ukrio.org/what-we-do/code-of-practice-for-research/>)

a) Have all of your research and findings been reported accurately, honestly and within a reasonable time frame?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
b) Have all contributions to knowledge been acknowledged?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
c) Have you complied with all agreements relating to intellectual property, publication and authorship?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
d) Has your research data been retained in a secure and accessible form and will it remain so for the required duration?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
e) Does your research comply with all legal, ethical, and contractual requirements?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

Candidate Statement:

I have considered the ethical dimensions of the above named research project, and have successfully obtained the necessary ethical approval(s)

Ethical review number(s) from Faculty Ethics Committee (or from NRES/SCREC):		REC ref:15/LO/1629 SFEC 2016-045
If you have <i>not</i> submitted your work for ethical review, and/or you have answered 'No' to one or more of questions a) to e), please explain below why this is so:		
<div style="background-color: #cccccc; height: 20px; width: 50px; margin-bottom: 5px;"></div>		
Signed (PGRS):	<i>Louise Barclay</i>	Date: 01/12/2018

18 References

- Abrams, L. S., & Curran, L. (2009). "And you're telling me not to stress?" A Grounded theory study of postpartum depression symptoms among low-income mothers. *Psychology of Women Quarterly*, 33(3), 351–362. <https://doi.org/10.1111/j.1471-6402.2009.01506.x>
- Abrams, L. S., & Curran, L. (2011). Maternal identity negotiations among low-income women with symptoms of postpartum depression. *Qualitative Health Research*, 21(3), 373–385. <https://doi.org/10.1177/1049732310385123>
- Afflerback, S., Anthony, A. K., Carter, S. K., & Grauerholz, L. (2014). Consumption Rituals in the Transition to Motherhood. *Gender Issues*, 31(1), 1–20. <https://doi.org/10.1007/s12147-014-9115-0>
- Akyn, B., Ege, E., Kocoolu, D., Demiroeren, N., & Yilmaz, S. (2009). Quality of life and related factors in women, aged 15-49 in the 12-month post-partum period in Turkey. *Journal of Obstetrics and Gynaecology Research*, 35(1), 86–93. <https://doi.org/10.1111/j.1447-0756.2008.00870.x>
- Alderdice, F., McNeill, J., & Lynn, F. (2013). A systematic review of systematic reviews of interventions to improve maternal mental health and well-being. *Midwifery*, 29(4), 389–399. <https://doi.org/10.1016/j.midw.2012.05.010>
- Arendell, T. (2000). Conceiving and Investigating Motherhood: The Decade's Scholarship. *Journal of Marriage and Family*, 62(4), 1192–1207. <https://doi.org/10.1111/j.1741-3737.2000.01192.x>
- Athan, A. (2011). *Postpartum flourishing: Motherhood as opportunity for positive growth and self-development*. *Dissertation Abstracts International: Section B: The Sciences and Engineering*. ProQuest Information & Learning, US. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psych&AN=2011-99240-385&site=ehost-live>
- Athan, A., & Reel, H. L. (2015). Maternal psychology: Reflections on the 20th anniversary of Deconstructing Developmental Psychology. *Feminism & Psychology*, 25(3), 311–325. <https://doi.org/10.1177/0959353514562804>
- Bahrami, N., Karimian, Z., Bahrami, S., & Bolbolhaghghi, N. (2014). Comparing the postpartum quality of life between six to eight weeks and twelve to fourteen weeks after delivery in iran. *Iranian Red Crescent Medical Journal*, 16(7), e16985–e16985. <https://doi.org/10.5812/ircmj.16985>
- Bailey, L. (1999). Refracted Selves? A Study of Changes in Self-Identity in the Transition to Motherhood. *Sociology*, 33(2), 335–352. <https://doi.org/10.1177/S0038038599000206>
- Barbarosa dos Santos, A., Santos, K., Monteiro, G., Rezende do Prado, P., & Lameira Maciel Amaral, T. (2015). Self-esteem and quality of life in a series of pregnant women attended in a public health network. *Cogitare Enfermagem*, 20(2), 389–396

8p. Retrieved from

<http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=108328184&site=ehost-live>

- Barclay, L., Everitt, L., Rogan, F., Schmied, V., & Wyllie, A. (1997). Becoming a mother - an analysis of women's experience of early motherhood. *Journal of Advanced Nursing*, 25(4), 719–728. <https://doi.org/10.1046/j.1365-2648.1997.t01-1-1997025719.x>
- Barimani, M., Vikström, A., Rosander, M., Forslund Frykedal, K., & Berlin, A. (2017). Facilitating and inhibiting factors in transition to parenthood - ways in which health professionals can support parents. *Scandinavian Journal of Caring Sciences*, 31(3), 537–546. <https://doi.org/10.1111/scs.12367>
- Barry, M. M. (2009). Addressing the determinants of positive mental health: concepts, evidence and practice. *International Journal of Mental Health Promotion*, 11(3), 4–17. Retrieved from <http://hdl.handle.net/10379/2221>
- Bartley, M. (2004). *Health Inequality: An Introduction to Theories, Concepts and Methods*. Cambridge: Polity Press.
- Bartley, M. (2017). *Health inequality : an introduction to concepts, theories and methods* (Second). Cambridge: Polity Press. Retrieved from <http://eds.a.ebscohost.com/eds/detail/detail?vid=1&sid=b7e9d3bd-85a1-43be-aff2-828b63f08707%40sessionmgr4008&bdata=JnNpdGU9ZWRzLWxpdmU%3D#db=cat01619a&AN=up.1225445>
- Benzeval, M., Bond, L., Campbell, M., Egan, M., Lorenc, T., Petticrew, M., & Popham, F. (2014). *How does money influence health?* Retrieved from <https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/income-health-poverty-full.pdf>
- Berger, R. (2015). Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research*, 15(2), 219–234. <https://doi.org/10.1177/1468794112468475>
- Biesta, G. (2010). Pragmatism and the philosophical foundations of mixed methods research. In *Handbook of mixed methods in social and behavioral research* (pp. 95–117). Thousand Oaks: SAGE Publications, Inc. <https://doi.org/10.4135/9781506335193.n4>
- Bize, R., Johnson, J., & Plotnikoff, R. (2007). Physical activity level and health-related quality of life in the general adult population: A systematic review. *Preventive Medicine*, 45(6), 401–415. <https://doi.org/10.1016/j.YPMED.2007.07.017>
- Bodhare, T. N., Sethi, P., Bele, S. D., Gayatri, D., & Vivekanand, A. (2015). Postnatal quality of life, depressive symptoms, and social support among women in southern India. *Women & Health*, 55(3), 353–365. <https://doi.org/10.1080/03630242.2014.996722>
- Bogossian, F. E. (2007). Social support: proposing a conceptual model for application to midwifery practice. *Women and Birth : Journal of the Australian College of Midwives*, 20(4), 169–173. <https://doi.org/10.1016/j.wombi.2007.08.003>
- Bradshaw, J., & Finch, N. (2003). Overlaps in Dimensions of Poverty. *Journal of Social*

