An interpretative phenomenological analysis of mothers' negative experiences and emotions during early motherhood

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I would like to dedicate this thesis to my Dad,

who never knew I would but

always knew I could.

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Abstract

Contemporary ideologies surrounding motherhood do not appear to reflect the experience for many women. Motherhood is often portrayed as idealised, romanticised and as a joyful experience however a large proportion of women do not find this and experience psychological distress, many receiving a diagnosis of postnatal depression. Current psychiatric systems may not adequately represent mothers' experiences or reflect the range and complexity of emotions experienced during the early stages of motherhood. In addition, most psychological research has explored mothers' emotions through the lens of a medical model, with a focus on depression; exploration of emotions, beyond depression, has been under-researched. This study aimed to explore the range of emotions mothers experience. A qualitative study of six women, who experienced distress postnatally, were interviewed using semi-structured interviews to ascertain their subjectively lived experience. Data were analysed using Interpretative Phenomenological Analysis (IPA). The study found an emotional conflict between the mothers' aspired and idyllic representations of motherhood and their lived experiences; three themes were identified: when idyllic notions of motherhood are not realised; when motherhood is not instinctive; and when prioritising childcare is not easy. When the mothers were unable to live up to these identified notions of motherhood, they experienced emotional distress, from resentment and guilt, to feeling broken and insecure. The amalgamation of emotions experienced created a landscape of emotional complexity the mothers had to negotiate. This study also found that these women's experiences were not represented in the psychiatric categorical systems; they did not identify with having postnatal depression in the early stages of motherhood and were therefore left unsupported. This study explored ways counselling psychologists may be able to offer support to this sub-clinical group of women through interventions and by viewing their experiences as a normal response to motherhood as opposed to pathologising them.

Introduction

Motherhood is romanticised, idealised and fantasised (for example, Nicholson, 2001; Rudolfsdoltir, 2000; Parker, 1994; Choi, Henshaw, Baker & Tree, 2005), however these portrayals do not resonate with many mothers' lived experiences of motherhood. On the contrary, motherhood can often evoke complex emotions, such as resentment towards their infant, fear of criticism or public disapproval and guilt when deviating from socially constructed norms (for example, Sutherland, 2010; Weissman, Paykel, Siegel & Klerman, 1971; Hays, 1996) and these can sit alongside love, joy and devotion creating conflicting tensions (Oberman & Josselson, 1996). 'The emotions are insane' said tennis star, Serena Williams, in a candid interview with The Guardian (Greenfield & Lutz, 2018) after giving birth to her daughter; 'I'll get angry about the crying, then sad about being angry, and then guilty, like, why do I feel so sad when I have a beautiful baby?' (Greenfield et al., 2018). Ms. Williams brought the emotional complexity of motherhood into the public eye after acknowledging that 'no one talks about the low moments' (Greenfield et al., 2018).

Mothers find it difficult to disclose their distress in the early stages of motherhood and this could be because their lived experience contrasts with the prominent idealised, romanticised sociocultural ideas and beliefs entrenched within western society (Nicholson, 2001). This study will explore some of these ideas and beliefs and the impact they may have on how mothers manage their experiences and emotions. The psychological literature suggests that many deeply embedded ideas about motherhood could be internalised by mothers, and these attitudes, standards and values of others are integrated to form a sense of self (Sutherland, 2010; Walters & Howard, 2009; Blackburn, 2007; Tangney & Dearing, 2002). The women can then use these ideas to inform their understanding of motherhood; a discrepancy between the mother's expectation and experience may have detrimental effects on the mother's psychological and emotional wellbeing (Higgins, 1987; Henderson, Harmon &

Newman, 2016; Sutherland, 2010) and these discrepancies will be explored in this study.

Not only do mothers find it difficult to disclose their distress, but they are also reluctant to seek help (Dennis & Chung-Lee, 2006; Park, Goyal, Nguyen, Lien, & Rosidi, 2015) and this could be for a number of reasons. If a mother visits her General Practitioner experiencing distress in early motherhood, she is likely to be pathologised as having postnatal depression (PND) (Westall and Liamputtong, 2011) and mothers may not identify with depression or with having a mental health condition (Coates, Ayers, de Visser, 2014). Pathologising difficult emotions as a mental health condition could shape our perception of what is 'normal' and 'abnormal' (Marecek & Gavey, 2011) thereby stigmatising mothers' experiences further. A statistic of up to 85% of mothers experiencing some form of distress (Mind, 2013) would suggest a normal response to motherhood. In addition, negative emotions experienced in early motherhood are rarely discretely experienced as depression and some mothers may not experience sadness or depression. Maternal emotions appear to be far more complex, for example, resentment can sit alongside feeling broken and with joy, as one of the mothers in this study found. Complex emotions like this are difficult to reconcile in a society that romanticises motherhood and promotes motherhood as joyful. Psychiatric nosology does not appear to reflect all mothers' experiences (Coates, de Visser, Ayers, 2015) and, although some mothers may identify with a mental health disorder perinatally or postnatally and for some mothers a diagnosis is useful and appropriate, this study aims to explore mothers' emotional experiences without pathologising them.

Using interpretative phenomenological analysis (IPA) (Smith, Flowers & Larkin, 2009), the focus of this study will explore the range and complexity of emotions experienced during motherhood and the impact of them on the mother's phenomenological experience. This thesis will also explore an alternative to psychiatric nosology and medication used at present to alleviate mothers' distress, facilitated through counselling psychologists. Counselling psychology

has the opportunity to play an important role in assisting mothers to not only come to terms with their emotions through psychological interventions, but also to normalise their experience if appropriate and to challenge the prevalent societal norms around motherhood.

With this in mind, the research questions for this study are:

- Which emotions do mothers experience during the early stages of motherhood?
- How do these emotions impact on their phenomenological experience or vice versa?
- Are mothers able to reconcile their subjective experience with their expectation of motherhood?

Chapter 1: Literature Review

Firstly, this chapter will consider a number of ideologies surrounding motherhood by drawing on psychological perspectives; the ideologies are not discrete and are interrelated and overlapping. The first is an exploration of a prevalent ideology that exists within Western society where mothers prioritise childcare above all other aspects of their life and this will be followed by a critique of the psychoanalytic underpinnings of this child-centred ideology.

The chapter will then discuss the impact societal ideologies have on mothers including the experience of distressing and often conflicting emotions; two specific theoretical explanations for these emotions will be explored: maternal ambivalence from a psychoanalytic perspective and the self-discrepancy theory from a social psychological perspective. However, these distressing emotions are often medicalised as a mental health illness called postnatal depression and a critique of the medical model will be highlighted. Lastly this chapter will consider an alternative to the medicalisation of these emotions facilitated by counselling psychologists.

1.1 Prevalent ideologies surrounding motherhood

1.1.1 'Good' mother mandate

Mothers make choices as to what constitutes a 'good' mother and the 'right' way to mother their children but Sutherland (2010) suggests that, although there is an element of choice, there are mothering 'mandates', imposed on mothers, which impact on their choices. These 'mandates' usually emanate from societal contexts and therefore it is important to consider ideologies surrounding motherhood from both psychological and sociocultural perspectives.

One prevalent 'mandate' surrounding being a 'good' mother is the child-centred approach to mothering where the mother identity transcends all other

identities (Hays, 1996; Orenstein, 2000; Warner, 2005). Child-centred, or intensive mothering, the term coined by Hays (1996), are where the onus is on the mother to prioritise childcare above all other aspects of her life; Hays (1996, p. 8) describes this approach as 'expert-guided, emotionally absorbing, labour intensive and financially expensive'. 'Experts' could include child psychologists who appear to endorse this approach where a prolific amount of empirical evidence extolling the virtues of this parenting style was produced (for example, Bowlby, 1997; Winnicott, 1964; Kohut, 1980). Theories were developed from the beginning of the 20th century about the essential components needed for a child's development; these revolved around the relationship and the love/responsiveness between the mother/caregiver and the infant. The theories provided an insight into elements of the relationship and the facilitating environment to optimise the infant's development; however, this is different to the intensive mothering ideal within 'public culture' which is represented by all forms of knowledge from parents and academics to mothering networks and the media (Faircloth, 2013).

The relationship between the mother and infant however is considered important within this child-centred ideal. There is an expectation for the mother to form a loving relationship with her infant and for the child to take centre stage; otherwise the child's wellbeing is at stake (Hattery, 2001). This not only changed some mothers' 'moral duty of care' in case she could be accused of 'maternal deprivation' but also many societal expectations about what constituted being a 'good' mother (Hattery, 2001). The intensive mothering ideology can set mothers up with unrealistic demands of how to mother as they strive to achieve their 'ideal role model' (Blackburn, 2007).

The inability to live up to these unrealistic demands can negatively impact mothers' sense of self (Walters et al., 2009) and can have detrimental effects on mothers' emotional and psychological wellbeing (Sutherland, 2010; Henderson et al., 2016). Elliott, Powell and Brenton's (2015) research corroborated this in their study on low income, black, single mothers who sacrificed themselves for

their children to adhere to the intensive mothering ideology. Sacrifices included expending energy and time to provide constant support to children; relocating to an environment better suited to raise children; and compromising their own psychological wellbeing. However, this phenomenon was not limited to this population of women; many working mothers find it difficult to live up to this intensive mothering approach, which will be explored next.

The impact of motherhood on working women is well documented within psychological literature, one example is where mothers try to reconcile work and the pressure of living up to the 'good' mother mandate, (for example, Johnston & Swanson, 2006; and Dallos & Draper, 2015); Johnston and Swanson (2007, p. 447) suggest some mothers carry out 'cognitive acrobatics' to manage the reconciliation. Christopher (2012) found that some mothers had to defend employment in novel ways to reconcile work with childcare responsibilities, for example, extolling the benefits of employment for themselves as well as their children, whilst some mothers, unlike fathers, may be considered a 'bad' parent if they work (Okimoto & Heilman, 2012) and some are discriminated against in the workplace (Crowley, 2013; Byron & Roscigno, 2014; Harris & Estevez, 2017). Another impact on working mothers might be the 'stubborn reality' of returning to work after the rich intersubjective experience of the mother/baby dyad (Hollway, 2010) producing conflicts between a mother's internal and external worlds.

Despite mothers' attempt to reconcile work and the pressure of living up to the 'good' mother mandate, there is research to suggest that there are no detrimental effects on the infant if the mother works (Hazen, Allen, Christopher, Umemura, Jacobvitz, 2015; Del Boca, Pasqua, Suardi, 2016); an infant would have to spend more than sixty hours a week in non-maternal care to risk compromising the formation of a secure attachment (Hazen et al., 2015). The relatedness between the mother and/or primary caregiver appears to be an integral part of this child-centred mandate and this study will now explore further the 'expert-guided' knowledge (Hays, 1996) from a psychoanalytic

perspective and the theoretical underpinnings potentially informing this ideology.

1.1.2 Underpinnings of a child-centred ideology

In order to understand the underpinnings of the 'good' mother mandate, it is necessary to review the psychoanalytical and child developmental theory. The premise of psychoanalytic theory is that future relationships are formed on the basis of the relationship experienced in infancy with the caregiver (Oberman et al., 1996). The relatedness between the mother and infant is considered important for the long-term social and emotional wellbeing of the child (Bowlby, 1997) and for the infant to thrive (Kennell & McGrath, 2005). Neuropsychological evidence also suggests that the affection babies receive initially impacts positively on the development of the nervous system (Gerhardt, 2004).

There have been some key developmental theorists whose work has been particularly influential. Psychoanalyst Karen Horney, early in the 20th century, theorised that maladaptive social conditions would predispose the child to develop defences and anxiety constraining functionality, however with loving support and guidance from the caregiver, the child would be able to tolerate and negotiate feelings of anxiety and vulnerability (Horney, 1945; Horney, 1950).

Psychologist John Bowlby (1958) highlighted the detrimental effects on the infant if the 'right' environment was lacking, including cognitive, social and emotional difficulties. Bowlby's work has been influential since the late 1960s when he developed Attachment Theory (Bowlby, 1969) which became a dominant approach to understanding early social development despite some of his peers critiquing his theory on the basis of reducing attachment to a single variable: physical separation and not taking into consideration central tenets of psychoanalytic theory including unconscious processes and drives (Freud, 1960;

Schur, 1960; Spitz, 1960). This enduring psychological model suggests a child's healthy emotional development is dependent on their attachment to their primary care giver(s) and the infant's emotional needs being met. Mary Ainsworth (1978) developed Attachment Theory further with her Strange Situation test, where a child's behavioural and emotional responses were observed when their primary caregiver (usually the mother) and a stranger left and returned to the experimental room. As a result, three different patterns of attachment relationship between infant and caregiver were initially identified. These included: *secure* where the child used the primary caregiver as a secure base to explore their novel environment; *insecure avoidant* where the child appeared to be independent from the primary caregiver and; *insecure ambivalent* where the child was ambivalent towards his/her primary caregiver. This theory was and continues to be an influential theory explaining attachment and its importance could contribute to the 'expert-guided' component of the child-centred ideology (Hays, 1996).

One leading theorist, however, could offer solace to mothers feeling the weight of responsibility to provide the 'right' environment for their infant in order for them to flourish. Winnicott espoused the importance of the mother's emotional availability to her infant but challenged the perception of the 'perfect mother' (Oates, Lewis & Lamb, 2005). Winnicott (1964) believed that if the infant's needs were not consistently met and the infant was allowed to feel frustrated, the infant would develop a tolerance to waiting for his/her needs to be met. Winnicott (1964) believed that by the mother being 'good enough'; the infant would develop a sense of independence and a sense of self (Winnicott, 1964). Mothers who adhere to the child-centred ideology, however, would not necessarily support Winnicott's (1964) 'good enough' mothering.

Most of these theories developed in the mid 20th century by key developmental psychologists and psychoanalysts focused on the infant and what was best for the infant's wellbeing and specifically the development of the 'self'. A different approach to Winnicott's (1964) 'good enough' mothering was from an object

relations perspective, where theorists explored interactions of self with others and the internalisation of the interactions. From this perspective, an infant's 'true self' would be facilitated if the infant was provided with empathetic attunement within a 'good enough' environment (Borden, 2009; Greenberg & Mitchell, 1983). If the mother fails to respond appropriately to the physical, biological and psychological needs of the infant then a 'false self' would be created and the child's development could be compromised (Greenberg et al., 1983), potentially leading to psychosocial problems later in life, for example 'psychopathology' and 'social dysfunction' (Borden, 2009, p. 154). Kohut (1980) also suggested that the development of self depended on responsiveness of the primary caregiver and the provision of 'selfobjects' were seen as essential in facilitating the development (Greenberg et al., 1983). 'Selfobjects' included 'mirroring' to provide acceptance and admiration, 'idealising' to demonstrate strength and 'twinship' to provide a sense of belonging (Borden, 2009; Kahn, 1997). However, if caregivers are unable to adequately supply these selfobjects then the development of self is compromised. These theories have come under some scrutiny since their conception and this will be explored next.

1.1.3 Limitations of child-centred approaches and research

A substantial amount of psychoanalytic theory was generated within the patriarchal gender relations existing during the 20th century in Western cultures and could be critiqued for overlooking or omitting a focus on mothers' perspectives; as Winnicott (1964, p. 15) acknowledged: 'I am a man … only a woman can experience this'. Even though Winnicott (1964) recognises that there is always 'a baby and someone', the protagonists appear to focus on *how* the primary caregiver can facilitate the psychological health and wellbeing of the infant but do not appear to consider the mother's subjective experience which could have an impact on the dyad being studied. Parker (1997) suggested that the preoccupation psychoanalytic theorists had with child development 'obscured' maternal development and Oberman et al. (1996) suggests that the mother's subjective experience is 'erased' from the discipline.

In addition to the mother's subjective experience being 'erased' (Oberman et al., 1996) when exploring the child-centred approaches, the mother's circumstances were not taken into account. Much of the psychoanalytic theory and practice is based on white, middle-class mothers (Craig & O'Dell, 2009; Phoenix, Woollett & Lloyd, 1991) who may experience ambivalence, or not, in different ways to marginalised groups (e.g., mothers with disabled children and mothers who are lesbian, working-class, and/or Black and Minority Ethnicities). In recent years, however, qualitative researchers appear to be redressing the balance with studies exploring liminal spaces of mothering children from different ethnicities (for example, Rauktis, Fusco, Goodkind & Bradley-King, 2016; Verbian, 2013; Wittkowski, Patel & Fox, 2017; Kelly, Nel & Nolte, 2016); experiences of motherhood from mothers with disabilities (for example, Molden, 2014; Gould & Dodd, 2014; Frederick, 2017) and exploring motherhood in lesbian mother families (for example, Clarke, 2000; Bos, Van Balen & Van Den Boom, 2004). Individual differences between women, however, are often overlooked (Hare-Mustin & Marecek, 1994; Hollway, 1994), for example different life experiences; financial situation; whether the mother is a 'stay at home mum', in full-time or part-time employment; different social circumstances; and the different understandings and subjective expectations of motherhood (e.g., the notions of motherhood mothers subscribe to).

After the development of the child centred approaches, Phoenix et al. (1991) noted that a number of factors were not considered when conducting the research including the number of children the mother looks after; the sex of the children; any special needs they or the mother has; and the social support surrounding the mother. Although important, these factors are not always evident in the sample, especially with a small sample, and this will be considered in the Methodology chapter. Adding to the complexity of contemporary motherhood are the different routes to becoming a mother, which may also impact on the mother's relationship with her child: adoption; being a step-parent; undergoing in vitro fertilization; or surrogacy. If the

infant's wellbeing is dependent on the responsiveness of the primary caregiver (Bowlby, 1997; Winnicott, 1964; Kohut, 1980), it seems important to consider factors which may affect the mother's responsiveness.

Despite these complex factors, the evidence produced by the developmental psychologists and psychoanalysts suggesting the best environment for the infant is potentially overwhelming and prescriptive of very particular ways of mothering (for example, Bowlby, 1997; Winnicott, 1964; Kohut, 1980). This could be a reason why the child-centred 'mandate' is deeply embedded within western society when the infant's wellbeing is at stake. There are also many other ideas surrounding motherhood, which may impact on mothers' perception of what denotes being a 'good' mother and now the review will explore the idea of normative motherhood.

1.1.4 Normative motherhood ideology

Normative ideology presents mothers in a specific way and behaving in certain ways; a mother who does not conform to societal expectations may be stigmatised or ignored. Kitzinger (2006, p. 255) stated that a 'good mother is one who conforms'. One normative idea is that women should become mothers. This motherhood imperative or mandate (first identified in the 1970s) is embedded within our culture and emanated from various aspects of our society including the media, the education system, the family itself and religious ideology (Macdonald, 2000). Some discourses suggest that those women who bear children are 'fulfilled' (Macdonald, 2000) and motherhood is often seen as the ultimate achievement in a woman's life (Tardy, 2000). These discourses are shared cultural understandings (Hoffnung, 2011). Women who have no children may be seen as 'potential' childbearing women or 'failed child bearers' (Phoenix et al., 1991).

For many women, motherhood is considered intrinsic to their feminine identity, however, becoming a mother is dependent on the biological nature of

conceiving (Selvaratnum, 2014) and Remennick's (2000) study revealed how infertile Jewish women considered their infertility as a 'disability' within the prevalent pronatalist culture. In Western society, those women who want children and struggle to conceive will go to great lengths to become mothers, for example using in vitro fertilization, sperm banks, adoption, fostering and surrogacy (Peacock, 2015); subscribing to the motherhood imperative ideology, the 'myth' that being a mother is essential to being a woman is promoted (Peacock, 2015).

Research has found that women who are childfree by choice may be stigmatised in a seemingly pronatalist society or a society that promotes motherhood (Moore, 2014; Blackstone & Stewart, 2012; Shapiro, 2014) and could be considered 'emotionally disturbed' or a 'man-hater' (Allen, 2005). Some women contest the motherhood imperative by challenging scholars to take into account their complex identities (Moore, 2014), and through the media where the League of Fabulous Women, a lifestyle network specifically for childfree women, aims to explore and expand a woman's potential without being a mother. Lesbians may also find it difficult to convey a desire to stay childfree in a society where heteronormative expectations extend to lesbian parents (Clarke, Hayfield, Ellis and Terry, 2017).

Another dominant construct is that of 'acceptable motherhood' whereby to be an acceptable mother is to be married and heterosexual and therefore anyone not conforming to this construct, for example, lesbians and unmarried women, may encounter social difficulties (Lewis, 1996). Although this research is over twenty years old, there is evidence to suggest that the LGBT community still encounter social difficulties and are reminded of heteronormativity, (for example, Vinjamuri, 2015; Blackwell, Hardy, Ammari, Veinot, Lampe & Schoenebeck, 2016). Women's age, too, is frequently socially stigmatised in relation to acceptable motherhood (Phoenix et al., 1991): older mothers were aware of dominant ideologies surrounding motherhood and the normative development of mothers (Shelton & Johnson, 2006) equally some mothers may

be stigmatised for being considered too young to parent (Vincent & Thomson, 2013). It appears therefore that the age at which it is appropriate to mother becomes tightly prescribed within a far narrower window than the ages at which women can produce children. Even those mothers who fall within the boundaries of normative motherhood may face difficulties in mothering, but due to the ways in which motherhood is constructed may not feel entitled to have problems (Lewis, 1996); prescriptive notions of motherhood therefore impact all.

Non-conformance to what is perceived as 'normal' and socially acceptable impacts other aspects of motherhood including breastfeeding. A mother who breastfeeds is perceived as being a 'good' mother where breastfeeding is perceived as the ideal, however a mother who decides not to may be judged and face a moral dilemma (Marshall, Godfrey & Renfrew, 2007; Malatzky, 2017a) and yet a mother who breastfeeds in a public place may be criticised (Kitzinger, 2006; Mulready-Ward & Hackett, 2014). In addition, a mother who experiences difficult emotions for a prolonged period of time could be considered or consider herself as a non-conformist; this could be for a number of reasons, for example, not adhering to social expectations of motherhood. Society can denigrate the non-conforming mothers and blame them if something goes wrong (Oberman et al., 1996). In some psychological literature, non-conformists of the 'good' mother are described as 'deviant' (Couvrette, Brochu & Plourde, 2016) and this provocative language could further stigmatise those mothers who are not perceived as 'normal', for example women with a dependence on illicit drugs (Couvrette et al., 2016) or those in prison (Kitzinger, 2006). Sitting alongside the normative motherhood ideology is the embedded romanticised ideal of what it is like to be a mother which will be explored next.

1.1.5 The romanticised ideologies

This ideal can involve the perception that being a mother is joyful (for example, Nicholson, 2001) and, based on biological discourses, being a mother is

instinctive (Craig et al., 2009). However, despite the lack of any scientific foundation, these perceptions remain prevalent and may impact on how mothers view and experience motherhood.

One romanticised ideology is based on sex differences and biology: that, in addition to mandates and pronatalism, women possess a maternal instinct, a biological compulsion and innate aptitude to bear and care for children and this seems to have been socially subscribed to (Nicholson, 2001). This biological essentialist ideology may have come to define women by constructing their identity through their reproductive capability (Craig et al., 2009). The idea of maternal instinct appears to be embedded within the biological discourses in Western society and some psychologists, including Bowlby and Winnicott, suggested that to be a 'good' mother depends on empathetic attunement with her infant and instinctual feelings (Tardy, 2000) which could imply that mothering is a natural phenomenon. However, this does not appear to reflect the reality of the experience of motherhood for many women (Mind, 2013; Parker, 1997).

Another 'myth' is the romantic ideal that motherhood is non-problematic and a positive experience: that it is full of 'happiness', 'joy' and 'pride' (Nicholson, 2001). This ideal appears to remain strong; admitting to themselves and others that they find motherhood difficult or view it as a negative experience results in some new mothers feeling that they have failed in some way (Lewis, 1996) and this can be seen as unnatural (Marshall, 1991). Nicholson (2001) suggests that women encounter a conflict between their experience and the idealised socially expected mother. An idealised version of motherhood denies any difficult aspects of motherhood (Craig et al., 2009) and if the idealised version of motherhood is strongly held to be 'true' and as motherhood 'should' be, then any deviance from this could induce thoughts of incompetence or abnormality (Dallos et al., 2015).

Psychoanalyst and psychotherapist Parker considers the cultural pressures wielded on the mother as her having to live up to 'persecutory maternal ideals'

(Nash, 1995). As a consequence, mothers may seek perfection in their pursuit of the cultural 'ideals'; perfectionism is ubiquitous within western society and dimensions of the concept include concern over making mistakes, high personal standards and a fear of criticism (Frost, Marten, Lahart & Rosenblate, 1990). Perfectionism is a known contributor to psychological distress (Geranmayepour & Besharat, 2010; Westbrook, Kennerley & Kirk, 2011). Some mothers impose harsh rules on themselves and others surrounding motherhood and these expectations can lead to competitiveness between mothers and a judgmental attitude (Almond, 2010), which could contribute to distress and potential isolation.

Unrealistic ideals surrounding motherhood are untenable for many mothers. Lupton's (2000) longitudinal study concluded that the twenty-five women interviewed were unable to live up to the cultural 'ideal of the good mother' and experienced an ambivalent love/hate relationship with their infants. There are strong social pressures and/or dominant discourses suggesting mothers should be naturally happy, and any ambivalence is prohibited in favour of the 'happiness imperative' (Parker, 1994). Choi et al.'s (2005) study investigated the myths surrounding motherhood and it was revealed that, based on these myths, mothers were unprepared for motherhood. Their participants admitted to feelings of inadequacy when they were unable to live up to the myths and therefore projected themselves as 'supermum, superwife and supereverything' (Choi et al., 2005, p. 177) to hide their inadequacy.