- Policy Jnl Soc. Pol*, 32(4), 513–525. <https://doi.org/10.1017/S004727940300713X>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Brunton, G., Wiggins, M., Oakley, A., & EPPI-Centre. (2011). *Becoming a mother : a research synthesis of women’s views on the experience of first time motherhood*. EPPI-Centre, Social Science Research Unit, Institute of Education, University of London. Retrieved from <https://eppi.ioe.ac.uk/cms/Default.aspx?tabid=3295>
- Budds, K., Hogg, M. K., Banister, E. N., & Dixon, M. (2017). Parenting agendas: An empirical study of intensive mothering and infant cognitive development. *The Sociological Review*, 65(2), 336–352. <https://doi.org/10.1177/0038026116672812>
- Buttner, M. M., Brock, R. L., & O’Hara, M. W. (2015). Patterns of women’s mood after delivery: A growth curve analysis. *Journal of Affective Disorders*, 174, 201–208. <https://doi.org/10.1016/j.jad.2014.11.022>
- Buttner, M. M., O’Hara, M. W., & Watson, D. (2012). The structure of women’s mood in the early postpartum. *Assessment*, 19(2), 247–256. <https://doi.org/10.1177/1073191111429388>
- Cameron, R. (2011). Mixed Methods Research: The Five Ps Framework. *The Electronic Journal of Business Research Methods*, 9(2), 96–108.
- Campos, A. C. S., Barbieri, M., Torloni, M. R., & Guazzelli, C. A. F. (2012). Does motherhood affect the quality of life of adolescents? *Journal Of Pediatric And Adolescent Gynecology*, 25(6), 380–383. <https://doi.org/10.1016/j.jpag.2012.07.003>
- Caunt, B. S., Franklin, J., Brodaty, N. E., & Brodaty, H. (2013). Exploring the Causes of Subjective Well-Being: A Content Analysis of Peoples’ Recipes for Long-Term Happiness. *Journal Of Happiness Studies*, 14(2), 475–499. <https://doi.org/10.1007/s10902-012-9339-1>
- Chang, S.-R., Chen, K.-H., Lin, M.-I., Lin, H.-H., Huang, L.-H., & Lin, W.-A. (2014). A repeated measures study of changes in health-related quality of life during pregnancy and the relationship with obstetric factors. *Journal of Advanced Nursing*, 70(10), 2245–2256 12p. <https://doi.org/10.1111/jan.12374>
- Cheng, C.-Y., & Pickler, R. H. (2010). Maternal psychological well-being and salivary cortisol in late pregnancy and early post-partum. *Stress and Health: Journal of the International Society for the Investigation of Stress*, 26(3), 215–224 10p. <https://doi.org/10.1002/smi.1285>
- Clark, A. M. (1998). The qualitative-quantitative debate: moving from positivism and confrontation to post-positivism and reconciliation. *Journal of Advanced Nursing*, 27(6), 1242–1249. <https://doi.org/10.1046/j.1365-2648.1998.00651.x>
- Cook, K., & Loomis, C. (2012). The Impact of Choice and Control on Women’s Childbirth Experiences. *The Journal of Perinatal Education*, 21(3), 158–168. <https://doi.org/10.1891/1058-1243.21.3.158>
- Cronin, A. M. (2015). ‘Domestic Friends’: Women’s Friendships, Motherhood and Inclusive

- Intimacy. *The Sociological Review*, 63(3), 662–679. <https://doi.org/10.1111/1467-954X.12255>
- Cummins, R. A. (2000). Personal Income and Subjective Well-being: A Review. *Journal of Happiness Studies*, 1(2), 133–158. <https://doi.org/10.1023/A:1010079728426>
- Currie, J. (2007). Leisure Studies Motherhood, stress and the exercise experience: freedom or constraint? <https://doi.org/10.1080/0261436042000251987>
- Currie, J. (2009). Managing Motherhood: Strategies Used by New Mothers to Maintain Perceptions of Wellness. *Health Care for Women International*, 30(7), 653–668. <https://doi.org/10.1080/07399330902928873>
- Currie, J. (2018). *Managing motherhood : a new wellness perspective*. Singapore: Springer Singapore.
- De Neve, J.-E., Diener, E., Tay, L., & Xuereb, C. (2013). *The objective benefits of subjective well-being*. London.
- De Schepper, S., Vercauteren, T., Tersago, J., Jacquemyn, Y., Raes, F., & Franck, E. (2016). Post-Traumatic Stress Disorder after childbirth and the influence of maternity team care during labour and birth: A cohort study. *Midwifery*, 32. <https://doi.org/10.1016/j.midw.2015.08.010>
- Dempsey, L., Dowling, M., Larkin, P., & Murphy, K. (2016). Sensitive Interviewing in Qualitative Research; Sensitive Interviewing in Qualitative Research. *Research in Nursing & Health*, 39, 480–490. <https://doi.org/10.1002/nur.21743>
- Diener, E., & Chan, M. Y. (2011). Happy People Live Longer: Subjective Well-Being Contributes to Health and Longevity. *Applied Psychology: Health and Well-Being*, 3(1), 1–43. <https://doi.org/10.1111/j.1758-0854.2010.01045.x>
- Diener, E., Heintzelman, S. J., Kushlev, K., Tay, L., Wirtz, D., Lutes, L. D., & Oishi, S. (2017). Findings all psychologists should know from the new science on subjective well-being. *Canadian Psychology/Psychologie Canadienne*, 58(2), 87–104. <https://doi.org/10.1037/cap0000063>
- Dodson, L. (2013). *Stereotyping Low-Wage Mothers Who Have Work and Family Conflicts*. *Journal of Social Issues* (Vol. 69). Retrieved from <https://spssi.onlinelibrary.wiley.com/doi/pdf/10.1111/josi.12014>
- Dolan, P., Peasgood, T., & White, M. (2008). Do we really know what makes us happy? A review of the economic literature on the factors associated with subjective well-being. *Journal of Economic Psychology*, 29(1), 94–122. <https://doi.org/10.1016/J.JOEP.2007.09.001>
- Drescher, K. M., Monga, M., Williams, P., Promecene-Cook, P., & Schneider, K. (2003). Perceived quality of life in pregnant adolescent girls. *American Journal Of Obstetrics and Gynecology*, 188(5), 1231–1233. <https://doi.org/10.1067/mob.2003.351>
- Duggan, L. (2012). *Transition to motherhood---A qualitative study of low income women's first term pregnancy experiences*. *Transition to Motherhood -- A Qualitative Study of Low Income Women's First Term Pregnancy Experiences*. University of South

Carolina. Retrieved from
<http://search.ebscohost.com/login.aspx?direct=true&db=cin20&AN=109858706&site=ehost-live>

- Eaton, K., Ohan, J., Stritzke, W. K., & Corrigan, P. (2016). Failing to Meet the Good Parent Ideal: Self-Stigma in Parents of Children with Mental Health Disorders. *Journal of Child & Family Studies*, 25(3), 3109–3123. <https://doi.org/10.1007/s10826-016-0459-9>
- Emmanuel, E., Creedy, D. K., St John, W., Gamble, J., & Brown, C. (2008). Maternal role development following childbirth among Australian women. *Journal Of Advanced Nursing*, 64(1), 18–26. <https://doi.org/10.1111/j.1365-2648.2008.04757.x>
- Emmanuel, E., St John, W., & Sun, J. (2012). Relationship between social support and quality of life in childbearing women during the perinatal period. *Journal of Obstetric, Gynecologic, and Neonatal Nursing : JOGNN / NAACOG*, 41(6), E62-70. <https://doi.org/10.1111/j.1552-6909.2012.01400.x>
- Eri, T. S., Bondas, T., Gross, M. M., Janssen, P., & Green, J. M. (2015). A balancing act in an unknown territory: A metasynthesis of first-time mothers' experiences in early labour. *Midwifery*, 31(3), e58–e67. <https://doi.org/10.1016/j.midw.2014.11.007>
- Fancourt, D., & Steptoe, A. (2018). Community group membership and multidimensional subjective well-being in older age. *Journal of Epidemiology and Community Health*, 72(5), 376–382. <https://doi.org/10.1136/jech-2017-210260>
- Fatemeh, A., Azam, B., & Nahid, M. (2010). Quality of life in pregnant women results of a study from Kashan, Iran. *Pakistan Journal of Medical Sciences*, 26(3), 692–697.
- Ferraro, K., & Wilkinson, L. (2013). Age, ageing and mental health. In C. Aneshenal, J. Phelan, & B. A (Eds.), *Handbook of the Sociology of Mental Health* (Second). Dordrecht: Springer.
- Field, A. P. (2009). *Discovering statistics using SPSS : (and sex and drugs and rock "n" roll)*. London: SAGE Publications.
- Fowles, E. (1996). Relationships among prenatal maternal attachment, presence of postnatal depressive symptoms, and maternal role attainment. *Journal of the Society of Pediatric Nurses*, 1(2), 75–82 8p. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cin20&AN=107388102&site=ehost-live>
- Friedli, L. (2009). *Mental health, resilience and inequalities*. Retrieved from <http://www.euro.who.int/pubrequest>
- Galbally, M., van IJzendoorn, M., Permezel, M., Saffery, R., Lappas, M., Ryan, J., ... Lewis, A. J. (2017). Mercy Pregnancy and Emotional Well-being Study (MPEWS): Understanding maternal mental health, fetal programming and child development. Study design and cohort profile. *International Journal of Methods in Psychiatric Research*, 26(4), e1558. <https://doi.org/10.1002/mpr.1558>
- Gebuza, G., Kaźmierczak, M., Mieczkowska, E., Gierszewska, M., & Kotzbach, R. (2014). Life satisfaction and social support received by women in the perinatal period.

Advances In Clinical And Experimental Medicine: Official Organ Wroclaw Medical University, 23(4), 611–619. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=25166447&site=ehost-live>

- Gichia, J. (2000). Mothers and others: African-American women's preparation for motherhood. *MCN: The American Journal of Maternal Child Nursing*, 25(2), 86–91 6p. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cin20&AN=107104705&site=ehost-live>
- Glass, N. (1999). Sure Start: the development of an early intervention programme for young children in the United Kingdom. *Children & Society*, 13(4), 257–264. <https://doi.org/10.1002/CHI569>
- Gordon, D. (2006). Principles: The concept and measurement of poverty. In *Poverty and social exclusion in Britain : the millennium survey*. Bristol: Policy.
- Green, J. M., & Baston, H. A. (2003). Feeling in Control During Labor: Concepts, Correlates, and Consequences. *Birth*, 30(4), 235–247. <https://doi.org/10.1046/j.1523-536X.2003.00253.x>
- Green, J. M., Coupland, V. A., & Kitzinger, J. V. (1990). Expectations, Experiences, and Psychological Outcomes of Childbirth: A Prospective Study of 825 Women. *Birth*, 17(1), 15–24. <https://doi.org/10.1111/j.1523-536X.1990.tb00004.x>
- Green, J. M., & Kafetsios, K. (1997). Positive experiences of early motherhood: Predictive variables from a longitudinal study. *Journal of Reproductive and Infant Psychology*, 15(2), 141–157. Retrieved from <http://www.tandfonline.com/doi/abs/10.1080/02646839708404540>
- Green, J., & Thorogood, N. (2018). *Qualitative methods for health research*. London: Sage Publications.
- Greene, J. C. (2008). Is Mixed Methods Social Inquiry a Distinctive Methodology? *Journal of Mixed Methods Research*, 2(2), 7–22. <https://doi.org/10.1177/1558689807309969>
- Grylka-Baeschlin, S., van Teijlingen, E., Stoll, K., & Gross, M. M. (2015). Translation and validation of the German version of the Mother-Generated Index and its application during the postnatal period. *Midwifery*, 31(1), 47–53. <https://doi.org/10.1016/j.midw.2014.05.002>
- Haas, J. S., Jackson, R. A., Fuentes-Afflick, E., Stewart, A. L., Dean, M. L., Brawarsky, P., & Escobar, G. J. (2005). Changes in the health status of women during and after pregnancy. *Journal of General Internal Medicine*, 20(1), 45–51. <https://doi.org/10.1111/j.1525-1497.2004.40097.x>
- Habel, C., Feeley, N., Hayton, B., Bell, L., & Zerkowitz, P. (2015). Causes of women's postpartum depression symptoms: Men's and women's perceptions. *Midwifery*, 31(7), 728–734. <https://doi.org/10.1016/J.MIDW.2015.03.007>
- Haga, S. M., Lynne, A., Slinning, K., & Kraft, P. (2012). A qualitative study of depressive symptoms and well-being among first-time mothers. *Scandinavian Journal Of Caring*