Cultural representations of these myths are portrayed through the media and the increasing popularity of manuals, childcare magazines and the Internet (Johnston & Swanson, 2003). These include childhood manuals offering a guide on how to 'do it properly' and theories from popular psychologists examining the relationship between the mother and the child and how best to facilitate the child's developmental potential (Phoenix et al., 1991) and this seemingly remains the case nearly thirty years later. There are many websites, which encourage parents to pool ideas, give advice and offer support, the number one

in the UK being Mumsnet (2016), which receives 85 million page views and 17 million visits per month; these figures suggest that many mothers turn to the media for support with mothering.

The large volume of published material indicates the popularity of these sources and may suggest that there are many different models of motherhood, however research suggests that although over time the advice given to mothers has changed to reflect different sociocultural practices, the messages within and the way advice is offered has not changed (University of Warwick, 2012). Discourses within published material present motherhood as joyful and positive, place the responsibility on the mother to raise a well-adjusted individual and contradictory meanings of motherhood are omitted (Marshall, 1991; University of Warwick, 2012). If the media portrays an idealised, perfect mother, it is conceivable that mothers may not be able to live up to that portrayal and believe it to be unachievable which may add to the mother's burden of responsibility (Oberman et al., 1996).

In summary, dominant ideas surrounding motherhood become the norm (Rudolfsdoltir, 2000) and 'qualified guides for action' (Sykes & Matza, 1957, p. 666) and then become deeply embedded within our society. One ideology, the happiness imperative, remains resolute despite substantial evidence that up to 85% of mothers (Mind, 2013) find their experience anything but happy. Having considered some of the pressures on mothers to conform to an ideal notion of mothering, the next section turns to focus on women's experiences of living with the pressure of these ideals.

1.2 Women's experiences of motherhood

1.2.1 The emotional experiences of mothers

Contemporary social science research identifies a number of ways in which the fairly monolithic ideological construction of contemporary motherhood impacts on women's lived experience: 'disjunctures prevail between the ideologies of mothering and motherhood and the experiences of real women' (Arendell, 2000, p. 1196). Mothers often experience and negotiate a concoction of powerful, often conflicting, emotions in their transition to motherhood. Guilt, isolation and ambivalence for example can sit alongside love, joy and devotion creating conflicting tensions (Oberman et al., 1996) and this can be problematic for some mothers. In opposition to the psychoanalytic theory outlined above, sociology is more concerned with the notion of the self as developed in the social realm where meanings are derived through the social process of communication; a mother will act based on the meaning she gives something drawing on the social context (Snow, 2001) for example the importance and acceptance of motherhood ideologies. If a mother deviates from one of these entrenched ideologies surrounding motherhood, for example a mother who does not enjoy motherhood, she may perceive herself, or may be perceived, as being 'different' or 'abnormal' (Marecek et al., 2011).

If a mother feels 'different' and has deviated from social and cultural norms, she may feel stigmatised by the potential for public disapproval. Self- and perceived-stigma impacts on whether someone adjusting to their identity seeks help (Barney, Griffiths, Jorm & Christensen, 2006). Many mothers are reluctant to seek help when they experience complex feelings after birth (Dennis et al., 2006; Park et al., 2015). A meta-analysis revealed that many mothers face barriers if they are struggling and thinking about seeking help and these included the inability to disclose feelings, lack of knowledge and the acceptance of societal ideologies surrounding motherhood (Dennis et al., 2006). A systematic review of one hundred and forty-four studies revealed that stigma played a significant part in help-seeking barriers (Clement, Schauman, Graham,

Maggioni, Evans-Lacko, Bezborodovs, Morgan, Rusch, Brown & Thornicroft, 2015; Halter, 2003). Corrigan & Matthews's (2003) study examined the stigma of disclosing feelings, which involved weighing up costs and benefits of seeking help, for example disapproval versus the potential / anticipation of improved psychological wellbeing. It has been well documented that mental health deteriorates with stigmatisation (Schulze & Angermeyer, 2003; Fink & Tasman, 1992; Link, Phelan & Sullivan, 2017). Therefore, for a number of reasons as discussed, a mother may find it difficult to seek help either from family/friends or professionally and her mental wellbeing could deteriorate; a mother could endure distress for a long period of time.

To avoid disclosing their distress and potential stigmatisation, mothers appear to conceal difficult emotions by putting on a 'performance' to others and acting as if they are adhering to society's expectation of them (Westall et al., 2011). This resonates with Goffman's (1990) model of dramaturgy where he uses a theatre metaphor to explain human behaviour where people perform roles in front of others. The self presented to others creates a specific impression usually based on sociocultural norms and expectations. Some mothers hide behind a mask of normalcy protecting their sense of self from society's harsh critics (Westall et al., 2011) and behave in a 'morally acceptable' way in order to belong to the social group (May, 2008). Despite the fact that women share many confidences with each other (Tardy, 2000), they do not always share their experience if it deviates from the socially acceptable norm and this supports Goffman's (1990) model of dramaturgy.

All this evidence suggests that if there is a dissonance between how mothers experience motherhood and idealised perceptions of motherhood, mothers may inhabit a new persona to conceal the difference (Goffman, 1990); this could impact their mental health because they may feel stigmatised and may be reluctant to seek help. This chapter will now turn to explore mothers' mental health and the distress and complex emotions they encounter during motherhood.

1.2.2 Matrix of emotions

Psychologists have tended to regard mothers and motherhood in dichotomies, for example mothers can love/hate, nurture/deny, be good/bad and motherhood can be described as joyous/miserable (Bowlby, 1958; Winnicott, 1994; Parker, 1994). This has usefully informed us about the contradictory emotions involved in motherhood, however it is unclear if the use of polarities captures the range of emotions usually experienced in motherhood (Oberman et al. 1996). This dualistic theoretical model of motherhood could therefore be disparate from how mothers experience being a mother.

When women experience distress in the early stages of motherhood, it is usually viewed as a mental health condition: postnatal depression (PND); psychological literature reflects this with the recognition of PND and the exploration of distress through a medical model lens. Literature searches evidence the prolific research into PND from recognising the condition (DSM-5, 2013; Mind, 2013), attempts to predict it (Cox, Holden & Sagovsky, 1987), attempts to prevent it (Cooper, De Pascalis, Woolgar, Romaniuk & Murray, 2015) and the impact of PND on a child's development (Netsi, Pearson, Murray, Cooper, Craske & Stein, 2018; Murray, Fearon & Cooper, 2015) amongst others; this will be explored further in a later section. The dominant and possibly assumed emotion associated with PND is depression (Coates, et al. 2014), often in conjunction with anxiety (DSM-5, 2013), however, the study of any other perinatal emotions appears to be under-researched. It is unclear if depression and anxiety fully captures mothers' emotional challenges, for example, according to Rallis, Skouteris, McCabe & Milgrom's (2014) study, stress should also be considered when exploring perinatal distress. Investigating other emotions experienced during the transition to motherhood could further enhance our understanding of phenomenological experience (Rallis et al., 2014).

Two other previously identified powerful emotions are guilt and shame: 'little consideration is given to how guilt and shame *feels* to mothers and how these

feelings impact her interaction with her children' (Sutherland, 2010, p. 318). They are described as the 'moral emotions' (Tangney et al., 2002) inextricably linked to a perception of self in relation to others and appear to be induced if mothers are unable to live up to their internalised, idealised self-concept (Liss, Schiffrin & Rizzo, 2013; Adams, 2015; Higgins, 1987). Sutherland (2010) corroborated this and suggested a fear of negative evaluation contributed to the induction of guilt and shame. The experience of guilt is well documented within psychological literature (e.g., Sutherland, 2010; Rich, 1976; Hays, 1996); Doucet (2000) found that guilt, in particular, exacerbates if mothers deviate from socially constructed norms. Guilt is now considered an intrinsic constituent of motherhood, an example of which is when mothers are unable to achieve the cultural representations of 'good' mothering (Seagram & Daniluk, 2002). However, shame is not recognised in the same way as guilt. Tangney et al. (2002) suggest that this is because guilt is a more commonly used noun within western society but believes that the two are often confused or conflated and referred to as 'guilt'. According to Sutherland (2010), both describe a negative evaluation of self, but guilt implies doing something wrong, either an act or behaviour, whereas shame is the 'social emotion' (Scheff, 2000) which induces 'public disapproval' (Sutherland, 2010).

Shame in particular is identified as the emotion caused through trying to live up to being a 'perfect' mother (Liss et al., 2013) or if a mother perceives herself as being a 'bad' mother (Parker, 1997) which can induce feelings of inadequacy or failure (Scheff, 2000). Shame, and the impact of shame on the mother's psychological wellbeing, is under-researched (Sutherland, 2010), but this is not surprising considering the essence of shame and the lengths mothers go to to disguise their feelings from others. However, shame appears to play an important part in depression (Orth, Berking & Burkhardt, 2006; Wright, O'Leary & Balkin, 1989; Tangney et al., 2002; Turner, 1999) and Dunford and Granger (2017) found that shame proneness was a predictor of postnatal depressive symptoms and reduced help-seeking behaviours.

Another emotion identified in the early stages of motherhood is feeling out of control as mothers learn to master motherhood as they did in other aspects of their life (Haga, Lynne, Slinning & Kraft, 2012). The more out of control they felt correlated with feelings of stress or depression (Haga et al., 2012) and is thought to be the final stage before thoughts of harming themselves or their baby (Westall et al., 2011). Women are reported to learn about motherhood through observation and through support from others (Westall et al., 2011; Haga et al., 2012). Loneliness is another emotion identified but there is limited literature exploring this although Yantzi, Rosenberg and McKeever (2007) recognised loneliness as a specific emotion felt by mothers of infants with specific care needs. Anger is another emotion acknowledged postpartum (Graham, Lobel & DeLuca, 2002) and considered to be a vulnerability factor in increasing the risk of developing postnatal depression (Bruno et al., 2017), however most emotions appear to be documented in the psychological literature under the guise of 'postnatal depression' (Paris & Dubus, 2005; Westall et al., 2011; Mind, 2013). For example, a 1972 study mentioned resentment (Weissman et al., 1972) but only in passing when studying depression. Similarly, despair was mentioned in passing by Westall et al., (2011). A general categorisation of emotions makes it difficult to understand individual emotions and the impact they have on the mother's phenomenological experience, especially if experienced over a long period of time and this study will address this.

There have been a number of explanations as to why women experience difficult emotions during motherhood and, building on the discussion above, this study will explore two explanations from psychological and social psychological perspectives. Even though the psychological theoretical perspective has been critiqued during this literature review, there have been many useful studies and ideas that elucidate our understanding of motherhood and why mothers feel complex emotions and distress during this time. Firstly, an explanation from a psychological perspective, which suggests that the experience is a naturally occurring psychological process called maternal

ambivalence, and secondly a social psychological approach which suggests that mothers experience distress because they are unable to live up to their idealised construction of motherhood.

1.2.3 Maternal ambivalence

Despite espousing the maternal responsiveness on the infant's wellbeing, psychoanalytic theorists recognise that many mothers experience contradictory feelings towards their infant and/or motherhood and refer to these feelings as 'maternal ambivalence' (e.g. Parker, 1997). Klein (1946) postulated that ambivalence (love/hate) emanates from the beginning of life where the mother's breast is split into gratifying breast (good) and frustrating breast (bad); feelings of hatred in adulthood are the re-experiencing of feelings felt towards their own mother during infancy (Parker, 1995). In his influential writings in the 1950s, psychoanalytic paediatrician Winnicott suggested that an integration of love and hate will enable the mother's 'proper functioning' and that the denial of hate will not help the child. He went on to list eighteen reasons why a mother might hate her baby, for example, 'if she fails him at the start she knows he will pay her out for ever' (Winnicott, 1994, p.355). By being a 'good enough' mother and being aware of her 'destructive impulses' she may have towards her infant will enable the mother to tolerate any feelings of hate (Christie & Correia, 1987).

Feminist and psychoanalyst, Barbara Almond (2010) suggests that love and hate should be expected and should not be regarded as destructive. The suppression of these feelings and the development of defences against these feelings prevent some mothers from 'relating deeply' with their infants (Christie et al., 1987). For example, Murray, Fiori-Cowley, Hooper & Cooper (1996) suggests that a mother who experiences depression-type symptoms may be 'less sensitively attuned' to her infant and this can have detrimental effects on the infant, both emotionally and behaviourally (Prenoveau, Craske, West, Giannakakis, Zioga, Lehtonen, Davies, Netsi, Cardy, Cooper, Murray & Stein,

2017; Tully & Donohue, 2017). An infant is more likely to be insecurely attached if his/her mother experiences postnatal depression type symptoms, for example low mood (Murray, 1992) and this may impact on what is considered by some theorists an important stage of developing the mother/baby dyad (Kokubu, Okano, and Sugiyama, 2012). It is unclear exactly why they occur and whether everyone experiences these feelings.

Psychologist E. Tory Higgins, through his work on social cognition and the role cognitive processes play in social interactions, developed the self-discrepancy theory (1987), which proposes that emotions are induced as a result of a discrepancy between a perceived actual and idealised self. This social psychological theory can also be applied to mothers' experiences where there is a discrepancy between their idealised perception of motherhood and their lived experience inducing complex emotions; this will be explored next.

1.2.4 Self-discrepancy theory

Higgins' (1987) self-discrepancy theory emanates from classical sociological and psychological literature, which suggests that emotional problems can stem from inconsistencies in a person's belief system or from self-conflicts, for example Adler's (1964) inferiority complex and Horney's (1945) work on neurosis and self-actualisation. Higgins (1987) purports that we all have 'self-state representations': 'actual' being attributes we actually possess; 'ideal' being attributes we would like to possess; and 'ought' being attributes we should possess. 'Actual' is our self-concept whereas the other domains of self are 'self-guides' which direct our motivations. Self-guides are personal and idiosyncratic and Higgins (1987) suggests that the aetiology of discrepancies emanate from negative interactions with parents, for example an 'ought' self-guide could stem from a critical relationship with a parent.

Higgins (1987) suggests that a discrepancy between our self-concept and our self-guide induces specific emotional discomfort. A person possessing

discrepancies between actual attributes and/or idealised attributes produce 'dejection-related emotions', and these include disappointment and shame, whereas a person possessing discrepancies between actual attributes and/or ought attributes produce 'agitation-related emotions' and these include fear and guilt (Higgins, 1987). Higgins (1987) specifically draws on shame, which he believes is usually based on the esteem of others and guilt, which is usually based on the self-esteem. If there were no discrepancies between the self-state representations, then there would be no detrimental emotional effect. Turner (1999, p. 147) corroborates Higgins's (1987) theory with his general sociological theory of emotions: 'interactions that begin with a high sense of self as an object in relation to others will produce more intense emotional reactions when incongruity occurs'.

Higgins (1987) believes that this theory can be applied to many aspects of psychology especially treating emotional problems by identifying and modifying self-concept and/or questioning the legitimacy of self-guides. Liss et al., (2013) corroborated this theory with mothers in a quantitative self-report study of 181 mothers who completed an online survey. They found that those who perceived themselves as failing to live up to their idealised self, when compared to those who didn't, experienced higher levels of guilt and shame. Those who expressed a fear of negative evaluation from others appeared to exacerbate the effects (Liss et al., 2013). They concluded that an adjustment of individual and societal beliefs around motherhood to realistic expectations might protect mothers from these detrimental effects (Liss et al., 2013). Adams (2015) suggested that the theory could be used prenatally to identify and modify discrepancies as a nursing intervention. However, it is unclear if mothers will be able to identify a discrepancy before they have experienced it and therefore it may be more usefully employed as a postnatal tool.

When the self-discrepancy theory is applied to motherhood, it would assume that firstly all mothers have expectations around motherhood and secondly that discrepancies between a self-concept and self-guides would induce two clusters

of emotions 'dejection-related emotions' or 'agitation-related emotions' (Higgins, 1987). However, it is unclear if the plethora of difficult and complex emotions experienced during motherhood can be categorised in this way.

In summary, the negative emotions some mothers may feel as a result of social norms can impact on mothers' phenomenological experience, for example they can feel stigmatised or encounter help-seeking barriers. Mothers often experience difficult and complex emotions and psychological and social psychological explanations as to why mothers feel this way were explored. According to the literature, there appears to be an acceptance that there are many emotions experienced in the transition to motherhood, but it appears that the broad understanding is that all difficult emotions are symptomatic of a mental health illness: postnatal depression (PND) and this will be explored next.

1.3 Pathologising negative emotions as postnatal depression

If a woman 'fails' to adapt to the role of mothering an infant she is often identified as having postnatal depression (Nicholson, 2001) and therefore as having a mental illness (Westall et al., 2011). PND is a medical concept and for those clinicians (e.g., GPs and psychiatrists) who subscribe to the psychiatric or medical model, the mother may be seen as a series of symptoms, which can be categorised according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (2013). PND symptoms include anxiety or melancholy, which include 'loss of pleasure' and 'lack of reactivity to usually pleasurable stimuli' (DSM-5, 2013, p. 187). The UK's National Institute for Health and Care Excellence (NICE) Guidelines (2014) define mothers with postnatal depression as being: 'down, depressed or hopeless', having 'little interest' or 'pleasure in doing things', or suffering with anxiety. They offer clinical guidelines to practitioners on the treatment and management of conditions and recommend talking to mothers about the benefits of medication. Therefore, if a mother

visits her GP postpartum experiencing any of the negative emotions described, she is likely to leave with a diagnosis of postnatal depression and will probably be offered psychotropic medication (Westall et al., 2011). Some mothers may find medication beneficial, however, Toates (2010) believes it should not be viewed as a panacea; medication may not be women's preferred form of support, for example, a phenomenological study found that women were dissatisfied with the medical profession because they were prescribed medication, which alleviated depression-type symptoms but reinforced their feelings of inadequacy as mothers (Holopainen, 2002).

The prevalence of PND diagnoses offers some insight into how commonly women may face challenges in adapting to motherhood. A study by Loyola University (2009) suggested that at least 80% of new mothers suffer with some form of postnatal depression. Here in the UK, Mind (2013) suggests that as many as 85% of women will be 'emotional', 'tearful' and 'overwhelmed'; these mothers' experiences are denigrated as 'baby blues' and for most women these feelings normally fade within the first few days of motherhood and 'is generally quite manageable' (Mind, 2013) or only requires 'support and reassurance' (Westall et al., 2011), although given mothers' adept ability to conceal their emotions from others and their help-seeking barriers, it is unclear how they will acquire support and reassurance. These statistics suggest the experience of distress is a normal experience for women in the early stages of motherhood and despite this the happiness imperative ideology remains intact.

According to Mind (2013) and the Royal College of Psychiatrists (2016) between 10% and 15% of all new mothers suffer from a more severe form of melancholy to the point of clinical depression, which could last for a year or more. NICE (2014) suggest that between 15% and 20% of people suffer with this more severe form of postnatal depression within the first year after childbirth, however the DSM-5 (2013, p.186) suggests between '3% and 6% of women will experience the onset of a major depressive episode during pregnancy or in the weeks or months following delivery'. One in a thousand women suffer with

postpartum psychosis (Mind, 2013). It is unclear if all mothers who experience difficult emotions 'fit' within the first two categories; either a mother experiences distress / 'baby blues' for a few days (Mind, 2013) or postnatal depression for up to a year or more (Mind, 2013; Royal College of Psychiatrists, 2016). Discrete, homogenised groups may be useful in the scientific research of these experiences/disorders to categorise certain understandings of mental health, however, it is unclear if they are useful in day-to-day practice: it is not evident from these categories where a mother who experiences distress for three, six or nine months 'fits' within this diagnostic model.

There are other mental health disorders which impact on mothers' experiences; for example, perinatal / postnatal anxiety is recognised as a mental health disorder and is often experienced alongside a peripartum major depressive episode (Mind, 2016; DSM-5, 2013). Anxiety disorders including obsessive compulsive disorder (OCD), panic disorder and generalised anxiety disorder (GAD) can be prevalent during the postnatal period (Ross & McLean, 2006; Fairbrother, Janssen, Antony, Tucker & Young, 2016) as well as post-traumatic stress disorder as a result of birth trauma (Beck, 2004; Simpson & Catling, 2016). However, any mental health difficulty can be experienced in the postnatal period and it is unclear whether separate diagnoses for mental health disorders in the perinatal period are warranted or desirable; depression experienced at any other time of life would be classed as clinical depression and yet if it experienced postnatally then it is classed as a unique disorder: postnatal depression.

It is clear that some women would best be supported by entering the psychiatric system based on their distress and symptoms and that the attribution of a diagnosis to explain or make sense of their experience is appropriate and important for some mothers. However, this study intends to explore the experiences of a subclinical group of mothers who experience distress for a significant amount of time, however do not identify with having a mental health disorder and are left for months, even years, without support.

Throughout the study the use of 'anxiety' and 'depression' will be interchanged with 'fear' and 'sadness'; this is not necessarily subscribing to medical discourses, but a recognition that medical discourses have become an integral part of society's vernacular (Pilgrim, 2010) and they are considered to be similar.

Symes (2017) suggests that how a woman adapts to the transition into motherhood may lead to the development of mental health difficulties. Wu and Hung (2016) suggest the identification of mothers with 'minor psychiatric morbidity' in their transition to motherhood would be useful although currently it does not seem to be easy to predict commonality or likely difficulties. Screening tools are available to detect mental health difficulties, for example the Edinburgh Postnatal Depression Scale (Cox et al., 1987) and the Beck Depression Inventory (Beck, Ward, Medelson, Mock & Erbaugh, 1961), and would be useful to predict or identify disorders, however Mallikarjun and Oyebode's (2005) study found no screening tools have been shown to be of benefit in predicting postnatal depression and validity data has been called into question (Westall et al., 2011). It therefore falls to self and others to identify the symptoms and whether they need support. Westall et al. (2011) suggest that healthcare professionals often fail to identify difficulties but with limited time available at postnatal checks and the fact that mothers are adept at concealing their emotions, it is perhaps not surprising that the symptoms go undetected.

The inability to recognise mental health difficulties either through observation or a clinical approach with the use of screening tools makes identifying those mothers who experience distress difficult; they are therefore left unsupported. It may be useful to explore a less medicalised screening tool if mothers do not identify with having a mental health disorder, for example offering them psycho-educational material about postnatal distress and the prevalence of it during health care appointments in order for them to recognise their distress and seek help.

Psychiatric diagnoses are hegemonic within western society and pathologising women's experiences into psychiatric categories may shape our perceptions around what is 'normal' or 'abnormal' (Marecek et al., 2011). This medicalised approach is challenged by some, including some psychoanalysts, psychotherapists and feminists. According to psychoanalyst Darian Leader (2009, p.12), the medical profession label depression as a 'certain set of biological states, with brain chemistry the basic problem' and that brain chemistry can be changed using anti-depressant drugs. It is unclear how many psychiatrists and General Practitioners subscribe to this idea; psychiatric research has yet to find any 'organic grounding' for the disorders listed in the DSM (Rapley, Moncrieff & Dillon, 2011, p.1). Wancata and Friedrich's (2011) study suggests that depression is over diagnosed and, whilst a diagnosis of depression appeared to be rare forty years ago, Leader (2009) and Horwitz and Wakefield (2007) believe the label 'depression' is used ubiquitously today to describe feelings of sadness. Haslam (2000, p.1036) suggests that the biomedical model presents disorders as 'discrete, culturally invariant conditions underpinned by singularly caused brain dysfunctions'. This reductionist approach would appear to ignore exogenous life circumstances, personality disposition, developmental pathways, social structures and all the other factors discussed earlier and locate the responsibility of women's experience within herself (Bohan, 1993). Seligman and Csikszentmihalyi (2014) also believe the illness model locates responsibility with the individual where a focus on pathology impedes a positive psychological framework. The illness model or 'deficit-oriented' view not only locates the responsibility of difficulties with the individual but also presents 'depression' and other disorders as 'fact' rather than as a 'subjective construct of an 'expert'' (Vossler, 2010, p.201).

There appears to be little evidence to support purely a biological aetiology favouring psychosocial factors (Abrams & Curran, 2009; Cooper & Murray, 1998); Abrams et al. (2009) challenge the bio-medical discourse by surmising that PND symptoms experienced by some mothers were due to mothering in

poverty. However, aetiology for PND is far from clear-cut and Yim, Tanner Stapleton, Guardino, Hahn-Holbrook & Dunkel Schetter (2015) suggest that more research into biopsychosocial precursors is required to further our understanding. However, there have been many studies exploring factors which contribute to the symptoms, including Chesler's (2005) study which suggests that hormones, stress and genetic predisposition to depression are all contributors. Two other contributory factors for developing postnatal depression include fatigue (McQueen & Mander, 2003) and sleep deprivation (Westall et al., 2011). A systematic review of the literature on postnatal depression suggests that biological processes and psychosocial factors, which include severe life events and partner support, are predictors of developing the symptoms of PND (Yim et al., 2015). Low partner support was deemed significant to the development of PND symptoms (Gremigni, Mariani, Marracino, Tranquilli & Turi, 2011; Thorp, Krause, Cukrowica & Lynch, 2004). Hannan's (2016) phenomenological study suggested six contributors to feeling the symptoms of postnatal depression: striving to be a perfect mother; feeling a failure; being sucked dry; shame of others' gaze; feeling stuck and overwhelmed and becoming lost. When thirty mothers who experienced postnatal depression type symptoms and their partners were asked to reflect on the causes of the symptoms, it was only the partners who intimated that society's pressure on women may be a contributory factor (Habel, Feeley, Hayton, Bell & Zelkowitz, 2015); this went unnoticed by the mothers.