- Sciences*, 26(3), 458–466. <https://doi.org/10.1111/j.1471-6712.2011.00950.x>
- Haga, S. M., Ulleberg, P., Slinning, K., Kraft, P., Steen, T. B., & Staff, A. (2012). A longitudinal study of postpartum depressive symptoms: multilevel growth curve analyses of emotion regulation strategies, breastfeeding self-efficacy, and social support. *Archives of Women's Mental Health*, 15(3), 175–184. <https://doi.org/10.1007/s00737-012-0274-2>
- Hampshire County Council. The Castle, W. H. S. 8UJ; info@hants.gov.uk. (2017). Census Household Composition. Retrieved from http://www3.hants.gov.uk/factsandfigures/population-statistics/census_pages/census_information/pop_household_composition.htm
- Hanna, B. (2001). Negotiating motherhood: the struggles of teenage mothers. *Journal Of Advanced Nursing*, 34(4), 456–464. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=11380712&site=ehost-live>
- Haran, C., van Driel, M., Mitchell, B. L., & Brodribb, W. E. (2014). Clinical guidelines for postpartum women and infants in primary care—a systematic review. *BMC Pregnancy and Childbirth*, 14, 51. <https://doi.org/10.1186/1471-2393-14-51>
- Harrison, M., Hepworth, J., & Brodribb, W. (2018). Navigating motherhood and maternal transitional infant feeding: Learnings for health professionals. *Appetite*, 121, 228–236. <https://doi.org/10.1016/J.APPET.2017.11.095>
- Hastings, A., Bailey, N., Bramley, G., Gannon, M., & Watkins, D. (2015). *The cost of the cuts: The impact on local government and poorer communities*.
- Heale, R., & Twycross, A. (2015). Validity and reliability in quantitative studies. *Evidence-Based Nursing*, 18(3), 66–67. <https://doi.org/10.1136/eb-2015-102129>
- Helitzner-Allen, D., Makhambera, M., & Wangeli, A.-M. (1994). Obtaining sensitive information: the need for more than focus groups. *Reproductive Health Matters*, 2(3), 75–82.
- Henderson, A., Harmon, S., & Newman, H. (2016). The Price Mothers Pay, Even When They Are Not Buying It: Mental Health Consequences of Idealized Motherhood. *Sex Roles*, 74(11–12), 512–526. <https://doi.org/10.1007/s11199-015-0534-5>
- Holton, S., Fisher, J., & Rowe, H. (2010). Motherhood: is it good for women's mental health? *Journal of Reproductive & Infant Psychology*, 28(3), 223–239 17p. <https://doi.org/10.1080/02646830903487359>
- Howard, L. M., Ryan, E. G., Trevillion, K., Anderson, F., Bick, D., Bye, A., ... Pickles, A. (2018). Accuracy of the Whooley questions and the Edinburgh Postnatal Depression Scale in identifying depression and other mental disorders in early pregnancy. *The British Journal of Psychiatry*, 212(01), 50–56. <https://doi.org/10.1192/bjp.2017.9>
- Huber, M., Knottnerus, J. A., Green, L., Horst, H. van der, Jadad, A. R., Kromhout, D., ... Smid, H. (2011). How should we define health? *BMJ*, 343.
- Hueston, W. J., & Kasik-Miller, S. (1998). Changes in functional health status during

- normal pregnancy. *JOURNAL OF FAMILY PRACTICE*, 47(3), 209–212.
- Huppert, F. A. (2005). Positive mental health in individuals and populations. In F. A. Huppert, N. Baylis, & B. Keverne (Eds.), *The Science of Well-Being* (pp. 306–340). Oxford: Oxford University Press.
<https://doi.org/10.1093/acprof:oso/9780198567523.003.0012>
- Huppert, F. A. (2009). Psychological Well-being: Evidence Regarding its Causes and Consequences. *Applied Psychology: Health and Well-Being*, 1(2), 137–164.
<https://doi.org/10.1111/j.1758-0854.2009.01008.x>
- Ibanez, G., Blondel, B., Prunet, C., Kaminski, M., & Saurel-Cubizolles, M.-J. (2015). Prevalence and characteristics of women reporting poor mental health during pregnancy: Findings from the 2010 French National Perinatal Survey. *Revue D'Epidemiologie Et De Sante Publique*, 63(2), 85–95.
<https://doi.org/10.1016/j.respe.2015.02.023>
- Jetten, J., Haslam, S. A., Iyer, A., & Haslam, C. (2009). Turning to Others in Times of Change. In *The Psychology of Prosocial Behavior* (pp. 139–156). Oxford, UK: Wiley-Blackwell. <https://doi.org/10.1002/9781444307948.ch7>
- Jetten, J., & Pachana, N. (2012). Not wanting to grow old: A Social Identity Model of Identity Change (SIMIC) analysis of driving cessation among older adults. In *The Social Cure: Identity, Health and Wellbeing*. Hove: Psychology Press.
- Jirapaet, V. (2001). Factors Affecting Maternal Role Attainment among Low-Income, Thai, HIV-Positive Mothers. *Journal of Transcultural Nursing*, 12(1), 25–33.
<https://doi.org/10.1177/104365960101200104>
- Jomeen, J. (2004). The importance of assessing psychological status during pregnancy, childbirth and the postnatal period as a multidimensional construct: A literature review. *Clinical Effectiveness in Nursing*, 8(3–4), 143–155.
<https://doi.org/10.1016/J.CEIN.2005.02.001>
- Kehily, M. J. (2014). For the love of small things: Consumerism and the making of maternal identities. *Young Consumers*, 15(3), 227–238. <https://doi.org/10.1108/YC-09-2013-00396>
- Kenway, P. (2008). *Addressing in-work poverty*. York. Retrieved from <https://www.jrf.org.uk/report/addressing-work-poverty>
- Keyes, C. L. M. (2002). The mental health continuum: from languishing to flourishing in life. *Journal of Health and Social Behavior*, 43(2), 207–222. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/12096700>
- Kiehl, E. M., & White, M. A. (2003). Maternal adaptation during childbearing in Norway, Sweden and the United States. *Scandinavian Journal Of Caring Sciences*, 17(2), 96–103. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=12753509&site=ehost-live>
- Koniak-Griffin, D. (1993). Maternal role attainment. *Image--The Journal Of Nursing Scholarship*, 25(3), 257–262 6p. Retrieved from

<http://search.ebscohost.com/login.aspx?direct=true&db=cin20&AN=107432892&site=ehost-live>

- Kurtz Landy, C., Sword, W., & Valaitis, R. (2009). The experiences of socioeconomically disadvantaged postpartum women in the first 4 weeks at home. *Qualitative Health Research, 19*(2), 194–206. <https://doi.org/10.1177/1049732308329310>
- Laney, E. K., Hall, M. E. L., Anderson, T. L., & Willingham, M. M. (2015). Becoming a mother: The influence of motherhood on women's identity development. *Identity: An International Journal of Theory and Research, 15*(2), 126–145. <https://doi.org/10.1080/15283488.2015.1023440>
- Leigh, B., Milgrom, J., Bennett, H., Josefsson, A., O'Hara, M., Swain, A., ... Heron, J. (2008). Risk factors for antenatal depression, postnatal depression and parenting stress. *BMC Psychiatry, 8*(1), 24. <https://doi.org/10.1186/1471-244X-8-24>
- Lewis, S. E., & Nicolson, P. (1998). Talking about early motherhood: Recognizing loss and reconstructing depression. *Journal of Reproductive and Infant Psychology, 16*(2–3), 177–197. <https://doi.org/10.1080/02646839808404567>
- Lindquist, A., Kurinczuk, J. J., Redshaw, M., & Knight, M. (2010). Experiences, utilisation and outcomes of maternity care in England among women from different socio-economic groups: findings from the 2010 National Maternity Survey. *National Maternity Survey. BJOG, 122*, 1610–1617. <https://doi.org/10.1111/1471-0528.13059>
- Loignon, C., Gottin, T., Dupéré, S., & Bedos, C. (2018). General practitioners' perspective on poverty: a qualitative study in Montreal, Canada. *Family Practice, 35*(1), 105–110. <https://doi.org/10.1093/fampra/cmz078>
- Luthar, S. S., & Ciciolla, L. (2015). Who Mothers Mommy? Factors That Contribute to Mothers' Well-Being. *Developmental Psychology, 51*(12), 1812–1823. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=26501725&site=ehost-live>
- Main, G. (2014). Child Poverty and Children's Subjective Well-Being. *Child Indicators Research, 7*(3), 451–472. <https://doi.org/10.1007/s12187-014-9237-7>
- Maxwell, J. A., & Mittapalli, K. (2010). Realism as a Stance for Mixed Methods Research. In T. A & C. Teddlie (Eds.), *SAGE Handbook of Mixed Methods in Social & Behavioral Research* (pp. 145–168). 2455 Teller Road, Thousand Oaks California 91320 United States: SAGE Publications, Inc. <https://doi.org/10.4135/9781506335193.n6>
- McBean, A. L., & Montgomery-Downs, H. E. (2015). What are postpartum women doing while the rest of the world is asleep? *Journal of Sleep Research, 24*(3), 270–278. <https://doi.org/10.1111/jsr.12265>
- McLeish, J., & Redshaw, M. (2017). Mothers' accounts of the impact on emotional wellbeing of organised peer support in pregnancy and early parenthood: a qualitative study. *BMC Pregnancy and Childbirth, 17*(1), 28. <https://doi.org/10.1186/s12884-017-1220-0>
- McLeish, J., & Redshaw, M. (2019). Maternity experiences of mothers with multiple disadvantages in England: A qualitative study. *Women and Birth, 32*(2), 178–184.