Kitzinger and Perkins (1993) suggest that 'psychological approaches teach us to privatise, individualise and pathologise our problems as women … rather than to understand these difficulties as shared consequences of oppression'. Davies's (1986) and Kitzinger's (1998) studies also imply that psychological approaches can pathologise individuals without taking into account social structures. Weisstein (1993) stressed that to understand social structures one cannot ignore the 'social expectations about women'. Johnstone (2000) argued that mothers do not appear to question the social structures or the expectations of the traditional 'sex role', for example within domestic and

maternal spheres, and contravening them leads to self-blame, thoughts of inadequacy and psychological distress. Some psychotherapists prefer to work with formulations, rather than diagnoses, which explore more than the presenting factors; these can include precipitating, perpetuating and predisposing factors (Johnstone & Dallos, 2014) which take into account social structures, gleaning a more comprehensive understanding of the presenting issues. In addition, Johnstone and Boyle have recently developed The Power Threat Meaning Framework (BPS, 2018), which is an alternative to diagnosis for clinicians; it aims to offer a new perspective on distress, moving away from the individual and viewing them as defective, to exploring the impact of wider social factors with the aim of eliciting more hopeful narratives. Wider social factors could include cultural ideologies as explored within the literature review.

Within families, Dallos et al. (2015) suggest that the process of diagnosis has led to labelling and the use of labels can potentially cause stigmatisation for those assigned the diagnoses. However, some patients find labels useful and can feel a sense of relief when there is an explanation for their difficult emotions (Westall et al., 2011). A name can often explain how they feel and can externalise the problem. According to Newnes (2002), the public embraces medical discourses, however some may internalise their distress as individual and that they are somehow 'defective' (Honos-Webb, 2001). Chesler, at the 1970 American Psychological Association conference, accused the mental health professions that patients were being 'abused' by them and being 'punitively labelled' and 'overtly tranquilised' (Wilkinson, 2009). Although Chesler's assertions / critiques were nearly fifty years ago, Kokanovic, Bendelow and Philip's more recent (2013) study proposes that depression is over-medicalised and pharmaceuticalised and this then ignores the highs and lows of what it is like to be human; Parker (1994) suggested that depression should be recognised as part of the 'maternal development milestone'. Critiquing the DSM-5's (2013) categorical and symptomatic approach to depression, Horwitz et al. (2007, p.6) believe the psychiatric profession appears to conflate 'normal sadness' where sadness is a normal emotional response to a life stressor, e.g.

motherhood, and 'sadness without cause' where there is no apparent reason for sadness (Horwitz et al., 2007 p.6). Therefore, with society's predilection towards diagnoses and the potential for 'normal sadness' to be conflated with 'sadness without cause', it is easy to see how mothers' distress could be understood as a mental illness.

Medicalisation is not simply an issue of what the medical world designates, but also of social policy and economics. The Department of Health (2013) issued statistics based on a report written by Knapp, McDaid and Parsonage (2011) from the London School of Economics stating that one in five women develop mental health issues during pregnancy and the months after childbirth; these include, anxiety, depression and psychoses. They predict that 'for all births in one year, there would be a long-term cost of more than £8 billion stemming from mental health problems'. The Lancet (2015) corroborated this figure and recommended research on perinatal mental health provision in the UK. This research has provoked a political response with the promise of midwives receiving mental health training and plans for specialist mental health staff to be employed in birthing units by 2017 (Department of Health, 2013).

Whilst it is encouraging that women's struggles around motherhood are on the public health agenda, it appears that policy is informed by ideas, research and perspectives that seemingly conflate overt common emotional experiences with mental health problems. It may well be that struggling with identity issues and ambivalence around motherhood could eventually lead to new mothers entering the psychiatric system. Many studies have been carried out to investigate postnatal depression (e.g., Cox, Murray & Chapman, 1993; Howard, 2005), but it is unclear from the literature if all mothers who present with the symptoms described are experiencing postnatal depression, instead, it could be a normal response to a significant life event: motherhood. Recognition that they need help is a good step, but it is unclear if medicalisation is the best route for them.

In summary, the literature considered above tends to suggest that mothers who experience emotional challenges in their transition to motherhood will be pathologised and will be presumed to have a mental health illness called postnatal depression. With most women encountering difficulties, up to 85% of mothers (Mind, 2013), pathology rather than normality is the dominant societal discourse in the Western world and although this is useful for some women, it is not necessarily beneficial for all.

Motherhood could be viewed in the same way as grief with distress being considered a normal emotional response to a life stressor (Horwitz et al., 2007), GPs could therefore play an important role in signposting more frequently those mothers who do not meet the criteria for postpartum major depressive episode (DSM-5, 2013) or those who do not identify with having a mental health disorder to talking therapies, as opposed to pathology and medication. Whether they receive a diagnosis or not, mothers are left negotiating some extremely difficult emotions during their transition to motherhood, which can impact significantly on their phenomenological experience. The role counselling psychology may be able to play in alleviating their distress will be considered next.

1.4 The role of Counselling Psychology

My interest in this area of study began during my undergraduate research, which investigated mothers' experiences of breastfeeding (Collins, 2011). In the findings, it was apparent that some new mothers were initially unable to bond or empathetically attune to their newborn child, which saddened them. I subsequently followed this research, using Grounded Theory methodology, with an investigation of the general process of how mothers negotiate the transition into motherhood. It seemed to be the case that, from this small sample, one element of the negotiation involved tolerating conflicting feelings: one participant described motherhood as a "bitch from hell and an angel from heaven" and these feelings created a great amount of distress for the mother

(Collins, 2014). Working with these difficult emotions professionally for a number of years in the context of my work as a counselling psychologist trainee, made me consider how counselling psychologists may facilitate this difficult negotiation.

Although counselling psychology could be perceived as a relatively new discipline, receiving full divisional status by the British Psychological Society in 1994, its roots can be traced to much earlier in the 20th century. The theoretical framework emanates from phenomenological and existential perspectives and is underpinned by humanistic values, which draws on specific work by Carl Rogers, Abraham Maslow and Rollo May (Strawbridge & Woolfe, 2003). The intentionality of counselling psychologists is different from other psychology disciplines; they move away from being the 'expert' applying specific techniques based on diagnostic criteria to 'being with' the client, facilitating wellbeing and amelioration (Strawbridge et al., 2003, p. 189).

Counselling psychology is an idiosyncratic approach. According to The British Psychological Society (2016, p. 1) counselling psychologists 'work with the individual's unique subjective psychological experience to empower their recovery and alleviate distress.' Contemporary counselling psychologists mainly draw on three theoretical models: behaviourism, psychoanalysis and humanistic approaches (Nelson-Jones, 1993); counselling psychologists are regarded as a 'collaborator' to develop a formulation with the client and devise an approach, based on the different theoretical models, to alleviate their clients' distress (Strawbridge et al., 2003).

Although the medical model has been critiqued within this study, counselling psychologists are not exempt from medical discourses; an example of this is the use of Cognitive Behavioural Therapy where specific techniques are applied to reduce distress. Therefore, psychologists who apply CBT as part of the idiosyncratic treatment plan would work with the mother to reduce her symptoms of distress; CBT is the preferred model of therapy within primary care

and therefore psychologists working within this domain would understand the medical model and symptom reduction. This symptom approach has been proven to be effective in reducing distress for mothers (O'Mahen, Woodford, McGinley, Warren, Richards, Lynch & Taylor, 2013). However, counselling psychologists who use medical discourses and work with a theoretic framework that reduces symptoms, do not necessarily pathologise mothers as having a mental health disorder.

There is unequivocal evidence that therapy works in alleviating distress (Cooper, 2008; Milgrom, Negri, Gemmill, McNeil & Martin, 2005 & 2010; Appleby, Warner, Whitton & Faragher, 1997; Cooper, Murray, Wilson & Romaniuk, 2003). Critics of therapy suggest that symptoms would have improved over the same time period, but this is disputed by randomised controlled trials (Cooper, 2008). Counselling psychologists believe that establishing a good therapeutic alliance based on humanistic values (i.e. empathy and warmth) is believed to be of fundamental importance on positive client outcomes (Lambert & Barley, 2001; Rogers, 2007 and Cooper, 2008).

Researchers suggest that postnatal distress occurs when 'women are unable to experience, express and validate their feelings and needs within supportive, accepting and non-judgmental interpersonal relationships and cultural contexts' (Mauthner, 1999, p.2). According to the psychological literature, relationships and support are found to be an important aspect for mothers adjusting to motherhood. Women learn to mother through observation and through support (Westall et al., 2011; Haga et al., 2012) and a lack of support will 'set women up for failure' (Westall et al. 2001, p. 75) and can lead to mental health difficulties including depression (Gottleib & Mendelson, 1995; Paris et al., 2005). Counselling Psychologists could offer this support, with the inclusion of partners as Haga et al. (2012) recommend, in order for the couple to learn how to support each other because men, specifically, find it difficult to know how to support their partners (Westall et al., 2011).

Briefly considering the practice literature, there are claims that counselling may be more beneficial than drug therapies and, in their review of literature, Cooper et al. (1998) suggest counselling would be considered the 'treatment of choice' by mothers. Various forms of psychological interventions have been offered to mothers postpartum and this appears to be the preferred pathway for many, compared to pharmacological interventions, according to participants in a qualitative systematic review of forty studies (Dennis et al., 2006). O'Hara, Stuart, Gorman and Wenzel's (2000) study corroborates this especially for breastfeeding women. Talking therapies generate a clinically significant reduction of depressive symptoms (Milgrom et al., 2005 & 2010; Appleby et al., 1997); the medical parlance ('symptoms') is appropriate and unavoidable for talking therapies offered in primary care as discussed earlier where certain therapeutic approaches, e.g. CBT, subscribe to medical discourses. Psychodynamic therapy producing a significantly superior reduction in depression when compared to control measured on the Edinburgh Postnatal Depression Scale (EPDS) (Cooper et al., 2003). Cooper et al.'s (2003) study suggested health visitors could administer the interventions, however, health visitors are reluctant to offer early interventions perceiving therapy as a diversion to their professional identity and believe that offering therapy would imply a counsellor's role (Brown & Reynolds, 2014).

Feminist counselling has also been effective at treating depression and more specifically depression experienced postnatally (Davis-Gage, Kettmann & Moel, 2010); this approach equips the client with the psychological insight and skills to manage any expectations and societal pressures related to traditional gender roles which could be contributing to their distress (Enns, 1993). An example would be reconciling work and the pressure of living up to the 'good' mother mandate as previously discussed (Sutherland, 2010; Hays, 1996; Orenstein, 2000; Warner, 2005; Johnston et al., 2006; Dallos et al., 2015; Christopher, 2012; Okimoto et al., 2012).

Feminist-informed counselling practice emerged in the 1960s as a result of movements intended to change political, social and cultural beliefs about women (Evans, Kincade, Marbley & Seem, 2005). The practice has not been without its critics with some feminists believing that the combination of feminism and counselling is politically problematic (Chesler & Bretherton, 2001); where problems are individualised rather than considered within a wider socio-political context (Kitzinger & Perkins, 1993). However, although there is no clear definition of feminist counselling due to the different conceptualisations of feminisms within the practice (Chesler et al., 2001), it is clear about its principles and these include: the building of an egalitarian relationship between the client and counsellor; the recognition of socio-political and cultural contexts and the empowerment of the client to negotiate social inequalities and stigmatisation (David-Gage et al., 2010; Conlin, 2017). With social inequalities and oppression shown to negatively impact mental health (Conlin, 2017; Meyer, 2003; Pascoe & Smart Richman, 2009) it is important to consider the contexts when working with women postnatally who encounter social pressures.

Feminist informed counselling practice shares similar principles with counselling psychology where an egalitarian, collaborative therapeutic relationship is considered essential; socio-political and cultural contexts are understood through the development of a formulation (Johnstone et al., 2014) which considers all aspects of a client's life. In addition to formulations, Johnstone and Boyle (BPS, 2018) have recently developed The Power Threat Meaning Framework, which views distress beyond the individual and explores wider sociocultural factors. Formulations and The Power Threat Meaning Framework are in conflict with the entrenched discourses within Western society: the psychiatric nosology based on the presenting symptoms. Although counselling psychologists 'understand' diagnosis, they are usually reluctant to respond to pathology. Counselling psychologists are also able to challenge embedded societal constructs outside of the therapeutic space through the use of

education, the social justice network, social justice campaigns and community psychology (BPS, 2017).

Early interventions are important to alleviate distress but also to prevent entrenched and prolonged psychiatric disorders, for example clinical depression; the World Health Organisation (2004) recommends early psychological interventions. A specific programme in the US is established to 'foster mental health and encourage bounce-back from psychological challenges that may otherwise result in pathology' (Steenkamp & Litz, 2013 p.257). To extrapolate this approach to mothers in order to promote mental *health* and prevent the onset of psychiatric disorders is appealing, however, trying to reach mothers who are adept at concealing emotions poses a conundrum to mental health practitioners.

Since some mothers may be reluctant to seek help, courses of Cognitive Behavioural Therapy have been developed and offered online. Some have reported that these courses have been effective (O'Mahen et al. 2013), however attrition rates for this and similar behavioural activation courses have been high (O'Mahen et al., 2013; O'Mahen, Grieve, Jones, McGinley, Woodford and Wilkinson, 2015) and, according to the participants, this was due to the lack of practical and emotional support. A peer support study found that volunteers felt they needed more training to support these mothers and an idiosyncratic approach would be useful (Leger & Letourneau, 2015). Most women in Westall's (2011) study expressed a need for individual counselling and for CBT to lower expectations around motherhood.

Research has identified that face-to-face, idiosyncratic psychological interventions are the preferred choice for mothers (Cooper et al., 1998), however, there is strong evidence to suggest group therapy provides greater benefits to some populations, for example those who feel stigmatised or those who experience social isolation, which is the case for many mothers (Yalom & Leszcz, 2005). Being involved with groups which have been created of similar others can be extremely therapeutic and this is achieved, according to Yalom et

al. (2005, p. 56) by the 'sharing of one's inner world and then the acceptance of others'. To be able to express aspects of self believed to be 'repugnant' and to be accepted in a non-judgemental way is deemed cathartic. However, this is contingent on establishing a cohesive, non-judgemental group. Anderson's (2013) phenomenological study suggests that groups established specifically for those suffering postnatal depressive symptoms were more helpful to mothers than generic groups; contact with similar others encourages disclosure.

Psychological therapy appears to be the preferred choice for mothers and therefore understanding the subjective experience of mothers and providing a space where ambivalent or negative powerful emotions can safely be examined, held and detoxified may inform counselling psychology and other disciplines to, not only normalise mothers' experiences if appropriate, but to also offer early interventions benefitting both the mother and infant. As well as practice recommendations, this study could have training implications. As discussed, counselling psychologists are also able to challenge embedded societal constructs.

1.5 Summary

The medical model in western society tends to view mothers who experience distress in the early stages of motherhood as defective; that their distress is an indicator of mental illness (PND). However, pathologising all mothers who find motherhood challenging as suffering with a mental illness may not be helpful for the mother or for society and its perception of what is 'normal' and 'abnormal' (Marecek et al., 2011); a statistic of up to 85% of mothers experiencing some form of distress would suggest a normal response to motherhood. Therefore, this study jettisons this reductionist approach; the rationale for this is to elucidate and validate all aspects of distress rather than reducing mothers' experiences to fit within the categories stipulated in the DSM-5 (2013).

There is a broad range of literature to underpin this study, however, the study of perinatal emotions, beyond the DSM-5 (2013) appears to be under-researched (Rallis et al., 2014). As discussed it is important to explore distress without the constraints of the psychiatric nosology and to understand how mothers experience the plethora of emotions. Serena Williams said: 'the emotions are insane' (Greenfield et al., 2018) but very few mothers feel able to disclose their feelings in a society that favours a romanticised version of motherhood (e.g., Nicholson, 2001). An understanding of this distress will enable clinicians and loved ones to support mothers in good time before the distress becomes deeply entrenched.

Using interpretative phenomenological analysis (IPA) (Smith et al., 2009), this study aims to explore the complex emotions experienced during motherhood and the impact of them on the mother's phenomenological experience. It also aims to explore other ways to help mothers negotiate these complex feelings and the role counselling psychology could play as an alternative to medicalisation. Psychological interventions could include acknowledging and normalising their experiences, adjusting their 'self-guides', or challenging public perceptions and societal norms of motherhood. With this in mind, the research questions for this study are:

- Which emotions do mothers experience during the early stages of motherhood?
- How do these emotions impact their phenomenological experience or vice versa?
- Are mothers able to reconcile their subjective experience with their expectation of motherhood?

Chapter 2: Methodology

2.1 Theoretical frameworks

The ontological stance taken in this study is critical realism (Harper & Thompson, 2012), which assumes that what participants say informs the researcher about their reality but that their lived experience is deeply embedded in and informed by the wider cultural context which informs that reality. Therefore, the data will not necessarily explicitly uncover the underlying structures behind the phenomenon and interpretations will be made to understand it more fully (Willig, 2013). For example, a psychiatric diagnosis of depression, as stipulated in the DSM-5 (2013), may be too simplistic and generic to understand women's lived experiences of illness / motherhood whereas a critical realist perspective would take into account the 'supra-individual' phenomenon, allowing for social and cultural aspects, to more fully understand distress (Pilgrim & Bentall, 1999).

The researcher's underlying assumptions about the nature of existence are therefore that people are social beings and are shaped by the wider socio-cultural context. Our experiences do not happen in a vacuum, they are influenced by our culture and social relationships; for example, the reality can change according to the audience and different social contexts (Smith, 2008). This is supported by the work of George Herbert Mead (1934), a pragmatic philosopher who, in the early 20th century, theorised that the development of 'self' emerges within the social realm. He believed that the self emerges from the social process of communication and the theory has three tenets: that we act based on the meaning we give something; that we give meaning to things based on our social interactions – the same thing can have different meanings for different people; and the meaning we give something is not permanent (Snow, 2001). People are apparently continually in a 'state of flux' (Loconto & Jones-Pruett, 2006); for example, friendships have an influence in constructing people's 'desired selves' and 'moral identities' by the connection or distancing of themselves from friends (Koontz Anthony & McCabe, 2015). Goffman (1990)

suggests we put on a 'performance' or a 'front' in social situations and can change how we act in accordance to the audience and their feedback, for example being a 'good' mother, roles then become embedded in identities. The chosen methodology for this study acknowledges that meanings are constructed within a social and personal world (Smith & Osborn, 2003).

Mead's work (Snow, 2001) has influenced my epistemological stance and, despite critiquing Bowlby's (1997) work earlier, his theories have also endorsed my stance by elucidating my understanding of early relationships and developmental psychology. He hypothesised the importance of relationships to the child's development, especially with the primary caregiver, and that we are all predisposed to form attachments. He proposed that the infant forms cognitive 'working models' based on his/her subjective experience of the relationship with the mother (Stern, 2006) and that these working models, whether functional or dysfunctional, form the basis of perceptions for future relationships (Bowlby, 1997). Working models can be revised through the therapeutic environment, for example by exploring the dysfunctional working models and modeling a secure therapeutic relationship, to promote better ways of relating (Borden, 2009). This learning can be applied to support mothers postnatally by exploring their working models and the relationship she has with her infant.

2.2 Interpretative Phenomenological Analysis

This study is interested in experience (Pietkiewicz & Smith, 2014) rather than causal relationships using objective methods, which can be 'propagated' universally (Pathak, Jenna & Kalra, 2013) and therefore employing a qualitative approach was deemed more appropriate as opposed to a quantitative approach. A qualitative, idiographic approach is the most appropriate way to capture mothers' subjective experiences and explore the meanings and emotions experienced in the early stages of motherhood. It is believed that 'how' and 'why' questions used in qualitative research are useful in order to tap

into the subjective experience and therefore this approach is best suited to elucidate the intricacies and complexities of lived experience (Lakshman, Sinha, Biswas, Charles & Arora, 2000).

This research aims to generate new knowledge about the mothers' subjective experiences in particular the plethora of emotions experienced, to give voice to mothers who have previously been unable to share their experience and explore any sociocultural pressures felt, for example, ideologies mothers subscribe to (Johnson & Worell, 1997). Through the use of semi-structured interviews, mothers are able to talk freely about their experience, eliciting rich, in-depth understandings of their lifeworld (Langdridge, 2007); a qualitative approach therefore captures the diversity, idiosyncrasy and complexity of motherhood.

Interpretative phenomenological analysis (IPA) (Smith et al., 2009) was chosen to capture how mothers' experience motherhood and how they make sense of the world. Two alternative qualitative methods were considered before settling on IPA: narrative analysis (NA) and grounded theory (GT). NA was considered because experiences are captured with complexity and richness and tap into wider social narratives (Webster & Mertova, 2007), however, with its focus on participants' stories, unlike IPA, with NA no assertions are made to discover human reality (Braun & Clarke, 2014). GT was considered because of its focus on human experience and meaning (Charmaz, 2006), however, this study specifically wanted to gain an in-depth understanding of motherhood based on mothers' experience of reality (Langdridge, 2007) rather than generating a theory of the social processes taking place. IPA was therefore deemed the most appropriate; the main aim for this study was to explore mothers' experiences and specifically how they experience emotions and capturing the subjectively lived experience is a strength of IPA (Braun et al., 2014).

IPA is based on three fundamental principles: phenomenology, hermeneutics and idiography (Pietkiewicz et al., 2014). Phenomenology is the study of experience and is underpinned by phenomenological philosophy where Husserl,

Heidegger, Merleau-Ponty and Sartre informed the discipline (Smith et al., 2009). Each contributed to our understanding of experience as a 'lived process' where unique meanings are derived from how a person relates to their lifeworld (Smith et al., 2009, p. 21). Hermeneutics refers to where rich descriptions of the idiosyncratic experience, through analysis, provide an insight into the subjectively lived experience (Langdridge, 2007). A double hermeneutic process occurs where the researcher attempts to make sense of the participants' accounts as they are trying to make sense of their experience (Smith et al., 2009; Langdridge, 2007; Pietkiewicz et al., 2014). Interpretation is iterative where analysis moves back and forth through the data rather than in a step process and this 'hermeneutic circle' approach is a prominent idea of hermeneutic theory (Smith et al., 2009). Interpretation is an important aspect of the process (Smith et al, 2003) and therefore the researcher acknowledges the double hermeneutic element.

The third fundamental theoretical principle of IPA is idiography; the process involves working with a small number of case studies to facilitate depth and subjectivity in their accounts as opposed to other methodologies which work with a large number of participants, the data of which can be calibrated and applied to the general population (Smith et al., 2009). The emphasis is on the particular, however, comparisons between case studies are carried out and these can give insights into universal patterns (Pietkiewicz et al, 2014). The researcher recognises her influence on data collection and analysis (Langdridge, 2007) and the potential problems with deleting the interviewer from the process (Potter & Hepburn, 2005) and this will be reflected upon in the Reflexivity section.

Other researchers have explored mothers' subjective experiences by using IPA and they found that this methodology provided a valuable insight into mothers' perceptions of their subjectively lived experience (Smith, 1999b; Hall, 2006 & Sheeran, Jones & Rowe, 2015). This potential for valuable insight is a strength of this methodology and perspective where a better understanding of the

subjective experience is achieved which can then be used to inform how to support other mothers who find motherhood challenging. Two critical phenomenological studies (Hall, 2006; Chan, Levy, Chung & Lee, 2002) provide insights into the experience of 'postnatal depression' and it was suggested that these insights might be used to, not only support mothers and their families, but to raise awareness within the caring profession when offering support. This study specifically aims to provide insight to counselling psychologists which will help them understand more about women's experiences to inform their practice.

2.3 Reflexivity

Reflexivity is the acknowledgement that the researcher plays an active role in the research process (Pike & Miell, 2007). Through the research the researcher will be drawing out processes by which the participants describe their world (Gergen, 1985). However, there is no separation between the research and the researcher (Sparkes & Smith, 2013) because the researcher's values and identities inform the analysis and the identification of themes (Krane & Baird, 2005). Therefore, reflexivity is an important part of the research process (Krane et al., 2005). Please also refer to my post-interview reflection (Appendix 1).

I initially became interested in this area of study during my undergraduate research and subsequent research on the doctorate programme as previously discussed (Collins, 2011; Collins, 2014). My interest in this study stems from being a mother; it saddened me that a large number of mothers experiencing psychological distress were unable to share their experience or seek professional help. This interest was exacerbated during my training to become a counselling psychologist; I have worked with difficult emotions professionally for a number of years and this has made me consider how the profession may be able to support these mothers.

It is important to state that, although I found motherhood challenging, I did not experience the same level of psychological distress the participants described in this study. I therefore position myself as a curious outsider (Elliott, Fischer & Rennie, 1999) and decided not to disclose my position because I did not want the mothers to feel uncomfortable; any assumptions they made to the contrary were of their own volition. I would have been reluctant to disclose my experience, especially at the beginning of the interview, because I think this would have compromised the process. Mindful of the disadvantages of this position, for example not having first-hand experience of this distress, I was however able to ask questions openly and did not make assumptions based on my own experience enabling a curious naivety throughout.

Consistent with IPA design, the researcher attempted to adopt epoché during the interview to suspend any preconceived assumptions or expectations and to gain a deeper understanding of how the participants experienced their unique lifeworld (Langdridge, 2007), however, it was recognised that this was difficult to achieve. 'Horizontalisation' (Langdridge, 2007) was also attempted by treating the data with 'equal significance' (Hollway, 2007), for example by not prioritising specific concepts when analysing the data, however, the researcher was aware of her part in co-constructing the meanings by the questions asked and the reasons for carrying out the research. To explore any preconceived assumptions held prior to conducting the research, and to familiarise herself with the questions asked, the researcher was interviewed using her own interview schedule by another researcher.

In addition to the 'double hermeneutic' of IPA (Smith et al., 2009; Langdridge, 2007; Pietkiewicz et al., 2014) (see above) another 'double hermeneutic' takes place: 'hermeneutics of empathy' where the researcher tries to capture the experience as closely as possible and 'hermeneutics of suspicion' where theories of knowledge are applied to the phenomenon (Smith et al., 2009). The former was clearly evident during the analysis of the data; I experienced a plethora of different emotions mimicking the participants' experiences from resentment to sadness, even sleep deprivation writing the Findings chapter.

2.4 Method

2.4.1 Design

Semi-structured interviews were considered the best means to capture the uniqueness of the mothers' experiences (Braun et al., 2014); the researcher used a schedule with specific open questions (Appendix 2), but this was used only as a guide and allowed the participants to express themselves freely and to elaborate on specific points or to digress. This enabled the participants to describe their experience in rich detail (Langdridge, 2007). The semi-structured interviews also allowed a dialogue to take place, but the researcher was able to modify the schedule and probe when unanticipated and interesting information arose (Smith et al., 2003) and enabled flexibility and space for any unexpected dialogues (Pietkiewicz et al., 2014).

Interviewing can be challenging on a practical and emotional level, for example this study explored distress and it was likely that by recounting some experiences some of the participants were likely to be emotional; it therefore required the researcher to be reflexive, ethically responsible and empathetic (Adams, 2010) and these are qualities that are practiced by counselling psychologists. The researcher was aware of a potential power imbalance (Richards & Emslie, 2000; David-Gage et al., 2010; Conlin, 2017) and therefore tried to form an egalitarian relationship which empowered the mother to tell her story.

It was anticipated that it may not be practical to meet the participants face-to-face due to the mothers' busy lives and schedules and therefore they were given three options to conduct the interviews: face-to-face, telephone/Skype or by e-mail. Skype was considered flexible, cost-effective and recordings of the visual and audio interaction may be carried out (Hanna, 2012), however building rapport can be different to face-to-face interviews, withdrawal from the study is more likely and there is the potential of technical / signal difficulties (Deakin & Wakefield, 2014). E-mail was considered cost effective, geographical distance

was overcome and the richness and quality of data were proven to be similar to face-to-face, however, challenges encountered included the asynchronistic nature of emails, relationship and communication difficulties, for example the absence of non-verbal cues and the dependency on access and knowledge of the internet (Ratislovova & Ratislav, 2014). All participants however preferred face-to-face interviews, which lasted approximately one hour each. Face-to-face interviews allowed the researcher to take into account embodiment, which is an important aspect of phenomenology (Langdridge, 2007), for example, embodied intersubjectivity (Burns, 2003) and how meanings are co-constructed through non-verbal communication. Paying attention to embodiment is important with the sensitive and emotional nature of the experience.

2.4.2 Participants

Inclusion criteria

Mothers who found motherhood challenging and experienced psychological distress were included in the study and all the mothers had at least one child under five years of age. However, they did not experience distress within the time parameters suggested by the DSM-5 (2013). Only one mother at the time of the interview was in the midst of her distress, she did not identify with having a mental health disorder, three others, however, were able to recall their experience readily with their distress only recently subsiding. Two mothers reflected retrospectively having experienced their distress a year ago or more, however, their recollection of their emotions and the effect on their experience was evident in their reflections. Mothers included those who have received a diagnosis of postnatal depression from a clinician, those who believed they were suffering with the condition or those who found the experience challenging, for example they experienced ambivalent feelings around motherhood. All mothers were invited and welcomed to take part in the study; for example, single mothers and lesbian mothers and there were no age stipulations but women of childbearing age.

Recruitment

Six participants who experienced complex feelings during the early stages of motherhood were interviewed. The recommendation for IPA studies is between three and six participants (Smith et al., 2009, Braun et al., 2014) which would yield sufficient data to explore similarities and comparisons without compromising subjectivity, which also fits with what is suggested for clinical doctorate trainees (Turpin, Barley, Beail, Scaife, Slade, Smith & Walsh, 1997). Due to the specific nature of the research, the homogeneous sample selection was purposeful and carefully worded advertisements were used to maximize recruitment potential (Appendix 3).

Participants self-referred through toddler groups, antenatal groups, postnatal depression groups and through word of mouth. Advertisements were distributed to the various groups and the researcher was reliant on the group leaders to distribute them. A counselling psychologist, the researcher met at the BPS conference, gave the advertisements to mothers in a parenting group she facilitated and also placed the advertisements in a café in Reading. Three of the women who took part in this study responded to the advertisement, one picking up the advertisement in the café, the other mothers were recruited through word-of-mouth. One other mother approached the researcher to take part in the study, however, she experienced her distress over ten years ago and she therefore did not 'fit' within the inclusion criteria.

However, recruitment was challenging. It could have been to do with the nature of the research. The advertisements were specifically recruiting mothers who experienced difficult emotions during motherhood as opposed to exploring all emotions and therefore this may have affected the sampling. Suffering with maternal ambivalence or postnatal depression evokes some very difficult feelings and some people may not want to revisit or disclose those feelings. It could also have been that the people who read the advertisement did not recognise their experience. Although the researcher does not recognise

mothers' ambivalent feelings as fitting with mental illness, it has been well documented that mental illness suffers with stigmatisation (Schulze et al., 2003; Fink et al., 1992). Potential participants may find talking about mental health, a source of embarrassment because it does not conform to cultural homogeneity (Herzfeld, 2005).

2.4.3 Pilot interview

One pilot interview was carried out with a mother who identified as having postnatal depression. This interview was predominantly to assess the feasibility of the approach (Leon, 2011), to pilot the schedule and as a reflexivity activity. A number of things were learnt as a result. First and foremost, the pilot study revealed the difficulty in recruitment as discussed above. Also, the pilot interview was carried out when the researcher was considering narrative analysis and the one question asked was considered too detailed and overly complicated; the interview schedule was then amended into a semi-structured format where the question was broken into many questions for subsequent interviews (Appendix 2). In addition, the participant's child frequently interrupted the interview and therefore with subsequent interviews I asked to meet the participant without their child being present.

2.4.4 Procedure and ethical considerations

Various recruitment strategies were used (see above) and potential participants interested in taking part in the study contacted me via telephone or email; I then emailed the information sheet (Appendix 4) which included details of the study, what would happen with their data, how to withdraw etc. and consent form (Appendix 5) to them. When they decided to participate, a mutually convenient time and location to conduct the interview was arranged; all six interviews were carried out in the participants' homes. Participants were also provided with the information sheet as a hard copy at the start of the interview to ensure that they were fully informed and were asked if they had any

questions. A hard copy of the consent form was also given to them at this time to sign. Both the information sheet and the consent form stated that they would be participating voluntarily, they understood what taking part involved and that their data would be anonymised. Participants were advised about how to withdraw and what would happen to their data if they chose to do so. However, they were informed that when data analysis took place, it would be difficult to eliminate the information they had already given from the process. Everything within this procedure adhered to UWE's Code of Good Research Conduct (2015) and the BPS's Code of Human Research Ethics (2014). The interview was initiated by asking the participant to sign the consent form (Appendix 5) and to complete a demographic questionnaire (Appendix 6), which asked personal questions, e.g. age and ethnicity, to give a sense of who has taken part. Non-directive, open questions were then asked from the interview schedule (Appendix 2).

The interviews were recorded, transcribed verbatim and analysed using Interpretative Phenomenological Analysis (Smith et al., 2009). Due to the sensitive nature of the interview, I assured the participants of their anonymity by changing their names and the names of their children. Any personal information gleaned, e.g. demographic questions, was stored responsibly in a locked filing cabinet and was only accessible by the researcher. Any demographic details used in the analysis of the data would only be used in relation to the pseudonym, e.g. 'Sally' a 36 year old mother. Other personal information, e.g. their email address and home address, was considered as confidential and held responsibly and will be destroyed once the research has been completed. The researcher assured the participants that the audio recordings and transcripts would be stored responsibly on a password-protected computer and that the audio and data files would be deleted at the end of the research process thus assuring confidentiality in accordance with the Data Protection Act 1998.

One ethical consideration was risk for both the participant and the researcher. It was recognised that talking about their struggles may provoke some anxiety/distress for the interviewees possibly due to cultural pressures or the recollection of a difficult time and they may be highly defended, i.e. resistant to talking about their difficulties (Hollway & Jefferson, 2008). Being a counselling psychologist in training, I was constantly assessing anxiety and specifically risk and on a practical level; I assessed this risk formally as part of the ethical process. I was highly vigilant to what was, and was not, being said as well as noticing transferences and counter-transferences, for example what was potentially being acted out between the participant and the researcher (Jacobs, 2010). The participant's non-verbal gestures were also noted and if I felt that the participant was suffering any anxiety during the course of the interview I would gently steer the conversation in another direction. If a participant became upset during the process I used my counselling skills to support them and I did not leave them until I felt that they were in a safe place and I drew their attention to the details supplied on the information sheet (Appendix 4) which signposted them to some appropriate organisations. Additionally, the day after the interview, I contacted each participant to thank them and to enquire after their well-being.

Potential risk to myself was also assessed. Due to the personal nature of the interview, I conducted the interviews in the participant's home. I was aware of the lone researcher risk involved with this decision and adhered to the guidance given in the UWE Safety Guidance Note. I used the buddy system to inform my 'buddy' of my whereabouts and telephoned them before and after the interview. I checked my mobile signal before entering the house and ensured I knew how to get out if necessary all in accordance with the UWE Safety Guidance Note. I checked in with myself and my own well-being post interview and would have sought support if it was deemed appropriate.

2.4.5 Data analysis

Interpretative phenomenological analysis (IPA) (Smith et al., 2009; Langdridge, 2007) was used to gain an understanding of the participant's subjectively lived experience. This was achieved inductively and iteratively through the researcher immersing herself in the transcripts and exploring patterns and idiographic content. After listening to the interviews, reading and rereading the transcripts some initial exploratory comments were noted; these included descriptive comments, linguistic comments and conceptual comments (Smith et al., 2009) and an anonymised excerpt is attached (Appendix 7). A number of themes were identified within the dialogue and the researcher then carried out the same process on each transcript. When all six transcripts were completed, a number of master themes were identified across the sample, which best encapsulated the participants' experiences. The themes were then discussed with the researcher's supervisors and some were merged to create three master themes which best represented the participants' experiences. Extracts used in the findings chapter were edited for ease of reading and were discussed in the final chapter in relation to the current psychological literature.

Chapter 3: Findings

Six white, heterosexual mothers were interviewed in 2017; all lived with their partner and were employed on a full-time basis or were self-employed. Holly, aged 33, has two children (both under six) and at the time of the interview identified with her diagnosis of postnatal depression; she lived with complex emotions for a number of years before seeking help from her GP and receiving her diagnosis. Ruth, aged 33, has two children under three and she experienced difficult emotions for more than six months; Ruth did not identify with a mental health disorder and did not seek help. Laura, aged 33, has one child who was ten weeks old at the time of the interview; Laura was in the midst of her difficult emotions and as a result found aspects of the interview upsetting; she had engaged in a course of CBT.

Clare, aged 34, also has one child aged 4; Clare sought counselling in the form of CBT to alleviate her distress a number of years after giving birth however she did not identify with postnatal depression. Jane, aged 42, has two daughters aged 14 and 5, and identifies with having a mental health disorder; this went unnoticed with her first child; however, Jane was diagnosed with postnatal depression eighteen months after having her second child when she cut her wrists in an act of desperation; she still takes anti-depressants to alleviate her distress and has not engaged with psychological therapy. Kate, aged 36, has two children under five and only experienced distress with her first child when she was preparing to return to work nine months after giving birth; Kate received a diagnosis of postnatal depression, took medication and engaged in psychological therapy. They all experienced negative emotions and not one of the mothers disclosed their distress to anyone.

An overriding theme emerged when researching mothers' negative emotions experienced during the early stages of motherhood: *the emotional conflict between mothers' notions of motherhood and their lived experiences*. Mothers

embarked on motherhood and aspired to mother according to notions that they held of what they believed motherhood 'should' look like, however their lived experiences often did not live up to these notions; this resulted in an emotional conflict between the two with the mothers enduring a significant amount of distress.

Three master themes emerged detailing the mothers' notions of motherhood; these are explored in detail and a consequence of the mismatch between the mothers' representations of motherhood and their lived experience is then explored in subsequent subthemes. The distressing emotions the mothers experienced as a result are explored throughout. These themes and subthemes are detailed in the table below and are discussed in detail with excerpts from the mothers' narratives to exemplify the themes. The combination of ideas the mothers subscribed to were unique and led to a personal and idiosyncratic experience, however there were convergent and divergent experiences, and these are also explored.

The emotional conflict between mothers' notions of motherhood and their lived experiences	Master theme:	Subtheme:	Emotional Consequences:	
	When idyllic notions of motherhood are not realised	'A wonderful, joyous fairytale'	The consequence of conflicting emotions:	'It's not what you're supposed to think ... feel'
		'You have to be perfect'		
	When motherhood is not instinctive	'Everything should come naturally'	The emotional consequences of not instinctively knowing how to mother:	'There's always something to feel guilty about'
				'Made me feel quite inadequate'
				'You feel like you're failing at everything'
	When prioritising childcare is not easy	'You should really devote yourself to them'	Significant loss:	'Sleep deprivation'
				'It's a lonely experience'
				'You're just a mum'
				'I shouldn't want anything for myself'
				'I just lost it completely'

3.1 Table of themes

3.2 When idyllic notions of motherhood are not realised

The first theme explores two specific idyllic notions of motherhood that the mothers in this study held. Firstly, when they embarked on motherhood they all expected it to be a pleasurable and joyful experience; their lived experiences however were the antithesis of pleasure and joy. In addition, three of the mothers subscribed to the idyllic notion of a 'yummy mummy' where they strove to appear, act and personify perfection in their role as a mother. When these idyllic notions were not realised, an emotional response was elicited which was in direct conflict with the expected and idealised emotions and this

impacted on the mothers' subjectively lived experiences which will also be explored.

'A wonderful, joyous fairytale'

All the mothers planned their pregnancies and embarked on motherhood with the realistic preconception that it would be hard work; however, they all made the assumption that they would enjoy motherhood, and this was often expressed with other idyllic assumptions as Clare reflected:

> *It's going to be wonderful and we are going to be you know having a fantastic relationship with our children and we'll be best friends [...] I thought that I would basically fall in love with my child after giving birth. [Clare]*

Clare's expressions about motherhood here are striking; she uses the metaphor of overwhelming giddiness and excitement of falling in love to describe her expectations of motherhood and the relationship she would form with her daughter. The emotive language with her use of superlatives demonstrates the idyllic assumptions she made about motherhood which conflicted completely with her experience. These idyllic notions of motherhood are not always realised, in fact it took Clare a long time to not only enjoy motherhood but to also feel she had bonded with her daughter:

> *It's taken me probably two years to like fully really like appreciate who I've got you know this beautiful girl and erm really bond with her and not see it as a burden and you know to really connect. [Clare]*

Clare experienced a lack of attachment with her daughter for two years and yet her feelings went undetected. For two years, she considered motherhood a 'burden' implying that she thought it was an encumbrance and a hindrance; this was extremely difficult for Clare because not only was her experience in direct conflict with her expectations but also, she felt trapped doing something she did not enjoy and was unable to progress her career which she did enjoy. As a result of the burden and lack of bond, feelings of resentment ensued. Clare was not alone with her assumption that motherhood would be wonderful; Holly also used emotive language to describe how she thought motherhood would be:

> *This expectation that you'll be able to do it you'll be it will be amazing and wonderful, and you know the best time of your life. [Holly]*

Holly expected to be proficient at motherhood and that motherhood would surpass any other experience in life. Both Clare and Holly use hyperbolic language when exploring motherhood retrospectively, emphasising their thoughts and feelings. However, the reality for Holly was that she found motherhood extremely difficult:

> *It was just the relentlessness of it that I think no one can prepare you for and like the being awake you know for most of the night and […] my husband would go off to work and just leave me with this baby who was still going to need me and I wouldn't have a cup of tea until he got home because I couldn't put her down because she would scream and she wanted to be held and like entertained or whatever all the time and just I was just I had no idea how like exhausted and like just generally kind of stressed out and anxious […] and you just kind of sit there and at some point you realise that actually like this is it now forever. [Holly]*

This excerpt is striking and demonstrates how Holly found motherhood relentless and overwhelming. Holly experienced exhaustion, stress, loneliness, isolation and anxiety and thoughts where she could not see a way out; Ruth also shared similar thoughts:

> *I thought oh no this is life now that was a bit of a kind of feeling of doom like this is it [laughs] we are stuck with this now we can't give her back. [Ruth]*

Here, Ruth laughs a laugh of discomfort when reflecting on her feelings however, at the time, she felt as if she was in an irrevocable situation; the use of the word 'doom' implies a deep sense of foreboding and this took many months to overcome. This contrasts strikingly with the wonder and amazement anticipated by all the mothers. Even a few days into motherhood Ruth describes feeling 'shell shocked', although an expression commonly used in our vernacular, originally it was a dramatic comparison to the death and destruction soldiers were subjected to during the First World War which is now referred to as post-traumatic stress. She was unprepared for the 'massive total shift' in her life, she 'didn't enjoy parenting' and was looking forward to returning to work after maternity leave as a way of 'escaping' her role as a mother; these thoughts and feelings were unanticipated and dichotomous with her

expectations. She also reports a feeling of obligation when it came to loving her daughter:

> *I did love her I would say umm right from the beginning, but it was a kind of I love you because I know you're my baby, but I don't really like you a lot of the time because you cry all the time and you're really hard work. [Ruth]*

This extract also demonstrates the conflicted nature of motherhood: Ruth loved her child and yet did not like her. Like Ruth, all the mothers expected motherhood to be enjoyable, but the opposite was realised. For three of the mothers an idyllic notion of motherhood extended beyond a subjective nature to their appearance and how they presented themselves to others; they aspired to be a 'yummy mummy' and this will be explored next.

'You have to be perfect'

Three of the mothers aspired to appearing, acting and personifying perfection in their role of mother; this idealised notion is represented in society as a 'yummy mummy'. One such mother is Jane:

> *I think the perception these days is you know you have to be a yummy mummy; you have to be perfect, you have to be you know wonderful … you have to be perfect at breastfeeding you have to be perfect at, your child always has to look amazing, you have to be perfect at, you know, you have to be perfectly manicured before you go out anyway, even though you have had like two hours sleep umm and I think but I think it's society pressure anyway. [Jane]*

The repeated use of 'you have to be' in this extract suggests that Jane believes there is a prescribed presentation of motherhood and the 'yummy mummy' representation is what motherhood 'should' look like. However, aspiring to this notion in all aspects of motherhood puts an inordinate amount of pressure on the mother because there is no room for error. Jane suggests that mothers are expected to be a yummy mummy, and this 'pressure' and quest for perfection she feels emanates from society; the concept 'Yummy mummy' is another idyllic representation of a specific portrayal of motherhood promoted within western society where celebrities appear to quickly regain their pre-pregnancy figure, appear well groomed after childbirth and retain an affluent, carefree

lifestyle. If mothers are unable to live up to an idyllic representation of motherhood, they may perceive themselves as failing in some way, as Jane explains:

> *I would look in the mirror and I'd think, I'd think I don't actually recognise that person that person is not me erm and, that's yeah that's yeah, you feel like you're failing at everything […] you become a perfectionist and you become more and more and more a perfectionist and if something is not perfect well it's crap so, so if I'm trying to lose weight it's got to be all or nothing. [Jane]*

Jane did not recognise herself in the mirror; this suggests there is a conflict between her idealised self and the self she sees in the mirror. Jane's use of 'everything' is interesting; in accordance with the notion of the 'yummy mummy', the way in which Jane feels under pressure to strive for perfection has seeped into all aspects of her and her infant's appearance including her own identity in terms of her body, for example losing weight. The striving of perfectionism is accepted ubiquitous within western society and Jane believes society puts pressure on mothers to seek perfection in all areas of motherhood; aspects of perfection include caring for your infant by 'breastfeeding'; presentation of self 'perfectly manicured' and the infant has to look 'amazing'. For Jane, perfection exacerbated the more she strove to achieve it and if she perceived something as not being perfect she thought it was 'crap'; conflicting and binary cognitions like this are present consistently in Jane's narratives and again demonstrates the dichotomous and conflicted nature of motherhood when mothers try but are unsuccessful in encapsulating specific notions of motherhood. When Jane was unable to attain perfection, she perceived herself as failing; failure is an emotion all the mothers identified with and will be explored further in the subsequent theme.

This 'yummy mummy' idyll of motherhood is conveyed through the media, especially contemporary magazines, which publish beautiful, often edited, photographs of high profile mothers and their infants. Holly reflects on one such magazine:

> *It's quite idealised like I think most of what you would see of motherhood is umm like may be in OK magazine or whatever and someone just had their baby and like, you*

> *know, the mum is dressed up amazingly and had her makeup done or whatever and the baby's not crying […] most of the time it's quite it looks quite shiny. [Holly]*

Holly used 'shiny' and Jane used 'perfect' repeatedly to describe a flawless portrayal of motherhood. The celebrities portrayed in the magazines receive help through styling and pictures can be 'photoshopped' to achieve the flawless look and yet some mothers aspire to achieve a similar look, which is potentially unrealistic and unachievable especially with little sleep. However, for one mother this 'yummy mummy' representation of motherhood extended beyond the media and celebrities:

> *Other mums I see when they've just had a baby and they just seem like so calm and together and they've even done their makeup and their hair, and they just look pristine and like like it's a breeze you know it was not a breeze for me it was really hard. [Clare]*

Based on her perception of others and how they presented themselves as 'pristine', Clare surmised that they must find motherhood a 'breeze'. This is another example of conflicted emotions: Clare perceived others as finding motherhood a 'breeze' or easy and yet she experienced the opposite. A number of emotions were elicited which were in direct contrast to the emotions represented by these idyllic notions of motherhood and these had an impact on the mothers' subjectively lived experiences and specifically their enjoyment of motherhood. As discussed, these included Ruth's 'feeling of doom', Clare's inability to bond, Holly's stress and Jane's overwhelming sadness:

> *I remember sitting at the table just looking at my laptop crying, just crying and crying and crying and crying and crying […] for eighteen months I'd, I'd just, I cried every day. [Jane]*

No one was aware of Jane's never-ending sadness; she experienced her distress on her own. Jane was not alone; all the mothers experienced these emotions for months, sometimes years, without detection. They concealed their emotions because they believed that their thoughts and feelings were in conflict with the thoughts and emotions traditionally associated with the idyllic, socially-accepted representation of motherhood: that motherhood should be pleasurable and enjoyable. The

impact of experiencing conflicting emotions and the non-conformity of idyllic and socially accepted notions of motherhood will be explored next.

3.2.1 The consequence of conflicting emotions: 'It's not what you're supposed to think ... feel'

As discussed, the two idyllic notions of motherhood above were not encapsulated in the lived experiences of the mothers in this study; they were all conscious that their emotions conflicted with emotions generally associated with motherhood and established within society, as Laura suggests:

> *You just sail through it that that's my perception of how people see motherhood [...] if you are having a hard time then there must be something wrong with you [chokes up] but actually most people have a hard time people just don't talk about it. [Laura]*

Laura's perception is that mothers 'sail' through motherhood, like Clare's 'breeze'; this suggests that motherhood is perceived as being easy which conflicts with the mothers' experiences. This conflict is exacerbated by the suggestion that a mother who finds motherhood difficult is defective in some way, the validity of the socially accepted representation of motherhood is not questioned. All the mothers in this study experienced emotions which conflicted with the idyllic notions of motherhood and as a result concealed their distress. As Laura said, mothers do not discuss their feelings with anyone and find themselves unable to confide in family, friends, or similar others; Ruth and Holly explain why:

> *I think I probably didn't share the way I was feeling because I think there is an expectation that you will love your baby and you'll be delighting in motherhood and I wasn't, and I suppose I felt like there was that was not how it should be. [Ruth]*

> *It's not what you're supposed to think is it? It's not what you're supposed to feel, and I know that there are some people that I couldn't say that to because you know they might never speak to me again. [Holly]*

From these two extracts, Ruth and Holly used 'should' and 'supposed to' implying a specific way to think and feel when you're a mother. If the mother perceived she was different/defective or she thought that others would perceive her as different/defective, she concealed her emotions and adopted

the socially accepted representation of motherhood, for example that motherhood is non-problematic. This suggests that the mothers could feel ashamed that they did not conform to society's representation of motherhood, however, if they were ashamed, they were not consciously aware of (or did not label their experience with) this emotion. They named fear as the dominant emotion behind the concealment; they feared being judged or rejected as Holly suggests above. She therefore 'sucked' all her negative emotions 'inside' and this is elaborated with this short extract:

> *I can put a face on yeah, I went to drama school I can act like everything is fine […] I didn't want people to know that I couldn't do it. [Holly]*

To 'put a face on' would imply adopting a different persona to the outside world and convincing everyone that all is well. 'Everything' suggests her adaptation to motherhood and Holly clearly explains why she concealed her distress: she didn't want people to know she 'couldn't do it'. 'It' being motherhood and yet she did 'it', despite her belief she couldn't do 'it' to the idealised standards. Holly was concerned that she would be perceived as failing and this felt 'really personal':

> *If someone said your mothering was bad that's like […] the deepest kind of thing inside you like that's what you were designed for and you can't even do that like it feels really personal […] I don't think I would have dared tell anybody because I could kind of see in my head the way they were going to look at me if I said it […] I didn't want them to look at me and think that I was a monster which was I think maybe how I felt […] the only way I could have any control over it if I kept it to myself then nobody else knew about it nobody else could do anything with it […] what if I told the wrong person and they you know went to social services? [Holly]*

There is a great deal going on in this extract. Holly was unable to express her thoughts and feelings around motherhood because she feared that people would see her as a 'monster' for not being able to do something that women were designed for; this was her perception and assumed that others would view her in the same way. Holly also feared what people might do if they knew that she couldn't 'do it properly' or that she was having thoughts and feelings that were not normally associated with motherhood; she might be reported to social

services. She even concealed her feelings from her husband for fear that he would be 'disgusted' and leave her. Holly was not alone as we turn to Laura:

> *When I'm out and about people look at me and think oh there's a mum who is coping really well […] don't want to be too open about it […] fear that they might judge me and then also for fear that they might avoid me after that […] I guess worrying about people judging me you know if I'm out with her and she's crying you know in the pram and I'm not I'm just carrying on with what I'm doing are people thinking God what a terrible mother? [Laura]*

Like Holly, the primary emotion behind Laura's deception is fear. Laura feared she may be judged and people might perceive her as a 'terrible' mother and avoid her; therefore, she becomes adept at concealing her true emotions. All the mothers were able to convince those around them that all was well: 'they wouldn't have known' [Ruth], 'people would think I was an amazing mother' [Jane], 'there's a mum who is coping really well' [Laura].