<https://doi.org/10.1016/j.wombi.2018.05.009>

- Mercer, R. (2004). Becoming a mother versus maternal role attainment. *Journal of Nursing Scholarship*, 36(3), 226–232 7p. <https://doi.org/10.1111/j.1547-5069.2004.04042.x>
- Milgrom, J., Westley, D. T., & Gemmill, A. W. (2004). The mediating role of maternal responsiveness in some longer term effects of postnatal depression on infant development. *Infant Behavior and Development*, 27(4), 443–454. <https://doi.org/10.1016/J.INFBEH.2004.03.003>
- Mood, C., & Jonsson, J. O. (2016). The Social Consequences of Poverty: An Empirical Test on Longitudinal Data. *Social Indicators Research*, 127(2), 633–652. <https://doi.org/10.1007/s11205-015-0983-9>
- Morris, S., & Earl, K. (2017). *Health Survey for England 2016 Well-being and mental health Health Survey for England 2016: Well-being and mental health*. London: Health and Social Care Information Centre. Retrieved from www.statisticsauthority.gov.uk/assessment/code-of-practice
- Mortazavi, F., Mousavi, S. A., Chaman, R., & Khosravi, A. (2014). Maternal quality of life during the transition to motherhood. *Iranian Red Crescent Medical Journal*, 16(5), e8443–e8443. <https://doi.org/10.5812/ircmj.8443>
- Mott, S. L., Schiller, C. E., Richards, J. G., O'Hara, M. W., & Stuart, S. (2011). Depression and anxiety among postpartum and adoptive mothers. *Archives of Women's Mental Health*, 14(4), 335–343. <https://doi.org/10.1007/s00737-011-0227-1>
- Mulherin, K., & Johnstone, M. (2016). Qualitative accounts of teenage and emerging adult women adjusting to motherhood. *Journal of Reproductive and Infant Psychology*, 33(4), 388–401. Retrieved from <http://eds.b.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=2&sid=eb81e4d2-d6d4-4f7a-844f-4937b1d84abb%40sessionmgr120>
- Nagpal, J., Dhar, R. S. G., Sinha, S., Bhargava, V., Sachdeva, A., & Bhartia, A. (2008a). An exploratory study to evaluate the utility of an adapted Mother Generated Index (MGI) in assessment of postpartum quality of life in India. *Health and Quality of Life Outcomes*, 6. <https://doi.org/10.1186/1477-7525-6-107>
- Nagpal, J., Dhar, R., Sinha, S., Bhargava, V., Sachdeva, A., & Bhartia, A. (2008b). An exploratory study to evaluate the utility of an adapted Mother Generated Index (MGI) in assessment of postpartum quality of life in India. *Health and Quality of Life Outcomes*, 6(1), 107. <https://doi.org/10.1186/1477-7525-6-107>
- National Institute for Health and Care Excellence. (2014). Antenatal and postnatal mental health: clinical management and service guidance | Guidance and guidelines | NICE. Retrieved from <https://www.nice.org.uk/guidance/cg192>
- Nelson, S. K., Kushlev, K., English, T., Dunn, E. W., & Lyubomirsky, S. (2013). In defense of parenthood: children are associated with more joy than misery. *Psychological Science*, 24(1), 3–10. <https://doi.org/10.1177/0956797612447798>
- Ngai, F.-W., & Ngu, S.-F. (2013). Quality of life during the transition to parenthood in Hong

- Kong: A longitudinal study. *Journal of Psychosomatic Obstetrics & Gynecology*, 34(4), 157–162. <https://doi.org/10.3109/0167482X.2013.852534>
- Ngai, F.-W., Wai-Chi Chan, S., & Ip, W.-Y. (2010). Predictors and correlates of maternal role competence and satisfaction. *Nursing Research*, 59(3), 185–193. <https://doi.org/10.1097/NNR.0b013e3181dbb9ee>
- Noble, H., & Smith, J. (2015). Issues of validity and reliability in qualitative research. *Evidence-Based Nursing*, 18(2), 34–35. <https://doi.org/10.1136/eb-2015-102054>
- Noonan, K., Burns, R., & Violato, M. (2018). Family income, maternal psychological distress and child socio-emotional behaviour: Longitudinal findings from the UK Millennium Cohort Study. *SSM - Population Health*, 4, 280–290. <https://doi.org/10.1016/j.SSMPH.2018.03.002>
- Norman, E., Sherburn, M., Osborne, R. H., & Galea, M. P. (2010). An exercise and education program improves well-being of new mothers: a randomized controlled trial. *Physical Therapy*, 90(3), 348–355. <https://doi.org/10.2522/ptj.20090139>
- Oakley, A. (1981). *From here to maternity : becoming a mother*. Penguin.
- Office for National Statistics. (2013). Population Age Groups Dependency Ratios. Retrieved December 1, 2017, from http://www3.hants.gov.uk/2011_census_portsmouth_summary_factsheet.pdf
- Office for National Statistics. (2015a). Family Spending - Office for National Statistics. Retrieved July 30, 2018, from <https://www.ons.gov.uk/peoplepopulationandcommunity/personalandhouseholdfinances/incomeandwealth/compendium/familyspending/2015>
- Office for National Statistics. (2015b). Persistent poverty in the UK and EU - Office for National Statistics. Retrieved November 1, 2018, from <https://www.ons.gov.uk/peoplepopulationandcommunity/personalandhouseholdfinances/incomeandwealth/articles/persistentpovertyintheukandeu/2015>
- Office for National Statistics. (2017). Health Survey for England 2016 Well-being and mental health Health Survey for England 2016: Well-being and mental health. Retrieved from www.statisticsauthority.gov.uk/assessment/code-of-practice
- Özkan, H., & Polat, S. (2011). Maternal Identity Development Education on Maternity Role Attainment and My Baby Perception of Primiparas. *Asian Nursing Research*, 5(2), 108–117. [https://doi.org/10.1016/S1976-1317\(11\)60019-4](https://doi.org/10.1016/S1976-1317(11)60019-4)
- Pantazis, C., Gordon, D., & Levitas, R. (2006). *Poverty and social exclusion in Britain : the millennium survey*. Bristol: Policy.
- Parratt, J. A., & Fahy, K. M. (2011). A feminist critique of foundational nursing research and theory on transition to motherhood. *Midwifery*, 27(4), 445–451 7p. <https://doi.org/10.1016/j.midw.2010.02.012>
- Perkins, R., Yorke, S., & Fancourt, D. (2018). How group singing facilitates recovery from the symptoms of postnatal depression: a comparative qualitative study. *BMC Psychology*, 6(1), 41. <https://doi.org/10.1186/s40359-018-0253-0>