The mothers in this study did not perceive other mothers as experiencing distress; when mothers get together the narrative in this study suggests they tend to avoid talking about feelings as conversations turn to practical elements of motherhood, for example, the child's sleeping and feeding patterns. The fact that they do not perceive others as experiencing distress is not surprising if mothers are adept at concealing distress. All the mothers in this study concealed their negative feelings which served as a fundamental function: to prevent people from knowing their thoughts and feelings because they believed that their experiences of being a mother conflicted with the cultural representation of motherhood and they feared society's reaction to their experiences.

In summary, when they embarked on motherhood, all the mothers in this study expected it to be pleasurable, however, they experienced a number of conflicting emotions and their idyllic and romantic notion that motherhood is 'wonderful' was not realised. Another expectation the mothers in this study presumed was that elements of motherhood would be instinctual, and this will be explored next.

3.3 When motherhood is not instinctive

'Everything should come naturally'

There was the established belief by all the mothers that being able to mother, or elements of motherhood, would be instinctive:

> *I never felt like a natural mother […] everything should come naturally, and you should know how to do everything and um the reality is you don't, and especially as babies don't come with a manual and every baby is different. [Laura]*

From this extract it is apparent that maternal instinct moves beyond an idealised *notion* to an *expectation* of motherhood; the use of 'should' implies that Laura believed she 'should' know how to do 'everything' and motherhood 'should' come 'naturally' despite her never feeling like a 'natural mother'. Laura believed that the possession of maternal instinct would enable the appropriate care for her infant and, without it, leads to her call for a manual or some form of instruction. Throughout Laura's narratives it became apparent that she wished infants did 'come with a manual' because not instinctively knowing how to mother distressed her. Holly also subscribed to the notion that mothers expect, and are expected to, decipher their infants needs using 'maternal instinct'.

> *There's an expectation that you will just know what to do like maternal instinct or whatever you call it, that whatever happens with your baby if it's crying you'll know how to make it stop […] there is this expectation that it will be magical, and you will somehow magically know what to do. [Holly]*

Much like Laura, Holly admitted that it took time to be able to decipher her infant's needs. Holly expected to know how to mother and she would know as if by magic. This expectation was especially prevalent elsewhere in her narrative because she has a 'family history of amazing motherhood' and felt a great deal of 'pressure of not living up to what would be expected' of her within the family. Ruth also thought a 'natural instinct' would be available to her when she became a mother as she explains:

> *You just expect that there will be this sort of inherent like natural instinct […] Reproducing is a natural thing, so you should naturally know how to bring up your children. […] I just assumed that like mothering would probably come quite naturally I would sort of know what to do and umm I suppose that yeah we would sort of*

instinctively know how to bring up our children.[…] I found breastfeeding very difficult and I hadn't that was something I definitely wasn't prepared for and that was certainly something I thought well this is it such a natural this must be completely natural and may be not easy but certainly straight forward and that was so hard and so painful. [Ruth]

This perception that women possess an innate aptitude to bear and care for children is deeply embedded within western society but the notion that all aspects of motherhood are instinctive are not borne out in the mothers in this study's experiences despite the prevalence of this idea in the wider culture. This is evident when Ruth talks about reproducing and breastfeeding where she appears to be conflating motherhood being a biologically 'natural' phenomenon with it being instinctive or straightforward ('natural'). Jane also conflated biologically 'natural' with instinctive:

I thought it was going to be easy […] yeah, yeah. I thought breastfeeding especially was going to be doddle, yeah you just stick the baby on and they eat oh no, no, no, no, no they don't. [Jane]

The lack of maternal instinct directly conflicted with the mothers' expectations and had a profound impact on their emotions and lived experiences. They felt guilty, they felt a sense of inadequacy and a sense of failure and this will be explored next.

3.3.1 The emotional consequences of not instinctively knowing how to mother:
'There's always something to feel guilty about'

Guilt was clearly evident in the mothers' narratives and all the mothers identified with it; some considered it intrinsically linked to being a mother:

I think guilt is just part of parenthood isn't it? 'Cos there's always something to feel guilty about. [Ruth]

Ruth was not alone: 'I permanently felt guilty' [Jane], 'mums feel guilty constantly' [Kate], 'all the time' [Laura]. The mothers recognised guilt as being an intrinsic part of motherhood and yet this does not appear to be the case in other aspects of the data, e.g., perfection in motherhood. However, for some, guilt was directly linked to the

idea that motherhood, or elements of motherhood, should be instinctive. This is evident in this extract from Ruth:

> *Feeling guilty that we were obviously weren't meeting her needs in the right way because she was not a happy baby and so there was obviously not doing something right or there was something we weren't doing. [Ruth]*

It is clear here that Ruth felt responsible for her child's unhappiness because she, and her husband, were unable to fulfil their child's needs, inducing feelings of guilt; she was expecting intuitively to know how to attend to her child's needs. She perceived that she was doing something wrong or neglecting her in some way; implying that if they were attending to her needs in the 'right' way, her child would be happier. Right versus wrong is another conflicting, dichotomous cognition that the mothers identify with and will be explored in more detail in the subsequent theme. Laura also believed that guilt emanated from not knowing how to meet her daughter's needs:

> *[Guilt is a] huge part when you perceive that you can't meet her needs you don't know what those needs are. [Laura]*

Both Ruth and Laura were at a loss as to how to fulfil their children's needs and this suggests that motherhood is not always instinctive and requires an element of learning and practice. If the cultural representation of motherhood was that being a mother often necessitated learning and practice, then there may be less pressure on mothers to be naturally competent and this might result in less distress because they would not feel they have failed to live up to their idealised perception of motherhood. It is evident that Ruth and Laura feel responsible not knowing how to meet their children's needs and this supports Laura's earlier thought that if a mother is unable to decipher her child's needs she must be defective in some way which is in direct conflict with the instinctive notion of motherhood. Holly took her lack of maternal instinct personally and her guilt permeated throughout her experience:

> *I felt guilty if I hadn't got to them quickly enough, or if they were sad or if I was resentful of them or if you know I had just spent ten minutes fantasising about how much sleep I would get if I left them in town. [Holly]*

It is evident that Holly's guilt included aspects of parenting, the responsibility she felt for her children's emotional wellbeing and guilt surrounding her own emotional response to motherhood. It is worth noting that in this excerpt Holly fantasises about meeting her own needs but here, and in other areas of her narrative, her imaginings are extreme in nature and this induces feelings of guilt.

It is clear that all the mothers related to the emotion guilt. It is also clear that they assumed some maternal instinct would be available and when it was not they took responsibility for any aspects of mothering that they perceived as lacking; they blamed themselves rather than questioning the validity of the wider sociocultural representation of motherhood. It is also evident that guilt appears to be induced when mothers perceive there is a mismatch between their ideal or unique perception of motherhood and their lived experiences; this is apparent by their acknowledgement of what they are 'not' doing. They all also experienced the sense of inadequacy which will be explored next.

'Made me feel quite inadequate'

Guilt was not the only emotion experienced when mothers found that motherhood did not come naturally to them; a lack of maternal instinct induced feelings of inadequacy or that they were not good enough. When asked how she felt about the challenges she faced when motherhood was not instinctive as anticipated, Ruth replied:

> *They made me feel quite inadequate [...] why am I not coping better with this umm I-I think I did feel quite resentful towards Lizzie even though I loved her but I would look at I would go to baby groups and look at these other mums with their babies who didn't cry all the time who would sleep in their you know pushchair or whatever and I'd think why are you why have I got I I felt like I had a really difficult baby. [Ruth]*

Ruth's sense of inadequacy stems from her perception that she was not coping well with motherhood and this became apparent when she compared herself to other mothers who, according to Ruth, did not have difficult infants. She perceived that other people's babies were better than her baby; not only did she

believe she was inadequate / imperfect, she also perceived that she had produced an imperfect baby. The helplessness she felt for not coping better and knowing how to attend to her daughter's needs led her to feelings of resentment. Ruth admitted to having 'no idea' what she was doing but over time she began to feel more confident about responding to cues and as a result motherhood became easier; Ruth's difficult feelings lasted for six months and went undetected by family, friends and professionals. Laura also reflected on lack of knowledge on how to mother:

> *Just feeling like I didn't know what I was doing and erm yeah just completely out of my comfort zone really [upset] erm and you know just just feeling like I remember saying that to one of the midwives that she would be better off with somebody else. [Laura]*

Laura's inadequacy was extreme enough for her to believe that her daughter would fare better with a stranger than with her which led to upset and distress. This was an important disclosure at a time when many women are unable to reach out to others, however this did not enable Laura to access support; the midwife's response was dismissive 'you can't do anything wrong; she won't remember' and therefore an opportunity to support Laura was missed. The distress she felt is in direct contrast to the anticipated thoughts and feelings around this instinctive notion of motherhood. Lacking confidence in her ability to mother was evident throughout Laura's narrative and she relied on others to guide her:

> *'Baby sensory isn't for her it's for you, for somebody to tell you how to play with your baby' at which point I burst into tears because I said 'I'm so glad you said that because I feel really stupid that I don't know how to play with her' because and it comes back to that expectation of you're just expected to know all this stuff. [Laura]*

Laura's relief is evident from this extract when she burst into tears because she felt she did not know how to interact with her child and felt 'stupid' as a result. Laura is an educated woman achieving a PhD and yet her inability to know how to interact with her child, a seemingly easy task to her, left her feeling uneducated. Society's promotion that 'you're just expected to know all this stuff' made Laura feel inadequate. This suggests that not only does Laura expect herself to know how to mother, she believes there is an expectation that

permeates in the wider culture as well. At ten weeks, the time of the interview, Laura still lacked confidence in her ability to mother; it is something she has had to learn through observation and instruction and is learning to feel better about herself however because motherhood was not immediately instinctive to her she worries that she is not a 'good mum'. This worry is an emotional response to the conflict between her idealised notion of motherhood and her lived experience; she feared that she does not live up to the notion of what constitutes a 'good mum' which left her feeling inadequate.

> *You don't let babies cry, babies don't cry so when she's crying there's the [sharp intake of breath] I haven't done something or oh dear god it's got to the point where she she's needs it so much that that she's she's crying and she's really upset and she's she is going to think that I'm a bad mother. [Laura]*

This extract demonstrates Laura's feelings of inadequacy as a result of not knowing how to respond to her child's needs. The 'good' versus 'bad' mother is a dichotomy that all the mothers in this study subscribed to:

> *You're not being a good mother you know you're obviously not doing it very well. [Kate]*

Kate, here, reflects the circular version of motherhood endorsing the idea that mothers aspire to being a 'good' mother and if she perceives she is not doing 'it' well or is inadequate then she considers herself as a 'bad' mother. Holly also buys into this dichotomy of good versus bad based on inadequacy:

> *I probably spent most of the time feeling like feeling quite ashamed of how badly I was doing or how badly I felt I was doing and like the thoughts that I was having that you know which obviously no good mother would have. [Holly]*

Rather than feeling good enough, Holly's cognitions are polemic in nature: she felt her performance as a mother was 'bad' and her thoughts were not conducive to 'good' parenting; thoughts included leaving her daughter in town in order to obtain some sleep before they were reunited. She admitted to feelings of shame when reflecting on this. Holly's sense of inadequacy was deeply rooted in her biologically essentialist view that:

> *We are women and like you know that's what our bodies are designed to grow babies, birth babies and feed babies and it kind of it feels like a real personal thing if it's hard*

like we're not enough like you're broken somehow because you can't do it properly. [Holly]

Holly assumed that she would be genetically predisposed to inherit her family's 'amazing motherhood' trait and therefore lack of instinct would mean she was inadequate and 'broken' and that she had 'failed at being a person'. The use of 'properly' suggests that there is a right/wrong way to mother, another conflicted emotion, which will be discussed in the following theme.

'You feel like you're failing at everything'

The mothers' feelings of inadequacy were rooted in their person; they perceived that they were in some way deficient and not up to the task of mothering. The sense of not being good enough exacerbated to feeling they had failed and this was felt at a practical level as well as a personal level. All the mothers identified with failure and it was usually based on elements of motherhood they assumed and expected to possess. Clare identified with failure because she considered herself as 'weak':

[A strong mother] can regulate their emotions in order to perform the role of being a good, fit for purpose mother […] my inability to cope with the day to day challenges and sort of to control my own feelings and erm the frustration and the irritability and the anger and erm you know like the resentment […] and all those negative feelings like I think that a stronger mother would be able to deal with better and would be able to control them or perhaps understand them better so that it wouldn't affect their relationship with their child as much and that there would be a more positive dynamic.

This extract demonstrates that Clare was unable to regulate her emotions and manage her distress and she believed that this rendered her as 'weak'; she aspired to be a 'strong' mother by which she meant one who could regulate her emotions and therefore this mismatch led her to believe she was failing. According to Clare, a 'fit for purpose' mother would not get angry, frustrated or irritable confronting daily challenges. Clare states that she is not suggesting that mothers do not feel these negative emotions, however she said, 'I definitely felt like I was struggling more'. These, again, are examples of conflicted or dichotomous cognitions: others are perceived as strong whereas she is weak, others can control their negative emotions, whereas she is unable

to, and she perceived herself as struggling more than others. This all leads to her perception that she is failing at motherhood. Holly's perceived failure was directed as a personal criticism:

> *It's like the deepest kind of thing inside you like that's what you were designed for and you can't even do that […] like it feels really personal […] basically means you've failed at being a person. [Holly]*

Here, the personal criticism extends to Holly's womanhood and her gender identity is under attack; Holly believes that she has failed at being a person based on her perception that women are biologically predisposed to mother because women are 'designed' to bear and care for children. Holly felt that she was unable to care for her children which caused distress and this, again, is in direct contrast to the notion of motherhood she was aspiring to: that motherhood would be instinctive.

The mothers only noticed that maternal instinct was lacking when elements of motherhood were perceived as challenging, for example, Laura interacting with her infant and Ruth with breastfeeding; it is evident that the mothers' lived experiences and expectations they held were fundamentally different. However, despite the differences, there was a shared expectation across all the mothers in this study that an element of maternal instinct goes hand-in-hand with motherhood. Clare expected to 'give birth naturally' and to 'fall in love' with her daughter after giving birth but neither of those expectations were realised; for Kate bonding was also anticipated: 'the attachment thing was a big expectation that didn't happen' and yet she held liberal expectations around elements of motherhood, for example breastfeeding: 'it doesn't come naturally to the baby or the mum' but this could be due to her experience as a nurse. Jane was the only mother who did not believe her maternal instinct was lacking: 'I have such a strong motherly instinct […] it's just a natural instinct'. Although Jane bought into the discourse of motherhood as instinctive, she did not attribute her distress to a lack of maternal instinct, which demonstrates the idiosyncratic and complex nature of motherhood.

When the mothers fell short of the idyllic instinctive representation of motherhood, they felt guilty, inadequate and as if they had failed in some way, whether that was at a conceptual level, for example, Clare's 'weak' mother conceptualisation, or at a deeply personal level, such as Holly's perceived failure at being a woman. Their thoughts and feelings conflicted with the thoughts and feelings they associated with their idyll and impacted significantly on their subjectively lived experiences. The final theme explores the emotions elicited when the mothers prioritised childcare over all other aspects of their life; they endure a tremendous amount of loss and this will be explored next.

3.4 When prioritising childcare is not easy

'You should really devote yourself to them'

The final theme elucidated from the mothers' narratives is the priority mothers gave to their children over all other aspects of their lives; as a result, the mothers experienced a significant amount of loss. Holly saw herself as sacrificing her own wellbeing for the sake of her children; however firstly, she talks about the pressure she felt to devote herself to her children:

> *I think there's quite a lot pressure if you to have children now that you should really devote yourself to them rather than them just kind of being part of the family and muddling along […] if you are going to be a mother because it's almost because it's more of a choice now that you will do it really well umm and like that you'll be able to be a mother and also like all the other things you were before. [Holly]*

This extract exemplifies Holly's belief that contemporary motherhood expects mothers to 'really devote' themselves to their children and to 'do it really well' in addition to all the other roles and identities. Holly reflected on the choice women have regarding motherhood and this choice could impact on their experience especially if their experience does not live up to preconceived ideas around motherhood. It is interesting that Holly said she felt pressure to mother in a specific way; this suggests that her lived experience is located within others' expectations of motherhood, whether that is familial or the wider sociocultural norms. She later reflected that she knew it would 'take over' her life and that she was 'desperate to do it right'; she believed that if a mother falls short of

what 'society expects of you then you are somehow less of a woman or less of a person or a bad mother'. Holly believed that motherhood is such a key aspect of being an adult woman; therefore, being a mother and being a woman are inextricably linked. This is evident with the following quote where in order for Holly to feel good about being a woman, she prioritised childcare and attended to her infants' needs completely:

> *The only way that I was going to feel any kind of good about myself was if they were getting absolutely everything that they needed. [Holly]*

Not only does prioritising motherhood emanate from the mother, Ruth reflected that there is an expectation in society that motherhood should be prioritised:

> *It's a vocation yeah mothering is yeah that-that's really your primary role then once they come along. [Ruth]*

Here, Ruth implies motherhood is a profession and the mother role should be considered of primary importance where childcare is prioritised. Laura also reflected on the expectation within society that motherhood should become 'your whole world', however she believes that there is an expectation to 'give up everything' else. Before embarking on motherhood, Clare underestimated the importance of her role:

> *I didn't imagine how important my role was you know [laughs] there's this human being is just looking to me for everything and to understand how to erm interact and and how to behave and erm just her personality traits my mood and my personality and what I do with her all just creates who she is and that that role is massive. [Clare]*

From this extract it is evident that Clare believes that the nurturing she provides to her daughter is implicit in her daughter's development; if she believes she is solely responsible for this then it is understandable why Clare believes that it is such a 'massive' role and this would therefore require complete devotion.

For the mothers, complete devotion involved attending to their child's needs. However, this was difficult for those mothers who were unable to ascertain their infant's needs and establish how to satisfy them. The mothers believed

that acting in a specific way, or 'right' way, their infant's needs would be satisfied, however, if their needs were unmet, they believed that they had not done something or had done something 'wrong'. Dichotomous cognitions, for example right/wrong or good/bad, are peppered throughout the mothers' narratives, however inflexible cognitions with no middle ground often leaves the mother feeling distressed as Holly's excerpt demonstrates:

> *If she was crying I felt like I was doing something really wrong […] I was just so desperate to do it right. [Holly]*

In her quest to devote herself to her child, Holly found herself unable to fulfil her child's needs which left her distraught and led her to question whether motherhood was right for her. She was not alone in her deliberations; both Laura and Ruth questioned their decision to start a family.

> *I guess you just kind of wonder and things you know was this the right thing to do and it's so permanent. [Ruth]*

After deliberately embarking on motherhood, to question that decision demonstrates the complex and difficult emotions the mothers experience; at this stage it is too late to revert to their pre-baby lives and this black and white thinking has a profound impact on their emotional distress. Laura went so far as to say that she thought that her daughter would be 'better off with someone else' and reflecting on this made her very upset.

The consequences of prioritising childcare and aspiring to mother in a specific, inflexible way, were profound on the mothers' emotions and their lived experiences. Paradoxically, the mothers experienced a significant amount of loss despite supposedly experiencing a significant gain with the addition of an infant, and this loss covered many aspects of their lives which will be explored next.

3.4.1 Significant loss experienced when prioritising childcare
'Sleep deprivation'

Loss has been expressed in many forms in the mothers' narratives as a result of devoting themselves to their children; this is experienced in the felt sense but also in a functional way, for example sleep as Kate explains:

> *The thought of being a working mum was what tipped me over the edge really and going back to work um not knowing how I was going to manage with nightshifts with having a baby waking me up in the night and then doing nightshifts, I think it all started just as I was going back to work which was when he was about nine months old umm I stopped sleeping and I thought that I was getting upset and crying a lot because I wasn't sleeping, I'm a big sleeper. [Kate]*

It is evident from the excerpt that Kate experienced her distress nine months into motherhood; this does not conform to mothers' usual understanding of postnatal distress which is understood to be experienced immediately after birth. She believed her sleep was affected with the thought of managing work and motherhood and this caused sadness and fear around her ability to cope with both aspects. Laura believed that sleep deprivation has a significant impact on a mother's resilience when faced with difficulties:

> *The sleep deprivation makes it difficult as well because I find that everything is then catastrophic even the smallest thing is is much more difficult to deal with when you are sleep deprived. [Laura]*

Lack of sleep provoked resentment in Holly:

> *There were definitely times when I resented them like and yeah it's kind of there were times when I thought you know if I left the buggy in town and got back on the bus by myself and just kind of went home like how long would it be before someone kind of matched us up like how much sleep could I get before they brought them home. [Holly]*

This demonstrates how desperate Holly was to sleep when she contemplated a drastic act without considering fully the consequences of this action. A lack of sleep appears to provoke distress for the mothers and these were expressed differently as discussed.

'You're just a mum'

When prioritising motherhood, some of the mothers felt their identities were compromised; some lost their social standing and felt lonely, some felt they had lost their life, others their career and Jane lost her purpose in life:

> *I didn't have a sense of purpose you're just a mum, you're a mum and you're a housewife and you you know you have to keep it all together and if you can't keep it all together what's the matter? [Jane]*

The use of 'just' is interesting; Jane minimises the role of the mother suggesting that it is easy and achievable and if a mother finds it difficult there is something wrong with her. She prioritised motherhood but suggests it was not enough to fulfil her and pursued a career alongside. Clare's experience contrasted with Jane's because she was unable to mother and have a career; she recognised the importance of her role as a mother but by prioritising motherhood she lost her career and feelings of resentment developed. Sacrificing her career to prioritise motherhood caused Clare a tremendous amount of angst:

> *There was resentment in there because it's like I wanted to get my career going and I wanted to be doing that and now it's got to stop when I've got a child and you know it's sort of not knowing what your future is going to be and how to balance your life now. [Clare]*

It is evident from this extract that Clare was finding it difficult to find a balance which enabled her career to be progressed and her infant's needs to be sufficiently met. Resentment ensued because the balance was not found, and as a result Clare lost her career in order to care for her child. Pressure to prioritise childcare also emanated from her partner; he told her that his responsibility was 'to be earning the money'. These traditional gendered roles became a problem for Clare because she was unable to progress her career; she expressed a 'need' to have her career and this caused her distress because her own needs were not met.

Another evident loss experienced by a few of the mothers as they prioritised the needs of their child was within their social sphere and they felt lonely. Even though they attended groups and most of the mothers had a good support

network around them they still felt lonely; Jane went out of her way to talk to others:

> *I used to go to Morrisons just so that I could talk to somebody. [Jane]*

This loss is unsurprising when considering that most of the women worked with people around them during the day before becoming a mother and toddler groups only provide brief interactions for a number of hours where deep connections with others may be difficult. It is also unsurprising that they felt unable to disclose their distress to others and perceived other mothers as living up to the idyllic notions of motherhood; they also felt unable to disclose their feelings to their nearest and dearest where they may have previously been able to share their feelings, and this is likely to have compounded their loneliness.

Two of the mothers reflected that by prioritising motherhood they had lost their lives:

> *What I have done and it's [life] over basically. [Holly]*

> *I think there was just a lot of like confused feelings and resentment probably about like my life has stopped. [Clare]*

These distressing reflections are shocking; both Holly and Clare made the comparison to death after embarking on motherhood. This demonstrates how desperate and unhappy they were with their new mothering role and the death of their previous lives. Clare reflects on the plethora of feelings experienced when motherhood is likened to death and this stems from her difficulty adjusting to motherhood and her inability to pursue her career.

'I shouldn't want anything for myself'

Holly also experienced loss through the neglect of her own needs but her needs were more functional; this led to resentment and feeling broken.

> *In reality it's not selfish to want a cup of tea and a shower like every couple of days like the reality is that actually and it's something that I'm still still learning now like six years down the line is that actually I do really need to take care of myself and that actually that is not selfish because if I have taken care of myself then actually I can*

> *look after everyone else a lot better but then I think especially when Emily was newly born and the idea of that I wanted to do something for myself I didn't want to be with my baby all the time felt like horrendously selfish and it felt like I shouldn't almost like I shouldn't want anything for myself because I had this perfect baby umm which is hard. [Holly]*

It evident from this extract and elsewhere in her narrative that Holly wanted her own time and space away from her infant and yet she prioritised devotion to her daughter over her own needs. Holly's gaining of a child was so big that all else is lost which, again, demonstrates the paradoxical nature of motherhood. It took her many years to realise that it was not selfish to attend to her own needs and this is still work in progress. At the end of the interview she reflected on the compromise she made of her own wellbeing for the devotion to her children with this small, powerful extract:

> *To give them everything they needed probably a bit more really umm and then kind of slightly fade away inside myself. [Holly]*

Laura, like Holly, felt she had sacrificed her own needs for her infant until someone gave her permission to attend to her own needs, even if that meant leaving the infant to cry. Without that permission she felt like she was a 'terrible' mother which supports the previous theme:

> *Actually, I'm not a bad mother if I just leave her to cry for ten minutes while I have a shower, she's in the Moses basket she's safe […] without somebody saying that they were doing it I would have felt like a terrible mother just leaving her to cry. [Laura]*

This extract is interesting because Laura is seeking validation from others about how to mother; she did not feel that leaving her baby to cry was 'right', however, somebody else telling her it was acceptable was considered more important than her own feelings. These extracts demonstrate the lengths mothers were prepared to go to in order to satisfy their infant's needs to the detriment of their own instincts and well-being. Sitting alongside this is the feeling of depletion and a loss of physical and mental reserves, where the infant draws on the mother's resources without repletion, as expressed by Ruth and Kate:

> *I felt like I was giving and giving and giving and you get nothing back. [Ruth]*

You put in a lot of effort and you give a lot of love and I have given up my career pretty much to this to this point I'm still working but I can't move on umm you give up a lot and then and then you don't get as much back at all. [Kate]

'I just lost it completely'

All of the mothers' mental health deteriorated when they embarked on and prioritised motherhood. Three of the mothers saw themselves as having a mental health disorder and eventually received a diagnosis of postnatal depression; they attribute their distress to being ill. Postnatal depression was only identified for Jane with her second child; it was unnoticed first time around when she coped with her distress for three years without support. However, it became evident when this happened:

I don't think I realised how ill I was postnatally until probably I was eighteen months erm and that was when I just I just lost it completely and stood in her room with a knife and slit my wrists. […] Depression is an illness and to me I take my inhalers because it it erm helps my breathing you know it stops me stops me dying umm I-I take an epipen if I have an allergic reaction because it stops me dying I take citalopram because it stops me dying. [Jane]

This is a shocking extract because Jane went to great lengths to demonstrate the extent of the difficulties she experienced and the pain she felt. It was only then that she received the professional help she required. Jane experienced clinical depression when she was an adolescent and her father has a mental health disorder and therefore it is not surprising that Jane believed she was 'ill' and subscribed to the medical model. She believed she had a 'chemical imbalance' in her brain and her symptoms were as a result of a reaction to a situation, for example motherhood; for Jane medication alleviates the symptoms, her distress and ultimately stops her 'dying'. In this respect where a diagnosis explains Jane's severe distress and she identifies with the disorder, the medical model could be considered useful and appropriate. Three years on and Jane is still taking Citalopram (an anti-depressant) despite attempts to desist, which suggests that only Jane's symptoms are alleviated. She received no formal specialist psychological therapy. Kate also identified with this bio-medical discourse, possibly due to her training as a nurse and she was glad to receive her

diagnosis. Holly was also diagnosed with postnatal depression, however, she found the label 'very frightening'.

Loss of mental health when embarking on motherhood can be difficult to admit and all of the mothers took months, sometimes years, to admit that they were in distress; some of the mothers felt unable to admit this even when they started to enjoy motherhood. All the feelings induced by loss of mental health are in direct conflict to the emotions usually associated with motherhood and this particular ill/well dichotomy is difficult for the other mothers who do not identify with being ill; they would rather view motherhood as 'really hard' provoking complex and difficult emotions, however, with the exception of Jane, all of the mothers would have welcomed psychological therapy to ease their distress.

When the mothers in this study embarked on motherhood with the intention of prioritising childcare over all other aspects of their lives, they were unaware of the significant impact it would have on them. The mothers wanted to add to their partnership to become three and yet ironically the addition induced a significant amount of loss.

In summary:

It is evident from the mothers' narratives that they held particular notions of motherhood which guided their view of what they believed motherhood should look like. Often these notions emanated from society, but the importance of each idea was personal to each mother and therefore an idiosyncratic template of ideas was established. However, there was often a conflict between the notions that mothers held dear and their lived experiences resulting in psychological and emotional consequences provoking an inordinate amount of distress. Conflicts were not only experienced between the representations of motherhood and the mothers' lived experiences but also their cognitions and emotions were peppered with dichotomies as explored throughout the themes,

for example ill versus well. With the mothers in this study, distress was endured for months, often years, leaving the mother trying to reconcile conflicting, often distressing, cognitions with a plethora of negative emotions, without support. Until mothers feel able to disclose their feelings openly without feeling vulnerable and exposed to judgement for not conforming to society's representation of motherhood, motherhood idylls remain unchallenged and the paradoxical nature of motherhood remains intact.

Chapter 4: Discussion

The findings in this study revealed three master themes; all explored notions mothers held and aspired to during motherhood. It was evident that these notions were rarely achieved or achievable and as a result there were repercussions including emotional and psychological distress; this emotional conflict between the mothers' notions of motherhood and their lived experiences became the overriding theme for the study. The themes elucidated a plethora of negative emotions experienced during the early stages of motherhood and this was the main aim of the study, which has been an under-researched area within the psychological discipline; Rallis et al. (2014) called for research investigating emotions, other than those traditionally associated with postnatal distress, to enhance the understanding of mothers' phenomenological experiences. This study contributes to this understanding by identifying a number of different emotions not previously identified as distress during the early stages of motherhood.

The other aims of the study are also addressed by the themes which elucidated the impact of these emotions on the mothers' phenomenological experience and they illustrated how the mothers are often unable to reconcile their subjective experience with their expectation of motherhood. The study identified a potentially large group of mothers whose distress is unidentified within the current western culture of diagnoses and medical discourses. Whilst the researcher recognises that for some mothers a diagnosis may be appropriate and desirable, this study focussed on this subclinical group of women who did not identify with having a mental health disorder in early motherhood.

4.1 Limitations of the medical model

Much of the psychological research exploring postnatal distress is generated looking through a medical model lens, thereby viewing mothers as having a mental health disorder: postnatal depression, with symptoms based on

psychiatric nosology (DSM-5, 2013). Using this perspective, it is generally assumed that postnatal distress involves melancholy or anxiety (DSM-5, 2013; NICE, 2014; Mind, 2013). However, it was evident from this study that women's experiences did not have to include melancholy or anxiety to experience distress; in fact, only two women overtly identified with melancholy or sadness and both experienced it differently. One described a clinical form of sadness which subsumed all aspects of motherhood (Jane), the other described a fear of not being able to manage motherhood on her return to work which induced sadness (Kate). Any mental health problem can be experienced during the postnatal period and postnatal depression is not the only lens through which problems are viewed (Ross et al., 2006; Fairbrother et al., 2016; Beck, 2004; Simpson et al., 2016); it therefore seems important to consider whether mental health diagnoses specific to the postnatal period are warranted or desirable.

The plethora of women's emotions elucidated in this study were far-reaching beyond anxiety/depression and included resentment, feeling broken, lonely, overwhelmed, and inadequate to name a few; emotions not captured within the list of symptoms used to describe the mental health disorder in the DSM-5 (2013). It is therefore understandable why three of the mothers did not identify with the disorder. However, it is likely that if they visited their GP describing their symptoms, their distress would have been generalised as postnatal depression (Westall et al., 2011); the three mothers who saw their GP received this diagnosis. All the mothers expressed a reluctance to go to their GP; those who went, only went when their symptoms of distress became intolerable, on two occasions years later.

As discussed in the literature review, psychiatric diagnoses are hegemonic within western culture and the use of medical discourses has become an integral part of the vernacular (Pilgrim, 2010), for example 'anxiety' and 'depression' as opposed to 'fear' and 'sadness'. However, discourses like this can induce perceptions of those without depression being 'normal' and those with depression being 'abnormal' (Marecek et al., 2011); the findings in this study

supports this where the mothers are unable to disclose their emotions to others perceiving them as 'different' and not consistent with society's portrayal of motherhood. However, with up to 85% of mothers experiencing distress postnatally (Mind, 2013; Loyola University, 2009), this would suggest that emotional distress is a normal response to motherhood. The mothers in this study appear to have had a normal emotional response to a life stressor (becoming a mother), as opposed to an emotional response for no apparent reason (Horwitz et al., 2007); if their distress had been widely considered a maternal milestone (Parker, 1994), they may have felt able to talk about their distress and to seek emotional support earlier without fear of being pathologised as having a mental health disorder.

Another assumption made, based on the medical model, is that distress falls into two distinct timeframes: either it lasts for a few days after childbirth ('baby blues') and is considered to be 'quite manageable' (Mind, 2013), or is a more severe form of melancholy to the point of clinical depression which could last for a year or more (Mind, 2013; Royal College of Psychiatrists, 2016). Three of the mothers in this study experienced prolonged distress lasting more than two years and yet only one of them identified with postnatal depression. One mother experienced her distress for more than six months and another, still in the midst of her distress, for three; neither of them identified with the mental health disorder. Kate experienced no significant symptoms for the first nine months of motherhood and this changed when she was preparing to return to work. This illustrates that postnatal distress is neither predictive nor prescriptive and suggests again that the psychiatric categorical system does not reflect or capture all mothers' experiences. This study also suggests that there is a subclinical group of mothers who are not being supported appropriately. This subclinical group of mothers experience a plethora of emotions beyond the symptoms suggested for 'baby blues' and they experience these emotions for months, and some for years without clinical intervention; adjusting to motherhood is well documented (Smith, 1999a; Smith, 1999b; Darvill, Skirton &

Farrand, 2010; Winson, 2009) and it is recognised that it can take a substantial amount of time (Herbert, 1993; Ockenden, 2000).

The main aim of the study was to elucidate the plethora of emotions experienced during the early stages of motherhood; the most pertinent emotions will be explored in detail, however, viewing emotions as a discrete list oversimplifies the mothers' experiences and therefore it seems important to explore the amalgamation of emotions to demonstrate not only the profusion and diversity of emotions but also the idiosyncratic and complex nature of mothers' experiences. It also demonstrates that the categorical approach (DSM-5, 2013) to mothers' distress does not capture all women's experiences.

4.2 Mothers' complex range of emotions

Motherhood for Jane was a lonely existence and she became overwhelmingly sad which exacerbated to clinical depression, where she was diagnosed with postnatal depression by her GP. She felt as if she needed to control everything around her and her sadness was exacerbated the more out of control she felt; this supports Haga et al.'s (2012) study where heightened out of control feelings correlated with stress and depression. This state is thought to be the last stage before thoughts of self-harming (Westall et al., 2011) and her overwhelming sadness culminated in an act of despair: she stood in the nursery and cut her wrists; she could no longer manage her feelings and hours later she received a diagnosis of postnatal depression. This supports the research that if mothers do not receive early psychological intervention, the symptoms of distress can exacerbate into a psychiatric disorder, i.e. clinical depression (WHO, 2004; Steenkamp et al., 2013). It therefore seems important to identify these women before they suffer prolonged, unnecessary distress and this is where counselling psychologists may be able to support them.

Often despair has an impact on the relationship a mother is able to build with her child (O'Higgins, Roberts, Glover & Taylor, 2013) and yet the constant in Jane's life was the love she felt for her child demonstrating again the idiosyncratic and complex nature of motherhood. The same, however, could not be said for Clare who experienced motherhood completely differently. She felt disconnected from her infant and didn't fall in love with her daughter after giving birth and believes this could have been due to the birth itself where she was 'out of it' having had a caesarean section, however this is not supported by research (Figueiredo, Costa, Pacheco & Pais, 2009). It took Clare two years to 'really connect' with her daughter, believing she was 'weak' as opposed to the other dichotomous position 'strong' because she was unable to regulate her emotions which included irritability, anger and frustration. During that time, she believed her life had stopped and feelings of resentment towards her daughter ensued. Clare wanted to work and yet she was expected to prioritise motherhood; this expectation came from her partner. Traditional gendered roles of the early-twentieth century are still evident in contemporary society, especially if the woman is materially dependent on the man (Ridgeway, 2011; Dotti & Giulia, 2014). Two years later, Clare found a work/motherhood balance through accessing psychological therapy and, with hindsight, she wished she had been able to access the 'tools for life' earlier in order to have alleviated her distress sooner.

Laura took part in this study three months into motherhood and was still in the midst of her distress. She did not delight in motherhood and felt overwhelmed by being out of her 'comfort zone' when it came to knowing how to mother. It was Laura's belief that she should experience a 'maternal instinct' rather than trusting that she could learn mothering as a new skill set (Westall et al., 2011; Haga et al., 2012); it was her inability to master these skills that left Laura with this overriding insecurity she felt. Ruth also felt overwhelmed, but this was due to the amount of conflicting guidance she accessed on the internet when she was trying to solve a problem, for example, implementing sleeping patterns, or guidance on feeding. Mothers are inundated with material in the form of

manuals, magazines or forums (Johnston et al., 2003; Mumsnet, 2016) and how mothers are represented in the media can add to a mother's burden of responsibility (Oberman et al., 1996). Ruth turned to the internet to assist her in fulfilling her daughter's needs, but nothing appeared to work; this led to Ruth's worry that she would never be able to satisfy her daughter's needs and that she would always be unhappy. Ruth could see no way out from this which led to Ruth's 'feeling of doom'; that life would never change, and this culminated in resentment towards her daughter.

Holly also felt resentment towards her children, but this was because she felt they prevented her from obtaining much needed sleep; according to McQueen et al. (2003) and Westall et al., (2011), fatigue and sleep deprivation are two contributory factors for developing postnatal depression. Holly's distress, like Jane's, lasted for over two years before the symptoms became intolerable and she consulted her GP; Holly too received the diagnosis of postnatal depression. The overriding emotion from Holly's narrative was feeling 'broken'; she felt this at emotional and physical levels. She felt 'less of a woman', 'less of a person' and 'a bad mother' because she felt she did not possess the inherent natural instinct that she believed mothers 'should' have. She also felt physically broken where she fantasised leaving the children in town in order to catch up on sleep before the children were returned to her.

Kate, on the other hand, loved motherhood and, although she admitted there was no emotional bond initially with her son, this did not prevent her from engaging with him and enjoying her time with him. Her difficulties appeared nine months into motherhood when she was returning to work. She feared how she was going to manage nights as a nurse around caring for her young child whilst at home; this impacted on her sleep (McQueen et al., 2003; Westall et al., 2011) and made her distressed which eventually led to a diagnosis of postnatal depression.

The exploration of the mothers' lived experiences elucidated a plethora of emotions felt during the early stages of motherhood, but they were not

experienced in a vacuum; the amalgamation of many emotions, often conflicted in nature, contributed to the mothers' lived experiences creating a landscape of emotional complexity. It was striking how diverse each experience was and also, even if two mothers experienced the same named emotion, the evocation of the emotion and the effect it had on the mother were markedly different. An amalgam of uniquely felt emotions created an idiosyncratic experience for each mother. Although the emotions identified in this study did not produce an exhaustive list, the most salient emotions experienced were identified, it therefore seems important to explore some of the prominent individual emotions felt in more detail.

4.3 Exploration of prominent individual emotions

4.3.1 Loneliness

Loneliness is high on social agendas at present, but mainly in relation to young adults (Matthews et al., 2018; Yayan, Dag, Duken & Emin, 2018; Macrynikola, Miranda & Soffer, 2018) and older adults (Gardiner, Geldenhuys & Gott, 2018; Hawkley & Kocherginsky, 2017; Dahlberg, Agahi & Lennartsson, 2018). Loneliness is usually taken to mean, in psychological thinking, the subjective experience of social isolation where there is an absence of social support (Weiss, 1973). Therefore, it is unsurprising that some of the mothers experienced loneliness; they transitioned from working women, where they were in contact with people on a daily basis over long periods of time and had established relationships, to motherhood where relationships with similar others are formed through various brief groups. Mothers have expressed dissatisfaction with the quality of these relationships and this is considered a factor contributing to loneliness (Lee, Vasileiou & Barnett, 2017); however, persistent playgroup attendance may be a protective factor (Hancock, Cunningham, Lawrence, Zarb & Zubrick, 2015; Strange, Fisher, Howat & Wood, 2014).

Other factors considered to contribute to loneliness include perceived deviations from social 'norms' and perceived discrepancy between idealised and actual notions of motherhood both of which were identified with by the mothers in this study (Lee et al., 2017). Loneliness is considered a salient emotion found in motherhood (Yantzi et al., 2007) and the degree of loneliness felt correlates with a smaller social network, and psychological distress (Mandai, Kaso, Takahaski & Nakayama, 2018; Hawthorne, 2008; Luoma, Korhonen, Salmelin & Tamminen; 2015). A pilot study revealed that offering regular support seemed to impact positively on mothers' mental health and on her relationship with her baby (Cust, 2016) and therefore extending support to mothers who are socially isolated may prevent feelings of loneliness and psychological distress.

4.3.2 Sadness / Depression

Sadness is generally understood within the psychological discipline as a negative emotion induced by the experience of pain or loss; it is considered to be an adaptive appraisal to a specific situation (Barker, Vossler & Langdridge, 2010; Parkinson, 2007). Bowlby (1998 p. 245) refers to sadness as a 'normal and healthy response to any misfortune'.

The emotion has specific understandings according to different psychological perspectives. From a psychoanalyst perspective sadness, or melancholia, is located in the psyche and a response to loss. Freud (1917) in his paper Mourning and Melancholia posits melancholia, an unconscious process, as a loss which the person is unable to fully comprehend. Leader (2008) postulates that melancholia involves an impossibility or a task that is perceived as impossible and a melancholic has a difficulty communicating this. If a melancholic is unable to communicate with the external world they may feel hopeless or helpless, a characteristic of depressive disorders, and negative emotions, e.g. aggression, are turned in on the self (Bowlby, 1998).

These intricate structures studied by psychoanalysts are often reduced to biochemical problems from a medical perspective (Leader, 2008); severe and prolonged sadness can be understood as a mental disorder: depression, based on a set of symptoms experienced for a number of weeks (DSM-5, 2013). Psychiatrist Beck (1967) developed a further understanding based on his cognitive theory of depressive disorders; he thought that depression was a natural expression based on how someone thinks about self, the world and the future. There are therefore different understandings of sadness and in addition, the word 'depression' has become an integral part of society's vernacular (Pilgrim, 2010) and is used ubiquitously to describe feelings of sadness (Horwitz et al., 2007).

Sadness or depression is the emotion most commonly associated with postnatal distress according to the criteria within the DSM-5 (2013); a mother visiting her GP experiencing sadness would probably leave with a diagnosis of postnatal depression (Westall et al., 2011) and this medical approach excludes other understandings of sadness and depression (Freud, 1917; Bowlby, 1998; Leader, 2008; Beck, 1967).

Only two of the mothers in this study expressed that they experienced sadness and interestingly they both went to their GP and received the diagnosis. As previously discussed, a diagnosis can ignore the naturally occurring 'highs and lows' of life (Kokanovic et al., 2013) where sadness is a normal response to a life stressor (Horwitz et al., 2007) and is considered an integral part of motherhood (Parker, 1994). However, this does not mean that sadness should be ignored or accepted; there could be other explanations for sadness where a 'normal' response to motherhood or a diagnosis are deemed inappropriate. There is a significant amount of research that implicates hormonal fluctuations with the onset of sadness or depression in early motherhood (e.g. Studd, 2015; Brummelte & Galea, 2016); and therefore, with a biological aetiology, medication may be the best course of action to alleviate distress. This may have been the case with Jane, however, Kate experienced her sadness nine months

into motherhood when she was considering returning to work and managing the two roles, which suggests a different aetiology and demonstrates the complexity of how emotions are experienced at the individual level.

Sadness or depression is also implicated in a mother's inability to form a relational bond with her infant. A depressed mother may be less sensitively attuned to her infant and less likely to form a secure attachment (Brummelte et al., 2016; Murray et al.,1996; Kokubu, et al., 2012) inducing reciprocal withdrawal which can have detrimental effects on the infant, both emotionally and behaviourally (Prenoveau, et al., 2017; Tully et al., 2017). Sadness could also be induced if the mother is unable to live up to her idealised notion of motherhood; the premise of the child-centred 'mandate' is the relatedness between the mother/infant. Two of the mothers found it difficult to bond with their children and although they expressed that a lack of bond was a prominent emotion for them, sadness could be implicated in their inability to relate to their child at a deep emotional level. This demonstrates that emotions are subjective and idiosyncratic at felt and expressed levels; they are also complex and rarely experienced in isolation.

4.3.3 Resentment

From a social psychological perspective, resentment is defined as an indignation at being unfairly treated (TenHouten, 2018); it may be induced if a discrepancy is perceived between one's own situation and the situation of others (Corning, 2000). It is thought to comprise three primary emotional components; anger, surprise and disgust (TenHouten, 2018). From a sociological perspective, perceived social inequality and competitive relationships can lead to resentment (Turner, 2011).

There is little research exploring resentment in motherhood, however two of the mothers identified resentment as a salient emotion: when they felt there was an injustice that their needs were being superseded by their infants' needs, they felt a sense of injustice and resented their child. For example, Holly's

resentment towards her daughter stemmed from sleep deprivation and a belief that attending to her daughter prevented her from acquiring sleep; Clare's resentment emanated from having to prioritise childcare over pursuing her career. They were both trying to live up to the idealised notion of motherhood of prioritising their infants' needs over their own, however, this led to resentment. This pressure mothers feel to live up to idealised notions can leave them feeling like a 'bad' mother, however it is believed that a relaxation of expectations will enable mothers to manage stressors and attend to her own well-being (Currie, 2018).

4.3.4 Overwhelmed

A mother who is unable to cope with a situation, bordering on feeling out of control, is considered to be overwhelmed (Ruthven, Buchanan & Jardine, 2018). This vulnerability is reinforced by loneliness, guilt and shame (Hubert & Aujoulat, 2018); all salient emotions experienced by the mothers. At worst, feeling physically and emotionally overwhelmed can induce extreme exhaustion or 'burnout' (Hubert et al., 2018); this appeared to be the case with Holly who felt she was 'broken' when she experienced extreme exhaustion.

Feelings of being overwhelmed can be induced in contemporary motherhood by the pressures mothers feel they have to live up to, exacting standards and idealised notions of motherhood. Not only are mothers often expected to build a career, but they are also expected to be an exceptional parent; this perception is often internalised through the idealised representations of motherhood, already explored. An example of feeling overwhelmed from this study is the expectation of knowing how to mother; if mothers are unsure, they turn to the prolific amount of knowledge available on the internet; all forms of knowledge within 'public culture' are represented (Faircloth, 2013), from other parents, social media and academics. Mothers often perceived that their lack of knowledge of how to mother was because they lacked 'maternal instinct' rather than an essential need to acquire a new skill set (Westall et al., 2011; Haga et al., 2012); this led to feelings of being overwhelmed and feeling out of their

'comfort zone'. These persecutory ideals place unreasonable demands on mothers (Nash, 1995) and contributes another layer to their psychological distress.

4.3.5 Guilt

Guilt is considered to be a negative evaluation of self (Sutherland, 2010) when a person perceives their actions have contravened a moral boundary and disadvantaged another person (Gibson, 2018); guilt was the one emotion that all the mothers identified with. Guilt is now considered an intrinsic constituent of motherhood (Seagram et al., 2002) and yet is not named as a symptom of postnatal depression (DSM-5, 2013) and, again, questions whether the categorical approach reflects women's experiences. Guilt was experienced differently by each mother and experienced in all aspects of motherhood, whether that was for the negative emotions experienced (Holly) or a perception of not being able to fulfil their child's needs (Ruth, Laura). When exploring guilt with the mothers, it was apparent that they felt the emotion if they perceived something was lacking or they had not lived up to their mothering ideal and this is supported, not only in the findings of this study but also in the psychological literature (for example, Sutherland, 2010; Liss et al., 2013; Adams, 2015; Higgins, 1987; Doucet, 2000).

Specifically, Higgins' (1987) self-discrepancy theory, which suggested that a discrepancy between a person's lived experience and their 'self-guide', for example aspirations, induces emotional discomfort. He elaborated further by suggesting that a discrepancy between actual attributes (lived experiences) and 'ought' attributes (attributes it is believed we should possess) produce 'agitation-related emotions' which include fear and guilt (Higgins, 1987). There is evidence to support this in this study; for example, Ruth and Laura both believed they 'ought' to know how to attend to the needs of their infants and when they felt they were lacking they felt guilty.

Higgins (1987) also draws on the experience of shame in the 'dejection-related emotions' where he suggests shame is induced if there is a discrepancy between the lived experience and idealised attributes; attributes mothers would like to possess. However, shame was only specifically named by one mother: 'quite ashamed of how badly I was doing' [Holly]. According to Sutherland (2010) guilt implies doing something wrong either an act or behaviour whereas shame is induced by fear of public disapproval or when the esteem of others is at risk. As discussed in the literature however, they are often conflated (Tangney et al., 2002) and it appears that Holly is describing a feeling of guilt. Shame is therefore not apparent in the mothers' narratives, however, stepping away from the data, it seems important to explore shame.

4.3.6 Shame

In the broadest sense, shame plays an important part in mental health difficulties (Orth et al., 2006; Wright et al., 1989; Tangney et al., 2002; Turner, 1999) and all the mothers in this study identified with distress. Shame in particular is identified as the emotion caused through trying to live up to be a 'perfect' mother (Liss et al. 2013) or if a mother perceives herself as being a 'bad' mother (Parker, 1997); these were identified in the findings through the aspiration of the 'yummy mummy' representation of motherhood and the dichotomous cognitions of 'good' versus 'bad' parenting. Specifically, shame can be produced by feelings of inadequacy or failure (Scheff, 2000) which the mothers in this study also identified with, as illustrated in the findings when the mothers found that motherhood was not instinctive as they expected. Shame is described as the 'social emotion' (Scheff, 2000) and is inextricably linked to relationships (Higgins, 1987; Liss et al., 2013; Adams, 2015) and could therefore be implicated in feelings of loneliness; the nature of shame is to conceal experiences from others, which are thought to be 'incommunicable to others' (Kaufman, 1980, p.vii) or induce 'public disapproval' (Sutherland, 2010) and all the mothers concealed their distress from others.