- Portsmouth City Council. (2015). Tackling Poverty in Portsmouth – Needs Assessment Refresh. Retrieved June 21, 2018, from [https://democracy.portsmouth.gov.uk/documents/s6724/Tackling Poverty in Portsmouth appendix - Needs assessment.pdf](https://democracy.portsmouth.gov.uk/documents/s6724/Tackling%20Poverty%20in%20Portsmouth%20appendix%20-%20Needs%20assessment.pdf)
- Public Health England. (2014). *Portsmouth. Portsmouth Health Profile 2014*. Retrieved from [http://www.portsmouthccg.nhs.uk/Downloads/Portsmouth CCG/HealthProfile2014Portsmouth00MR.pdf](http://www.portsmouthccg.nhs.uk/Downloads/Portsmouth%20CCG/HealthProfile2014Portsmouth00MR.pdf)
- Puffett, N., & Woods, R. (2016). Exclusive: 400 children’s centres at risk across England | Children and Young People Now. Retrieved November 3, 2018, from <https://www.cypnow.co.uk/cyp/news/1155688/exclusive-400-childrens-centres-at-risk-across-england>
- Räisänen, S., Lehto, S. M., Nielsen, H. S., Gissler, M., Kramer, M. R., & Heinonen, S. (2014). Risk factors for and perinatal outcomes of major depression during pregnancy: a population-based analysis during 2002-2010 in Finland. *BMJ Open*, *4*(11), e004883. <https://doi.org/10.1136/bmjopen-2014-004883>
- Rallis, S., Skouteris, H., McCabe, M., & Milgrom, J. (2014). The transition to motherhood: towards a broader understanding of perinatal distress. *Women and Birth : Journal of the Australian College of Midwives*, *27*(1), 68–71. <https://doi.org/10.1016/j.wombi.2013.12.004>
- Ramazanoglu, C., & Holland, J. (2002). *Feminist methodology : challenges and choices*. Sage.
- Ramírez-Vélez, R. (2011). Pregnancy and health-related quality of life: A cross sectional study. *Colombia Medica*, *42*(4), 476–481 6p. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cin20&AN=104223023&site=ehost-live>
- Rapley, M. (2003). *Quality of life research : a critical introduction*. London: SAGE Publications.
- Robertson, E., Grace, S., Wallington, T., & Stewart, D. E. (2004). Antenatal risk factors for postpartum depression: a synthesis of recent literature. *General Hospital Psychiatry*, *26*(4), 289–295. <https://doi.org/10.1016/j.genhosppsych.2004.02.006>
- Rogan, F., Shmied, V., Barclay, L., Everitt, L., & Wyllie, A. (1997). "Becoming a mother" -- developing a new theory of early motherhood. *Journal Of Advanced Nursing*, *25*(5), 877–885. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=9147193&site=ehost-live>
- Rubin, R. (1967). Attainment of the maternal role: Part I. Processes : Nursing Research. *Nursing Research*. Retrieved from https://journals.lww.com/nursingresearchonline/citation/1967/01630/attainment_of_the_maternal_role__part_i__processes.6.aspx
- Rubin, R. (1967). Attainment of the maternal role. Part 1. Processes. *Nursing Research*, *16*(3), 237–245. Retrieved from

http://journals.lww.com/nursingresearchonline/Citation/1967/01630/ATTAINMENT_OF_THE_MATERNAL_ROLE__Part_I_.6.aspx

- Ruddick, S. (1994). Thinking mothers/conceiving birth. In D. Bassin, M. Honey, & M. Kaplan (Eds.), *Representations of motherhood* (pp. 29–45). New Haven, CT: Yale University Press. Retrieved from <http://psycnet.apa.org/record/1996-98512-001>
- Ryan, A. B. (2006). Post-Positivist Approaches to Research. In *Researching and Writing your Thesis: a guide for postgraduate students* (pp. 12–26). Maynooth: MACE: Maynooth Adult and Community Education. Retrieved from <http://eprints.maynoothuniversity.ie/874/>
- Schieman, S., Bierman, A., & Ellison, C. G. (2013). Religion and mental health. In C. S. Aneshensel, J. Phelan, & A. Bierman (Eds.), *Handbook of the Sociology of Mental Health* (Second, pp. 457–478). Dordrecht: Springer.
- Seefat-van Teeffelen, A., Nieuwenhuijze, M., & Korstjens, I. (2011). Women want proactive psychosocial support from midwives during transition to motherhood: a qualitative study. *Midwifery*, *27*(1), e122–e127. <https://doi.org/10.1016/j.midw.2009.09.006>
- Seligman, M. E., & Csikszentmihalyi, M. (2000). Positive psychology. An introduction. *The American Psychologist*, *55*(1), 5–14. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/11392865>
- Sethi, S. (1995). The dialectic in becoming a mother: experiencing a postpartum phenomenon. *Scandinavian Journal Of Caring Sciences*, *9*(4), 235–244. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cin20&AN=107364323&site=ehost-live>
- Sheeran, N., Jones, L., & Rowe, J. (2015). Joys and challenges of motherhood for Australian young women of preterm and full-term infants: an Interpretative Phenomenological Analysis. *Journal of Reproductive & Infant Psychology*, *33*(5), 512–527. <https://doi.org/10.1080/02646838.2015.1042962>
- Silverman, D. (2000). *Doing qualitative research: A practical handbook*. London: Sage Publications.
- Smith, J. A. (1999). Identity development during the transition to motherhood: An interpretive phenomenological analysis. *Journal of Reproductive and Infant Psychology*, *17*(3), 281–299. <https://doi.org/10.1080/02646839908404595>
- Snitow, A. (1992). Feminism and Motherhood: An American Reading. *Feminist Review*, *40*(1), 32–51. <https://doi.org/10.1057/fr.1992.4>
- Sserwanja, I., & Marjoribanks, D. (2016). *Relationship distress monitor: Estimating levels of adult couple distress across the UK*. Retrieved from https://www.relate.org.uk/sites/default/files/relationship_distress_monitor_0.pdf
- Stock, L., Corlyon, J., Castellanos, C., & Gieve, S. M. (2014). *Personal Relationships and Poverty An Evidence and Policy Review A Report prepared for the Joseph Rowntree Foundation by the Tavistock Institute of Human Relations*. Retrieved from

<http://www.tav institute.org/wp-content/uploads/2014/08/Personal-Relationship-and-Poverty-Final-Report.pdf>