None of the mothers in this study recognised that their inability to disclose difficult emotions was perhaps due to shame; this is not surprising when shame is often conflated with guilt (Tangney et al., 2002) and all the mothers identified with guilt. This mismatch suggests that shame is perhaps a terminology clearly defined by those studying it but is not generally understood in this way within society. However, shame could explain why all the mothers felt a need to conceal their emotions and act as if all was well to society. The mothers felt that their experiences of motherhood did not conform with society's acceptable view of motherhood and if a mother feels 'different' and has deviated from social and cultural norms she may feel stigmatised fearing public disapproval (Kitzinger, 2006) and this may impact on whether they seek help (Barney et al., 2006); as discussed at length in the literature review (Dennis et al, 2006; Park et al., 2015; Clement et al., 2015; Halter, 2003; Barney et al., 2006; Corrigan et al., 2003; Schulze et al., 2003; Fink et al., 1992; Link et al., 2017). All the mothers found it difficult to seek help and for those who did, it took months often years; shame proneness is a predictor of reduced help-seeking behaviours and depressive symptoms (Dunford et al., 2017). It therefore should be considered that shame could be a contributory factory to mothers' distress despite the apparent absence in the mothers' narratives in this study.

Although these emotions have been explored individually and as a discrete list, in reality they overlap, merge and impact on each other; it is also not an exhaustive list. For example, fear is another dominant emotion evident when the mothers perceived public disapproval; fear, however, will be explored in the following section because it is particularly relevant to the notions of motherhood where mothers hide behind a mask of normalcy to avoid public disapproval. This, again, illustrates that it is important not to explore emotions as a discrete list and demonstrates the complexity of how they are experienced.

The mothers learn to negotiate a powerful concoction of emotions and these are often conflicted, for example guilt and isolation sit alongside love and devotion (Oberman et al., 1996); although reflecting on any positive emotions

was difficult for the mothers in this study. The conflicted nature of emotions permeated into motherhood and this was clearly evident throughout the themes where the mothers aspired to specific notions of motherhood which were expected to elicit specific positive emotions and yet the mothers' lived experience fell short of their aspirations and elicited negative emotions as previously discussed. This conflict between the mothers' notions of motherhood and their lived experience became the overriding theme in the findings.

4.4 Notions of motherhood

Motherhood is represented in many forms in society and although buying into the representations suggests an element of choice, Sutherland (2010) believes 'mandates' are imposed on mothers which guide them to mother in a society-accepted way; after all, a 'good mother is one who conforms' Kitzinger (2006, p. 255). Dominant ideas become the norm (Rudolfsdoltir, 2000) and 'qualified guides for action' (Sykes et al., 1957 p.666) and this appears to be the case with the mothers in this study. They aspired to three specific representations or 'mandates': the idyllic notion that motherhood is 'wonderful'; the notion that motherhood, or aspects of motherhood, is instinctive; and the notion that caring for your child should be prioritised. All the mothers in this study aspired to these notions but their expectations were not realised, in fact their lived experiences were in direct contrast to their expectations and as a result, there were psychological and emotional consequences.

All the mothers embarked on motherhood believing that it would be 'wonderful'; only one mother found it to be so until she encountered difficulties nine months later. As discussed in the literature review, within western society, motherhood is portrayed as non-problematic and a positive experience (Nicholson, 2001) and it appears that the mothers in this study bought into this portrayal. However, this left the mothers unprepared for their experience (Choi et al., 2005) when they found they were not enjoying motherhood or found it

problematic and this resulted in a great deal of distress; a plethora of negative emotions were elicited as previously discussed.

Sitting alongside this idyllic notion of motherhood is the 'yummy mummy' and three of the mothers identified with this notion. To appear well groomed after childbirth to the point of perfection typifies the 'yummy mummy' representation and this perception is in 'deep conflict' with other discourses surrounding good mothering (Malatzky, 2017b). This quest for glamour is encouraged through the media placing a significant amount of pressure on the mothers to adhere to this representation; Daniel (2006), a freelance writer, attacks her colleagues for doing this in her article. Perfectionism is a known contributor to psychological distress (Geranmayepour et al., 2010; Westbrook et al., 2011); the concept of perfectionism is ubiquitous within western society and dimensions within the concept include concern over making mistakes, high personal standards and fear of criticism (Frost et al., 1990).

The literature also suggests that mothers who do not conform to these idyllic representations of motherhood may be subjected to criticism and judgement (Marshall & Thompson, 2014). Society as a whole (Oberman et al., 1996) and other mothers specifically (Almond, 2010) can denigrate non-conforming mothers; and some psychologists describe non-conformists as 'deviant' (Couvrette et al., 2016). This fear of criticism and judgement for non-conformance was the harsh reality for the mothers in this study and the use of provocative language extends into the mothers' narratives, for example Laura's 'defective'.

If a mother perceives she is not conforming to the social and cultural norms, she may feel 'different' and stigmatised fearing public disapproval; deviance from the norms could induce thoughts of incompetence or abnormality (Dallos et al., 2015). To reconcile this conflict, mothers avoid disclosing their distress by putting on a 'performance' (Goffman, 1990) to others that all is well thereby adhering to society's expectation of them. It was evident from this study that the mothers hid behind a mask of normalcy to protect their sense of self from

society's harsh critics (Westall et al., 2011) and behave in a 'morally acceptable' way in order to belong to the social group (May, 2008); they often projected themselves as 'supermum' to hide their inadequacy (Choi et al., 2005), one example would be those who aspired to the 'yummy mummy' representation in their public sphere. Despite the fact that women share many confidences (Tardy, 2000), they do not always share their experience if it deviates from the socially acceptable norm and this supports Goffman's (1990) model of dramaturgy.

This study supports the literature given that the mothers identified fear as one of the primary emotions behind their concealment: fear of being negatively judged by others because their thoughts and feelings did not conform to the socially acceptable representation of motherhood as previously discussed (Lewis, 1996; Marshall, 1991; Nicholson, 2001). Holly, for example, feared she would be viewed as a 'monster' for not being able to do something she believed she was biologically designed for, i.e. motherhood; she thought others may report her for being a 'bad' mother and her husband would leave her feeling 'disgusted'; Laura feared that others would view her as a 'terrible mother' and avoid her. As discussed, mothers hold idealised perceptions of motherhood which often reflect society's idealised and romanticised representations of motherhood and therefore, if a mother presents a mask of 'normalcy' she is able to reflect the sociocultural norms and expectations (Nicholson, 2001; Parker, 1994; Westall et al., 2011, May, 2008). The mothers in this study wore a metaphorical 'mask' to protect themselves from society's harsh critics (Westall et al., 2011). By wearing a mask of normalcy, difficult aspects of motherhood are denied, and these unrealistic, idyllic representations of motherhood remain unchallenged.

The second notion identified was the idealised perception that elements of motherhood should be naturally instinctive; this perception is deeply embedded within western society and the idea that women possess an innate aptitude to bear and care for children has been socially subscribed to (Nicholson, 2001).

This biological essentialist ideology may have come to define women by constructing their identity through their reproductive capability (Craig et al., 2009). Maternal instinct appears to be embedded within the biological discourses in Western society and some psychologists, including Bowlby and Winnicott, suggested that to be a 'good' mother depends on empathetic attunement and instinctual feelings (Tardy, 2000) which could imply that mothering is a natural phenomenon. However, this is not reflected in the experiences of the mothers in this study, despite their apparent belief in the phenomenon and their perceived deficiency in experiencing it, or in wider society (Mind, 2013; Parker, 1997).

All the mothers subscribed to this idealised perception of motherhood; they all expected an inherent instinct in certain areas of motherhood where they perceived it was lacking. For some, it was the biologically natural phenomena, for example breastfeeding (Ruth) or giving birth (Clare), where they conflated 'biologically natural' with 'natural' or straightforward. Based on her belief that being a woman and being a mother are inextricably linked, Holly assumed natural instinct would be available to her and therefore appears to subscribe to the motherhood imperative ideology where being a mother is essential to being a woman (Peacock, 2015). For others it was knowing how to mother and Laura called for a manual for guidance; it was evident that motherhood involved unanticipated elements of learning and required practice to hone their skills (Westall et al., 2011; Haga et al., 2012). If the cultural representation of motherhood was that being a mother often necessitated learning and practice, then there is likely to be less pressure on mothers to be naturally competent and this may result in less distress if they do not feel they have failed to live up to their idealised perception of motherhood.

A consequence of a conflict between aspiring to this perceived instinctual notion of motherhood and their lived experiences were feelings of guilt, inadequacy and failure. All the mothers identified with these emotions where inadequacy (Dallos et al., 2015) and guilt (Seagram et al., 2002) are seen as intrinsic parts of

motherhood. As discussed in the literature review, feelings of failure (Lewis, 1996), which all the mothers subscribed to, may be induced when a mother encounters difficulty or her experience is in direct contrast to dominant portrayal of motherhood (Lewis, 1996; Marshall, 1991). Failure is also implicated in postnatal distress (Hannan, 2016).

The final notion identified in the study was how the mothers prioritised childcare over all other aspects of their life and this phenomenon is also recognised within the psychological literature (Hays, 1996; Orenstein, 2000; Warner, 2005). The literature suggests that a child-centred approach was not a choice but a 'mandate' imposed on mothers by society (Sutherland, 2010) and if a mother did not prioritise childcare then the child's wellbeing was at stake (Hattery, 2001). This is supported by eminent child development theorists and psychoanalysts who extolled the importance of the relationship between the child and primary care giver, usually the mother (Bowlby, 1958; Winnicott, 1964 and Kohut, 1980). The relatedness between the mother and infant is considered important for the long-term social and emotional wellbeing of the child (Bowlby, 1997) and for the infant to thrive (Kennell et al., 2005) and this is supported by neuropsychological evidence (Gerhardt, 2004).

Bowlby (1958) espoused that if the nurturing environment is lacking the infant would suffer detrimental effects including cognitive, social and emotional difficulties and this was endorsed by Ainsworth (1978) in the Strange Situation test as explored in the literature review. Winnicott (1964), however, suggested that mothers only had to be 'good enough' but this mitigating approach was not reflected in the narratives and experiences of the mothers in this study who subscribed to the deeply entrenched child-centred ideology. A consequence of subscribing to this notion of motherhood resulted in the mothers experiencing a tremendous amount of loss.

Loss was experienced in all aspects of life from functional needs to the loss of a sense of self. The most prominent functional need was sleep and its deprivation is implicated in postnatal distress (McQueen et al., 2003; Westall et al., 2011). A

child-centred approach also impacts working mothers and this is well documented within the psychological literature as already explored (Johnston et al., 2006; Dallos et al., 2015; Christopher, 2012; Okimoto et al., 2012; Hollway, 2010); both Clare and Jane tried to reconcile work with this notion of motherhood. Laura and Holly found it difficult to attend to their own needs and this impacted their sense of self; this is evidenced in the psychological literature (Walters et al., 2009; Elliott et al., 2015) and is known to have detrimental effects on mothers' emotional and psychological wellbeing (Sutherland, 2010; Henderson et al., 2016).

Control is another loss that was evident in the mothers' narratives. For Jane this had a detrimental effect on her psychological well-being where she self-harmed at her peak of desperation; the psychological literature suggests that stress and depression correlate with loss of control (Haga et al., 2012) and can lead to self-harm (Westall et al., 2011). Holly and Clare used the metaphor of death, a shocking reflection which demonstrates the powerful conflicting emotions at play during motherhood. It is ironic that they have given birth to new life and yet they consider their own life had stopped. Loss for the mother is clearly evident in all the mothers' narratives and yet appears to be an under-researched area by psychologists in favour of research into child development (Parker, 1997; Oberman et al., 1996).

There appear to be strong social pressures and dominant discourses for mothers to aspire to and yet these ideals could be considered unrealistic and untenable for these mothers and this is supported in the psychological literature (Lupton, 2000; Parker, 1994; Choi et al., 2005). These pressures are amplified further through the media and the increased popularity of manuals, childcare magazines and the internet (Johnston et al., 2003; Phoenix et al., 1991; Mumsnet, 2016); the prevalence and impact of media on the mothers was evidenced in the mothers' narratives; Ruth, for example, searching for ideas to solve her motherhood challenges and the identification of the 'yummy mummy', which added to the mothers' burden of responsibility (Oberman et al., 1996).

It is evident from these themes that mothers strive for idealised notions of motherhood but there is a disjuncture between them and the mothers experiences (Arendell, 2000; Blackburn, 2007). Idealised versions of motherhood deny any difficult aspects of motherhood (Craig et al., 2009) and appear to cause an inordinate amount of distress. This is an area where mothers can be supported by a counselling psychologist to explore the conflicted notions they hold and to reconcile the differences through acceptance and normalising.

The conflict between the notions of motherhood the mothers held, and their lived experiences was clearly evident, however this was not the only area of motherhood where the mothers encountered conflict; they demonstrated conflicted cognitions. The use of dichotomies was apparent in all the mothers' narratives, for example, good mothering as opposed to bad, the right way to mother as opposed to the wrong way. Psychologists have tended to regard mothers and motherhood in dichotomies, for example providing the 'right' environment for the infant (Bowlby, 1958), good breast/bad breast (Klein, 1946), or Winnicott's (1994) call for the mother's integration of love and hate; it is evident from this study that the mothers also viewed themselves and/or motherhood using specific polarities.

When a mother did not identify with a particular dichotomy, she was able to view her world less as black and white but with more variation and areas of grey, for example, Laura initially believed she was a 'bad' mother if she left her baby to cry and after receiving reassurance from another that in certain circumstances, for example when she was having a shower, leaving her baby to cry would not make her a 'bad' mother, she was able to see the grey. The only dichotomy all the mothers identified with was whether they perceived themselves as ill or not. As discussed earlier, three of the mothers bought into the medical discourse and identified with having a mental illness, the others openly rejected the notion of being ill. Black and white thinking is considered to

be a cognitive distortion where mothers are unable to see anything in between and the distortions are implicated in mental health difficulties (Beck, 1963); a consequence of dichotomous cognitions is psychological distress. Although they go some way to elucidate how mothers regard motherhood, dichotomies do not capture the range of emotions experienced in motherhood (Oberman et al. 1996) and this, again, is an area that could be explored with a counselling psychologist: to unpick the grey in those areas regarded as only black and white.

The three major themes that most strongly emerged are not considered to be an exhaustive list of ideologies mothers aspire to, but these were clearly identified and prevalent within this study. As discussed, their narratives suggest that when the mothers felt there was a conflict between their aspirations and their lived experiences, they experienced emotional distress. This supports Higgins' (1987) self-discrepancy theory, however, it is unclear if the plethora of emotions experienced by the mothers in this study can be reduced to two clusters of emotions: 'dejection-related emotions' or 'agitation-related emotions' as explored at length in the literature review; although guilt and possibly shame appear to play an important part in the mother's experience. However, the conflict that occurs can help us understand how mothers negotiate motherhood and also guide counselling psychologists with offering emotional support and this will be explored next.

4.5 Supporting mothers and the role of Counselling Psychology

One difficulty identified during this study is the paradoxical nature of support: the mothers do not appear to recognise the need for support or are reluctant to seek support and are therefore reliant on others to identify problems and yet mothers are adept at concealing their distress from others. All the mothers in this study were reluctant to seek help; they all perceived that their experiences were different when compared to societal norms and, based on fear, concealed their distress from society; it is recognised that stigma plays a significant part in help-seeking barriers. This is a well-documented phenomenon within

psychological literature, as previously discussed (Dennis et al., 2006; Park et al., 2015; Barney et al., 2006; Clement et al., 2015; Halter, 2003; Corrigan et al., 2003) and is implicated in mental health deterioration (Schulze et al., 2003; Fink et al., 1992; Link et al., 2017). It therefore seems important to find a way to support this subclinical group to ease their distress before it becomes an entrenched prolonged psychiatric disorder (WHO, 2014).

One of the mothers, Jane, suggested that support should start in the birthing units where there is 'nothing about the mum' but plenty of information about caring for the baby; psycho-educational material about postnatal distress could be given to mothers and birthing partners with a guide to the negative emotions to look out for. This psycho-educational work could also be offered as an essential part of ante-natal classes which many mothers attend. Postnatally, all the mothers found that health professionals prioritised the welfare of the infant over their own wellbeing and therefore it seems important to consider the mother's wellbeing more fully at the baby's developmental checks (Coates, 2015), bearing in mind that the mothers are adept at concealing their true feelings.

From the experiences of the mothers in this study, distress eventually subsides after many months (Ruth), or the distress becomes intolerable, after months sometimes years, and the mothers seek support. Clare and Laura sought psychological therapy and Jane, Holly and Kate sought support from their GP. At present, if a mother visits her GP postpartum experiencing distress, she is likely to leave with a diagnosis of postnatal depression and will probably be offered psychotropic medication (Westall et al., 2011); this is what happened to three mothers in this study. Medication for some mothers may be beneficial to reduce symptoms however it can reinforce feelings of inadequacy and failure (Holopainen, 2002), which the mothers in the study identified with. Three years after commencing medication, Jane is finding it difficult to desist because her symptoms reappear; she did not want psychological therapy. Both Holly and Kate took medication but also sought professional support in the form of

psychological therapy; for Kate, being a mother made her world lack clarity and the medication eased her symptoms enough to engage in therapy, therefore, a combination of the two alleviated her distress. Medication may not be women's preferred form of support and should therefore not be viewed as a panacea (Toates, 2010); in addition, research suggests that the efficacy of psychological interventions is superior to medication (Cooper et al., 1998; Dennis et al., 2006; O'Hara et al., 2000). Therefore, psychological interventions may be the best course of action to support these mothers who fall within this subclinical group.

It is clear that the mothers in this study who engaged in psychological therapy thought it was beneficial and they wished they had accessed it earlier; and those who did not receive any treatment in hindsight believed that therapy would have been beneficial. Psychological intervention could be considered essential: not only to promote mental health and wellbeing for the mother and to facilitate the enjoyment of motherhood, but also for the benefit of the infant, for example developmental and attachment benefits (Bowlby, 1958; Winnicott, 1964; Kohut, 1980; Gerhardt, 2004). Referral to a local NHS IAPT (Improving Access to Psychological Therapy) provider is the context most mothers are referred to where they will have access to Cognitive Behavioural Therapy (CBT). Some IAPT providers fast-track mothers experiencing distress. Clare accessed CBT from her local NHS IAPT provider and valued the work with the therapist where she was given 'tools for life'; it provided perspective and insight by developing self-reflection skills and the practical, solution-focused approach was useful to aid problem solving and time management.

Kate was not fast-tracked to her local IAPT provider and decided to seek therapy privately because she felt waiting for the referral was 'going to take forever'. Together Kate and her therapist formulated some practical solutions, for example a step approach back to work; in addition, they worked 'through things' which involved delving into Kate's past and processing some traumatic events, for example being bullied at school. The idiosyncratic nature of Jane, Kate and Clare's experiences is striking. Not only did they experience their psychological

distress differently, they also required and received different therapeutic approaches to alleviate their distress. The approaches were client-led considered to meet the needs of the mothers: Jane wanted medication, Clare wanted a solution-focused approach and Kate wanted an explorative approach. It should not be assumed therefore that one approach suits all.

This study has highlighted some commonalities the mothers share: firstly, the representations of motherhood they hold, although unique to each mother, are in direct conflict with their lived experience; negotiating conflict appears to be an intrinsic part of motherhood. Identifying and modifying mothers' representations of motherhood and/or questioning the legitimacy of their self-guides is a potential point of exploration. In addition, dichotomous cognitions also appear frequently in the mothers' narratives and therefore challenging the usefulness of them may be impactful, especially because cognitive distortions are implicated in mental health difficulties (Beck, 1963). As a result of this study some implications for practice have been elucidated which will be discussed next.

4.6 Implications for practice

With up to 85% of mothers experiencing distress (Mind, 2013) it seems important to identify the women within this subclinical group who have become adept at concealing their emotions and to validate their experience preventing prolonged distress (Coates, et al. 2014). Normalising their experience may also be important; however, some mothers may need to know that the feelings they are experiencing are not 'normal' and for that reason it is appropriate to seek help. Preventative work could be carried out in the form of psycho-educational information given to mothers pre- and postnatally to detail some of the symptoms they may experience and also information for loved ones to look for cues of emotional distress. Open and frank discussions about this normal response are essential as is letting mothers know that support is available. Early psychological intervention is beneficial to promote mental *health* and prevent

the onset of a psychiatric disorder as outlined previously (WHO, 2004; Steenkamp et al., 2013). Health professionals, for example midwives and health visitors, could also engage in conversations with new mothers about psychological distress being a normal response in the transition to motherhood and explain how mothers often feel the need to conceal these difficult feelings. They could then be referred for psychological therapy.

It was evident that those mothers who accessed talking therapy reported its efficacy; and, in order to prevent the mothers experiencing prolonged distress without support, it seems important to offer support to the mothers that fall within this subclinical group. It was evident that the mothers experienced distress differently and they each required a different approach in the form of therapy and therefore treatment should take this into account as explored above based on a formulation (Johnstone et al., 2014). Individual counselling was considered the preferred option by mothers (Westall et al., 2011) where an individualised treatment plan could be devised, however in the researcher's previous study (Collins, 2014), it was evident that women seek similar others and therefore therapy groups may also be beneficial. There is strong evidence to suggest group therapy provides greater benefits to some populations, for example those who feel stigmatised or those who experience social isolation (Yalom et al., 2005), which is the case for many mothers, as discussed within the literature review and findings.

From a practicing perspective, a space to explore ambivalent or negative powerful emotions where they can be validated, normalised, if appropriate, held and detoxified may be beneficial or, from a cognitive perspective the adjustment of cognitive distortions, for example adjusting dichotomous cognitions. Based on this study, it seems important to understand a mother's perception of her role and the importance she places on societal norms and expectations around motherhood. The identification of the notions of motherhood she holds and the modification of self-concepts and/or questioning the legitimacy of self-guides, in accordance with Higgins' (1987) self-discrepancy theory, would prevent a

conflict between representations of motherhood and mothers' lived experiences. This would induce realistic expectations (Liss et al., 2013) and serve to protect mothers from the detrimental emotional effects and alleviate distress (Higgins, 1987). The aim would be to reduce risk factors and enhance protective factors.

From a community perspective, Holly appealed for a more accepting, validating society and this would undoubtedly alleviate much of the distress experienced during motherhood. Given the idealised, deeply entrenched, cultural representations of motherhood already discussed in the literature review and in the findings, this seems implausible at present. However, counselling psychologists are able to challenge embedded societal constructs through the use of education, the social justice network, social justice campaigns and community psychology (BPS, 2017); therefore, it is possible to give these women a voice through these influential social groups. With many mothers sharing prolonged distress, they should also be encouraged to speak out; Holly believes that if people are willing to discuss their difficulties openly, normalising mothers' experiences within the wider social context would prevent enduring psychological distress and possibly prevent many mothers receiving a psychiatric diagnosis.

4.7 Strengths and limitations of this study

This study set out to explore the plethora of emotions involved during the early stages of motherhood and the impact they have on mothers' subjectively lived experiences; the methodological approach was appropriate to elucidate this. As a result, a number of emotions not normally associated with postnatal distress were identified; the study also identified a group of women who are not represented within the standard psychiatric categorical system (DSM-5, 2013; Mind, 2013; Royal College of Psychiatrists, 2016), who do not identify with having a psychiatric disorder and are therefore left unsupported. This goes some way to further inform our understanding of motherhood, however, this

new knowledge leaves a number of key questions unanswered. Firstly, although this group of unsupported women could be large in number, it is impossible to know from this small study how many women are affected. In addition, it does not comment on the politics of provision or why women's issues are not always prioritised. It is also unclear from this study why feminist informed counselling practise, which has been proven to be effective at treating postnatal distress (Davis-Gage et al., 2010), has been unable to impact significantly on counselling for women experiencing distress in a range of ways. Further research is therefore required.

Dissemination and accessibility is an important factor to consider when conducting research (Parker, 2004). It is my intention to communicate my findings to mothers, to validate their experience and to facilitate change. I recognise that, in its current form, this study is unlikely to reach all mothers, however it was vital to ground this research within current psychological thinking and theory. Despite wanting to make this research accessible to all mothers, I am aware that this study lacked diversity in its presentation. Although psychological research is redressing the balance away from research based on white, middle class mothers (Rauktis et al, 2016; Verbian, 2013; Molden, 2014; Gould et al., 2014; Frederick, 2017; Clarke, 2000; Bos et al., 2004), this study did not reflect difference and minority groups were not represented. I wanted to represent diversity in this study to be more inclusive; based on this small sample it is unclear if this would have made a difference in the findings, however future studies could endeavour to be more inclusive to explore this. Difficulties with recruitment could have impacted on representing minority groups. In addition to minority groups not being represented in this study, it is also acknowledged that complex contemporary motherhood is also not represented, i.e. children with special needs, mothers with step-children (Phoenix et al., 1991) and this could be explored in future research.

Recruiting participants proved difficult and despite advertising locally in Somerset, Bristol and Bath, in Berkshire and Cambridgeshire, specifically with

toddler and postnatal depression groups, the advertisement failed to attract a large number of participants. There could be a number of reasons for this. It could have been to do with the advertisement. It may not have been placed in the right locations to attract participants, especially those in minority groups, and potentially not enough people who experienced complex feelings saw it. After the first appeal for participants only yielded one mother, I changed the wording and design of the advertisement to make it more impactful as suggested in Berg, Hughes, Coben, Danziger, Martin and Knesewich's study (1982). Word of mouth appeared to be the most effective way of recruiting. Recruitment difficulties, of course, could simply be related to mothers' reluctance to share their experience or they could have been ashamed that their experience did not conform to cultural representations.

To overcome recruitment difficulties in the future, other avenues of recruitment should be considered. These could include recruitment through social media e.g. Mumsnet or similar, placing advertisements in different contexts other than toddler groups, e.g. GP surgeries, and possibly asking health visitors to give the advertisement to mothers when they visit them postnatally.