- Strange, C., Bremner, A., Fisher, C., Howat, P., & Wood, L. (2016). Mothers' group participation: associations with social capital, social support and mental well-being. *Journal of Advanced Nursing*, 72(1), 85–98. <https://doi.org/10.1111/jan.12809>
- Sullivan, G. M., & Artino, A. R. (2013). Analyzing and Interpreting Data From Likert-Type Scales. *Journal of Graduate Medical Education*, 5(4), 541–542. <https://doi.org/10.4300/JGME-5-4-18>
- Sullivan, G. M., & Feinn, R. (2012). Using Effect Size-or Why the P Value Is Not Enough. *Journal of Graduate Medical Education*, 4(3), 279–282. <https://doi.org/10.4300/JGME-D-12-00156.1>
- Symon, A. (2003). A review of mothers' prenatal and postnatal quality of life. *Health And Quality Of Life Outcomes*, 1, 38. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=14521719&site=ehost-live>
- Symon, A., & Dobb, B. R. (2008). An exploratory study to assess the acceptability of an antenatal quality-of-life instrument (the Mother-generated Index). *Midwifery*, 24(4), 442–450. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=17850937&site=ehost-live>
- Symon, A., Downe, S., Finlayson, K. W., Knapp, R., & Diggle, P. (2015). The feasibility and acceptability of using the Mother-Generated Index (MGI) as a Patient Reported Outcome Measure in a randomised controlled trial of maternity care. *BMC Medical Research Methodology*, 15(1), 100. <https://doi.org/10.1186/s12874-015-0092-0>
- Symon, A., MacDonald, A., & Ruta, D. (2002). Postnatal quality of life assessment: introducing the Mother-Generated Index. *Birth: Issues in Perinatal Care*, 29(1), 40–46 7p. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cin20&AN=106922828&site=ehost-live>
- Symon, A., MacDonald, A., & Ruta, D. (2002). Postnatal Quality of Life Assessment: Introducing the Mother-Generated Index. *Birth*, 29(1), 40–46. <https://doi.org/10.1046/j.1523-536X.2002.00154.x>
- Symon, A., MacKay, A., & Ruta, D. (2003). Postnatal quality of life: a pilot study using the Mother-Generated Index. *Journal of Advanced Nursing*, 42(1), 21–29 9p. <https://doi.org/10.1046/j.1365-2648.2003.02575.x>
- Symon, A., McGreavey, J., & Picken, C. (2003). Postnatal quality of life assessment: validation of the Mother-Generated Index. *BJOG: An International Journal of Obstetrics and Gynaecology*, 110(9), 865–868. <https://doi.org/10.1111/j.1471-0528.2003.02030.x>
- Symon, A., Nagpal, J., Maniecka-Bryła, I., Nowakowska-Głąb, A., Rashidian, A., Khabiri, R., ... Wu, L. (2013). Cross-cultural adaptation and translation of a quality of life tool for

- new mothers: a methodological and experiential account from six countries. *Journal of Advanced Nursing*, 69(4), 970–980 11p. <https://doi.org/10.1111/j.1365-2648.2012.06098.x>
- Teddle, C., & Tashakkori, A. (2010). Overview of contemporary issues in mixed methods research. In A. Tashakkori & C. Teddle (Eds.), *SAGE Handbook of Mixed Methods in Social & Behavioral Research* (Second, pp. 1–41). Thousand Oaks, CA, US: SAGE.
- Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., ... Rutter, C. (2007). The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation. *Health and Quality of Life Outcomes*, 5(1), 63. <https://doi.org/10.1186/1477-7525-5-63>
- Thoits, P. A., & Hewitt, L. N. (2001). Volunteer Work and Well-Being. *Journal of Health and Social Behavior*, 42(2), 115. <https://doi.org/10.2307/3090173>
- Thorstensson, S., Andersson, A., Israelsson, S., Ekström, A., & Hertfelt Wahn, E. (2016). To build a bridge between two worlds: Mothers' experiences of professional support at the maternity ward. *Health Care for Women International*, 37(10), 1067–1081. <https://doi.org/10.1080/07399332.2015.1094072>
- Treanor, M. C. (2014). Deprived or not deprived? Comparing the measured extent of material deprivation using the UK government's and the Poverty and Social Exclusion surveys' method of calculating material deprivation. *Quality & Quantity*, 48(3), 1337–1346. <https://doi.org/10.1007/s11135-013-9838-0>
- Webster, J., Linnane, J. W. J., Dibley, L. M., Hinson, J. K., Starrenburg, S. E., & Roberts, J. A. (2000). Measuring Social Support in Pregnancy: Can It Be Simple and Meaningful? *Birth*, 27(2), 97–101. <https://doi.org/10.1046/j.1523-536x.2000.00097.x>
- Webster, J., Nicholas, C., Velacott, C., Cridland, N., & Fawcett, L. (2011). Quality of life and depression following childbirth: impact of social support. *Midwifery*, 27(5), 745–749. <https://doi.org/10.1016/j.midw.2010.05.014>
- WHOQOL Group. (1993). Study protocol for the World Health Organization project to develop a Quality of Life assessment instrument (WHOQOL). *Quality of Life Research*, 2(2), 153–159.
- Wilhelm, K., Wedgwood, L., Parker, G., Geerligs, L., & Hadzi-Pavlovic, D. (2010). Predicting mental health and well-being in adulthood. *The Journal of Nervous and Mental Disease*, 198(2), 85–90. <https://doi.org/10.1097/NMD.0b013e3181cc41dd>
- Wittenauer, J., Ludwick, R., Baughman, K., & Fishbein, R. (2015). Surveying the hidden attitudes of hospital nurses' towards poverty. *Journal of Clinical Nursing*, 24(15–16), 2184–2191. <https://doi.org/10.1111/jocn.12794>
- Wrennick, A. W., Schneider, K. M., & Monga, M. (2005). The effect of parenthood on perceived quality of life in teens. *American Journal Of Obstetrics and Gynecology*, 192(5), 1465–1468. <https://doi.org/10.1016/j.ajog.2005.01.026>
- Xu, J., & Roberts, R. E. (2010). The power of positive emotions: It's a matter of life or death—Subjective well-being and longevity over 28 years in a general population. *Health Psychology*, 29(1), 9–19. <https://doi.org/10.1037/a0016767>

Zhang, Y., & Jin Shenghua. (2016). The impact of social support on postpartum depression: The mediator role of self-efficacy. *Journal of Health Psychology, 21*(5), 720–726. <https://doi.org/10.1177/1359105314536454>