4.9 Opportunities for further research based on the findings

This study has opened up possibilities for further research. Firstly, it is difficult to ascertain the size of the subclinical group identified and therefore a quantitative study to gauge this would be useful. This would not only inform public policy in health care provision but also help health care practitioners to provide the appropriate care. Also, shame appeared to feature as a salient emotion for mothers and yet the mothers did not overtly identify with it; this could have been because psychologists understand shame in a different way, however, exploring this further may better our understanding of mothers' experiences and how best to support them. In addition, although this study has elucidated a number of emotions it is not an exhaustive list and therefore

research exploring further emotions and how mothers experience emotions would be worthwhile. Also, it would be interesting to explore the effect of the baby's temperament on mothers' emotions and experiences.

Chapter 5: Conclusion

In an interview with The Guardian (Greenfield et al., 2018), tennis star Serena Williams said when asked about motherhood: 'The emotions are insane'. Most mothers experience emotional distress postnatally (Mind, 2013; Loyola University, 2009) and this study set out to explore the range of emotions experienced in the early stages of motherhood. There is a dearth of psychological research exploring postnatal distress beyond postnatal depression (Rallis et al., 2014); without the restraints of the medical model this study explored a range of emotions from resentment and loneliness to feeling weak and broken.

At present, if a mother experiences postnatal distress she falls into one of two categories: 'baby blues' which lasts for a few days and is considered to be 'quite manageable' (Mind, 2013) or a more severe form of melancholy to the point of clinical depression which could last for a year or more (Mind, 2013; Royal College of Psychiatrists, 2016). The latter is based on psychiatric nosology and therefore mothers are likely to be pathologised as having a mental health disorder. The DSM-5 (2013) however does not reflect the plethora of emotions discovered in this study and questions whether this categorical approach reflects the experiences of all mothers experiencing distress. This study suggests that there is a subclinical group of mothers who are ignored and not being supported appropriately; they experience a plethora of emotions beyond the symptoms suggested for 'baby blues' and they experience these emotions for months, and sometimes for years, without clinical intervention. It therefore seems important to identify these women and offer them support; counselling psychologists may have a prominent role to play however availability to access support in a timely manner may need to improve.

The themes identified in this study elucidated the conflicted nature of motherhood where mothers held notions of motherhood, which were in direct conflict with their lived experience. This is an area in which counselling psychologists can offer support: identifying and modifying the notions of

motherhood and/or questioning the legitimacy of their self-guides. In addition, dichotomous cognitions also appear frequently in the mothers' narratives and therefore challenging the usefulness of them may be impactful, especially because cognitive distortions are implicated in mental health difficulties (Beck, 1963).

It also seems important to validate mothers' experiences allowing them to express their emotions without the restrictions of the medical model and to normalise their experience, if appropriate. With up to 85% of mothers experiencing distress postnatally (Mind, 2013; Loyola University, 2009), this appears to be a 'normal' response to motherhood and if distress is normalised then society's representations of motherhood, as elucidated in the themes, can be challenged. Mothers will then be able to seek help without fear and receive support preventing the onset of a psychiatric disorder (WHO, 2004). Encouraging this subclinical group to come forward and offering them early psychological intervention is therefore important not only for the benefits of the infant but also for the mother's enjoyment of motherhood and her own emotional and psychological wellbeing.

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Appendix 1

Researcher's reflection post interviews:

I became interested in this specific topic during my undergraduate research where I explored women's experiences of breastfeeding (Collins, 2011). Seemingly adoring mothers at the time of the interview disclosed how difficult they found the initial few weeks of motherhood; they did not enjoy motherhood and found it difficult to bond with their child and this elicited psychological distress. I found this surprising and at the same time interesting and decided to explore this further for my masters' dissertation (Collins, 2014) where I explored the process of how mothers negotiate the transition into motherhood. It seemed the case that, from this small sample, one element of the negotiation involved tolerating conflicting feelings; being a mother myself, it saddened me that women were experiencing psychological distress without feeling able to share their experiences or seek help. My interest was exacerbated during my training to become a counselling psychologist; I have worked with difficult emotions professionally for a number of years and this has made me consider how the profession may be able to support these mothers.

It also saddened me that if a mother visited her GP experiencing psychological distress in the early stages of motherhood she would most probably leave with a psychiatric disorder. A diagnosis suggests to me that the presentation and symptoms are 'abnormal' and yet my understanding of the literature at the time suggested that distress during the early stages of motherhood appeared to be a normal response to motherhood. In my professional career I resist categorising clients in this manner and prefer not to define them by their symptoms alone; this can be challenging at times working in a psychiatric hospital where the medical model is the main discourse used within the multi-disciplinary team. I always ask the service user if they relate to their diagnosis, surprisingly in that environment where diagnoses are well-established, many do not. Working with them I explore all aspects of their life rather than focusing

solely on the symptoms and draw up a formulation which I use to guide interventions. I am always reluctant to carry out neurological and psychometric tests which may indicate a diagnosis unless there is a very good rationale for doing so.

With my reluctance to use the medical model to categorise people, it therefore pains me that mothers are often given a diagnosis and offered medication because they are finding motherhood challenging. Motherhood is challenging! In my view this does not suggest they have a psychiatric disorder; a psychiatric disorder suggests that there is something 'wrong' and yet experiencing psychological distress at this time appears to be a normal response to motherhood. I would rather psychological support was offered in the first instance; I believe that normalising their experiences and supporting them to explore some of their conflicting cognitions seems more appropriate. The caveat to that, which I am familiar with at work, some mothers may prefer a diagnosis as an explanation to their distress and that also is important to respect.

My preference therefore is for those mothers who do not identify with a mental health disorder but would welcome some form of support should be offered psychological therapy; I recognise that for some mothers where their symptoms are severe, e.g. psychotic symptoms, then a diagnosis with specific medical interventions are probably the best course of action for some women.

I was aware that the mothers in this study were able to disclose some very personal and difficult aspects to me; they opened up well. This could have been because the interviews were carried out in their own home and therefore felt comfortable; it could also have been because they felt at ease talking to a woman who was interested in their narrative. A couple of the mothers reflected afterwards that they found recalling some of the details cathartic. They also could have assumed that my interest in the study was because I had been through a similar experience; they did not ask if I had and I did not disclose

my own personal experience of becoming a mother. If I had disclosed that I did not share their experience this may have impacted on their willingness to talk, perhaps believing I would not be able to emphasise or understand their experience. If I had experienced distress like the mothers in this study and then researched the phenomenon, the findings may have been different, and I may have a different attitude towards pathology, especially if I had found the diagnosis useful. The findings may also have been different if I had been a man or a different type of woman.

When the mothers became distressed when recalling difficult aspects of their suffering, I found it difficult not to engage with them as a counselling psychologist by offering them empathy and allowing them to explore their feelings in detail. Instead, conscious of the research ethics, I tried to remain in a researcher identity and gently steered them away from their distress. At times I think I steered them away from their distress a little too quickly and would have elicited more detail had I stayed with them a little longer. One mother in particular was quite hostile throughout the interview because she thought she had cancelled the interview and I had driven two hours to see her. She agreed to carry out the interview but when I tried to probe in certain areas she became quite defended and closed a little; during this time, I was conscious that I wanted to be quite efficient with the time and finish in a timely manner because she had tried to cancel the interview.

The exploratory technique of interviewing was different to the usual counselling psychology assessment techniques I practice on a daily basis. For work I am usually interested in trying to ascertain aetiology, the circumstances that led up to their mental health difficulties and what perpetuates the problem to inform my formulation and often a more probing approach is necessary; for this study the focus was on how they experienced motherhood and therefore required a solely exploratory approach into their experience. This exploratory approach allowed me to be in the moment with their experience rather than trying to devise treatment plans and a formulation; it was difficult initially to adopt this

approach but after a couple of interviews I learned how to transition from practitioner to researcher.

Some of the experiences that the mothers described and the emotions they felt made me feel sad, especially when they endured their distress alone for such a long time without professional support or support from loved ones. I also found some of the details shocking and made sure I did not communicate this in my facial expression; to remain accepting of their experiences allowed them to explore some difficult emotions. Before embarking on the research, I realised how challenging motherhood could be for some mothers but was surprised by the impact motherhood had on them and the desperate acts mothers carried out whilst distressed. It has also made me reflect on how many women were distressed who attended the social groups I attended with my children; according to the statistics this was likely to be high, however, if there were, unsurprisingly they concealed their emotions well.

I set out to explore emotions and was not surprised by the range of emotions discovered. However, I did not set out to explore specific representations of motherhood and yet, whilst exploring the range of emotions, this appeared to be an intrinsic part of motherhood. Failure to achieve these aspirations resulted in specific consequences and this became the central theme of the thesis; an important find was Higgins's (1987) self-discrepancy theory which offered one way to explain why mothers experienced distress. I found the representations fascinating and they featured strongly in the mothers' narratives.

Appendix 2

Interview Schedule

How do you think people see motherhood today?
Do you think all women are expected to become mothers?
Would you say there are any pressures to being a mum?
Are there expectations about what being a mum involves?

Can you tell me when you decided to have children?
What did you think of motherhood before you had a baby?
Did you have any expectations?

Once you had your baby was being a mum what you imagined it would be?
In what ways was it similar?
In what ways was it different?

So, what was good about being a mum?
What did you find difficult?

When did you realise it wasn't as you imagined?
Can you tell me a bit more about what it was that you found more of a struggle?
What was that like?
How did those struggles make you feel?
Did you feel like you were doing something wrong? Or failing in some way?
How did you face those difficult times of being a mum?
How did that feel?
How did you cope?
What did you do about it?

Some people talk about guilt or shame, does that ring true for you?
Did you feel guilty? About what?
Did you feel ashamed? (expectations?)

Did you feel as though you had to cope on your own?
Did you feel you could talk to others? If you did, who? And how did they respond?
Did it make a difference if other people were around you? How did you cope with your feelings around others?
Did you feel like others were having similar challenges to you?
How do you think others saw you?

Did you seek help? If went to GP, were you diagnosed with Postnatal Depression?
Were you offered medication / therapy of any sort?
What do you think about the offer of therapy in this situation?

Have you come across the idea of Postnatal Depression? Do you identify with it as being a mental health difficulty?
What do you make of it? Would you say you experienced it?
Would you say that everyone who finds motherhood challenging as having postnatal depression? When does it become a mental health difficulty?
In hindsight, would you describe yourself as having had mental health difficulties?

How long did you feel this way? How is motherhood for your now ?? years on?

Thank you.

Appendix 3

University of the West of England
BRISTOL

You're not alone. According to research, up to 80% of mothers experience some difficult feelings in motherhood. These could be mixed emotions towards motherhood and/or the baby, 'baby blues' or postnatal depression. If you are/have been one of these mothers, would you like to share your experience to help future mothers understand and deal with these feelings?

I am carrying out research into this for my professional doctorate in counselling psychology and would love to speak to you. It would involve approximately an hour of your time and would be anonymous and completely confidential.

If you would like to find out more, please contact me:
Sharon Collins
01934 712543
sharonjanecollins @gmail.com

University of the West of England
BRISTOL

PARTICIPANT INFORMATION SHEET

PROJECT TITLE
The feelings experienced when there is a dissonance between the expectations and the reality of motherhood: A phenomenological study.

INVITATION
You are being asked to take part in a research study to investigate:

- How motherhood is understood within our society.
- Your expectations of motherhood.
- The struggles of motherhood.
- The feelings associated with your experience.
- If you shared your experience with anyone.
- Whether you identify your experience as a mental health difficulty.

I am conducting this research for my Professional Doctorate in Counselling Psychology at the University of the West of England. The University's Research Ethics Committee has approved this research.

WHAT WILL HAPPEN IF YOU DECIDE TO TAKE PART
Having read this information sheet and signed the consent form, I will start by asking you a few demographic questions e.g. your age etc., to give me a sense of who has taken part. I will then start recording the interview and will ask you a series of questions relating to your experience of the early stages of motherhood. You do not have to answer a question if you do not want to. There are no right or wrong answers so hopefully you can just relax and tell me how the experience was for you. Your participation in this study is voluntary.

TIME COMMITMENT
I would anticipate that the interview will last for around one hour, but if you have lots to say and have the time then it may take longer.

WHAT TO DO IF YOU CHANGE YOUR MIND
You may decide to stop being a part of the research study at any time without explanation. All you have to do is let me know and any data you have supplied which is

held electronically or as a hard copy will be withdrawn/destroyed. However, once the data has been analysed, it may be difficult to eliminate your data from the process.

BENEFITS AND RISKS

I hope you will enjoy talking about your experience of motherhood, however, there is always a risk that talking about an emotive topic may leave you feeling distressed. I hope this is not the case, but I have listed some support services below that you may find useful.

CONFIDENTIALITY/ANONYMITY

This is very important to me. I will change your name, and your child's name, to protect your anonymities and therefore I will be the only person who knows your true name. No one will link the data in my thesis to the personal information you have supplied to me (e.g. name, address, email).

The recording and transcription of the interview will be kept on a password-protected computer at the researcher's home and will be deleted as soon as the research is completed in accordance with the Data Protection Act 1998.

When the data is analysed and my thesis is written, I may present my findings at a conference, in the community or send it for publication in relevant journals. Rest assured that your experience would not be identifiable.

FOR FURTHER INFORMATION

If you feel you would like further information regarding your experience, here are a few organisations that may be able to support you:

The Association for Postnatal Illness
Apni.org
Helpline: 020 7386 0868

Mumsnet
www.mumsnet.com

NCT – The National Childbirth Trust
www.nctpregnancyandbabycare.com
Helpline: 0300 330 0773

Netmums
www.netmums.com/parenting-support/help-and-support

Pandas Foundation
www.pandasfoundation.org.uk
Helpline: 0843 28 98 401

QUESTIONS

Are there any questions before we proceed?

University of the West of England
BRISTOL

INFORMED CONSENT FORM

PROJECT TITLE
The feelings experienced when there is a dissonance between the expectations and the reality of motherhood: A phenomenological study.

PROJECT SUMMARY
You are being asked to take part in a research study to investigate:

- How motherhood is understood within our society.
- Your expectations of motherhood.
- The struggles of motherhood.
- The feelings associated with your experience.
- If you shared your experience with anyone.
- Whether you identify your experience as a mental health difficulty.

By signing below, you are agreeing that:

- You have read and understood the Participant Information Sheet, including the purpose for collecting the data; how your personal information will be disseminated; how long recordings/transcripts will be kept and where they will be stored in accordance with the Data Protection Act 1998.
- You understand you will be able to withdraw from the study and your personal information will be deleted. However, once the data has been analysed, it may be difficult to eliminate your data from the process.
- Questions about your participation in this study have been answered satisfactorily.
- You are taking part in this research study voluntarily (without coercion).

_____
Participant's Name (Printed)*

_____ _____
Participant's signature* Date

**Participants wishing to preserve some degree of anonymity may use their initials (from the British Psychological Society Guidelines for Minimal Standards of Ethical Approval in Psychological Research).*

THANK YOU FOR TAKING PART.

Appendix 6

DEMOGRAPHICS QUESTIONNAIRE	
Name:	
Age:	
Ethnicity:	
Religious preference:	
Sexuality:	
Marital status:	
Who lives with you?	
Age of child/ren:	
Education:	
Employment status:	
Maternity leave? How long for?	

Interview with [redacted]			
	Researcher	could you tell me how you think people see motherhood	
Societal perception of motherhood	Participant	umm so I think there's a perception of motherhood as being this wonderful you know fairytale everything beautiful everything's amazing and umm and you you just sail through it that that's my perception of how people see motherhood.	
Perception vs reality dissonance	Researcher	yeah	
	Participant	it's not like that [laughs]	
	Researcher	no do you think all women are expected to be mothers?	
Motherhood imperative Natural mother concept Said didn't comply	Participant	yes I do yeah which has been something that actually I think I have struggled with certainly before I became pregnant and even kind of now I never felt natural with children although friends of ours always said 'you're really good with them' and I'm like 'really? Am I?' I don't you know I don't really know what I'm doing I to be honest I'm quite a big kid so toddlers I'm quite good with playing with because I'm I'm a bit childish anyway umm but I never felt like a natural mother and it wasn't something that I was ever you know there are people out there who [sighs] who it's the only thing they've ever wanted	
	Researcher	yeah	
	Participant	and I'm not like that at all so	
	Researcher	but there is societal pressure maybe?	
Motherhood imperative	Participant	societal pressure just expect expects everyone to become a mum yeah	
	Researcher	umm and would you say there are pressures with being a mum?	
Pressures of motherhood	Participant	yeah, absolutely	

	Researcher	what sort?	
right/wrong mothering relates to medical model	Participant anxiety distorted thinking safety behaviours	to .. to do it right even though there is no right there is what works for you which I think is something you only learn when you become a mum and you know I from somebody who suffers with anxiety anyway I struggle with accepting what I'm doing as right you know I seek reassurance through saying to other people I'm doing this and kind of wait for their reaction of you know	right vs wrong unconstructed right/wrong way? has anxiety accepting being right seeks reassurance - safety behaviour right vs wrong.
	Researcher	so you think there might be a right and wrong way of doing it?	
	Participant - intellectualising	yeah, yeah I think it's expected, people think there's a right and wrong way to bring up children but I think actually the right and wrong way varies depending on the people	contradiction intellectualising through CBT?
	Researcher	yeah	
	Participant	and people will always say that you know 'oh I wouldn't do it like that' so yeah there is absolutely but everyone's opinion is different	absolutely right vs wrong depending otherwise
	Researcher	so are there expectations about what being a mum involves?	
	Participant	umm from society?	
	Researcher	yes	
motherhood takes precedence expectation child-centred doesn't fit with society's perception of motherhood rebelling self?	Participant	I think so I think the expectations are that you know you you kind of I think it depends on the generation to be honest but I think there is an expectation that you give up everything and that is you know this becomes your whole world umm which again is not something that I subscribe to personally [laughs] but th-that's kind of what I feel is the expectation yeah of motherhood	repetition - difficult to articulate? motherhood should (whole world) doesn't correspond to society's way or ruling about motherhood. funny
	Researcher	umm can you tell me when you decided to have children?	
	Participant	umm so it was where are we? 2017 in 2015 so we got married in 2012 umm and we wanted to have some	

Perceived difficulties		time just being married umm and then we sort of actively made the decision sort of spring 2015 umm but we it took us nearly a year because I have POS which wasn't diagnosed for nearly a year	difficulty with pregnancy
	Researcher	what's that, sorry?	
	Participant	polycystic ovaries and so we had to have a bit of help	
	Researcher	yes, right	
	Participant	to get pregnant	
	Researcher	right ok so you got to the point where you wanted to have a baby	
contradictory non-conformity self?	Participant	yes, yes oh yeah we did it was definitely, it was always on the cards, she was planned umm despite the fact she ended up being a planned surprise if that makes sense [laughs]	wanted baby but ed/es struggled with conception & becoming a mum.
	Researcher	so what did you think of motherhood before you had a baby?	
assumption it would be easy	Participant	umm I don't know I looked at all of our friends who have children and saw what they did and thought to myself it doesn't look that hard you know actually I can probably do that	perception it won't be difficult. Believed she could do it.
	Researcher	yeah	
hidden aspects of motherhood	Participant	it looks alright but you only see some of it you don't see the nights [laughs] you don't see you don't see the hard bits	hidden hard bits hidden from view
	Researcher	no	
	Participant	so yeah it was	
	Researcher	did you have expectations then about what it would be like	
contradictory hidden reality of motherhood	Participant	I don't know I expected that to be one of your questions and I was trying to think about my answer to that and I don't know if I ever had any expectations as to what it would be like I think I knew it would be hard and I knew I would be sleep deprived but I don't think you're ever	unsure of own expectations before becoming mother realistic vs unrealistic view

motherhood easy vs difficult. unprepared self.		actually truly prepared for how sleep deprived you are and how hard it actually is so I don't really think I had any expectations per se but just sort of more not really appreciating how difficult things would be	sleep deprivation hard, difficult unprepared.
	Researcher	right ok so once had your beautiful baby was being a mum what you imagined it would be?	expectin Qs & yet struggling with them
contradictory no expectations nor imagined life as mum?? baby stage denial Needs guidance unprepared self.	Participant	umm gosh so many difficult questions erm cos I'm not sure I ever imagined it to be anything I think I think I imagined it more so kind of at the toddler age and dealing with them you know when we can have conversations and when we can have a bit of dialogue and they can tell me what they want and obviously we have to get through this stage to get to that stage so I don't think I had I don't really think I ever prepared myself for this stage	had no preconceived idea of baby stage) alright if told b4 second stressful needs difficult.? unprepared.
	Researcher	so do you think you weren't told about this stage enough? Or ..	
baby stage denial Dismissive self alleviates anxiety unreceptive	Participant	yeah perhaps, perhaps or maybe I just didn't didn't take it in and I've had subsequent conversations with our friends who have children and said 'you didn't tell me it was this hard' and they went 'yeah we did you just didn't listen' or you do listen but you just don't take it in because you have nothing to compare it to you're just going to go 'oh' and just sort of you know pass it by so I think it's quite difficult until you've gone through it you people can tell you everything and but you just you it until you've gone through it you you don't appreciate actually what they're saying I think is what it comes down to	denial of baby stage & practical difficulties didn't listen to people telling how difficult it is. dismissive? unable to appreciate how hard it is until you go through it.
	Researcher	right ok	
unreceptive	Participant	I just don't think there is anyway you could fully understand and take in somebody saying it's going to be like this or it's going to be like this or this happened to	inability to take in/appreciate what it could be like until in situation.

		me or this happened to me cos every baby is different erm I just you I just don't think you take it in	
	Researcher	no, no ok so it's not that people umm didn't say	
	Participant	yeah, I don't think you kind of you just don't you just can't take it in	inability to comprehend difficulties beforehand
	Researcher	no ok so what's good about being a mum?	
contradictory	Participant	[laughs] umm umm I love watching her grow but equally that makes me sad	contradictory
	Researcher	right	
grief/grief mastered stage?	Participant	so when she grew out of her newborn sleepsuits and I packed them away I was like awhh she's not my tiny baby anymore but equally I was talking to somebody yesterday that umm the feeding position is a bit different on this side to that side umm when I feed her across body on this side I spend quite a lot of time looking at her ear because you know that is how she is facing and I remember when she was first when she was new born and just looking at her ear and looking at how small it was just how tiny everything was and I have watched her ear grow over the past ten weeks and all of that and yeah so watching her change watching her oh gosh I'm getting emotional [choked up]	sad she's growing up more sadness than happiness? happy because she's growing up but sad because ...? not mastered his stage? enshrined by reminiscing
	Researcher	awhh are you ok?	
	Participant	umm watching her change, we get smiles now from her so all of that is makes it worth it	getting friendship back is worthwhile
	Researcher	yes yes because you get something back now	
reciprocal motherhood	Participant	yes when you start getting something back it starts to actually feel much better [laughs]	drawing closure?
	Researcher	so what do you find difficult?	
deciphering baby's needs communication difficulties	Participant	oohhh [laughs] umm do you know I think I find a lot of it difficult I find not knowing what she wants difficult because she can't tell me and the only way she can communicate is cry and that's quite upsetting because I	baby stage difficult not understanding baby's needs upsets Lisa

		don't want her to cry umm [silence] the sleep deprivation makes it difficult as well because I find that everything is then catastrophic even the smallest thing is is much more difficult to deal with when you are sleep deprived	
	Researcher	yeah	
	Participant	umm I find it [sighs] I go to groups and we have you know I'm part of an NCT group and we meet up regularly and we chat regularly and there are other groups that I go to but I still find it quite lonely	
	Researcher	do you?	
	Participant	yeah I think it's still quite lonely a lonely experience umm	
	Researcher	why's that?	
	Participant	umm I-I don't know you know I'm fine when I'm with groups of other mums because you sit there and you chat and you discuss what each baby is doing	
	Researcher	yeah, yeah	
	Participant	oh yeah, yeah, yeah doing that oh no that's oh oh but we've had this instead and I'm absolutely fine because then you realise that actually everything you are going through is completely normal	
	Researcher	yeah	
	Participant	but when I'm on my own I think I then I start sort of overthinking it a lot and you know that is probably as a result of the fact that I suffer from anxiety anyway so I think it it kind of um perpetuates itself really umm	
	Researcher	is it a lack of confidence?	
	Participant	I think so yeah I think there was always a lack of confidence in um so when I - I guess I didn't really realise until towards the end of my pregnancy when my anxiety got overwhelmingly bad umm and it was actually anxiety related to whether or not I would be a	

'good' mum		good mum [choked up]	finds it difficult - important to be 'good' mum
	Researcher	right	what is 'good' mum?
unable to meet infants needs Bad mum?	Participant	and having yeah being confident in knowing what to do [laughs] [upset]	lack of confidence in ability to meet needs. upset
inconsistent	Researcher	are you alright?	
inadequate self. inadequate 'good' mum	Participant	yeah umm but you know the more and more I'm I'm her mum the better I feel about it but I still lack confidence in what I do and I still worry that I'm not a good mum [choked up]	growing confidence. doesn't know what to do. upset. 'good' mum
	Researcher	awhh	
	Participant	so yeah it is hard	
	Researcher	yeah	
right vs wrong	Participant	it's hard to know you're doing the right thing	right vs wrong
black/white thinking	Researcher	so it goes back to that right and wrong again	
	Participant	yeah	
[one way of mothering]	Researcher	that there is a right way of mothering	
right vs wrong cbt knowledge relationship scientific approach 'truths'	Participant	I think the problem with that is that suffering from it and I think this is probably quite skewed because I suffer from anxiety so I don't know if it's going to actually skew your what your kind of data is going to look like but erm but I'm a very black and white thinker so the kind of the right and wrong aspect is comes into that where as actually I need to start realising that there's a lot more grey and life is a lot more grey and there isn't you know being a scientist there's a right and wrong as far as I'm concerned	cbt - thinking style - knowledge. new perspective as a result of cbt? relates to scientific approach of right/wrong.
	Researcher	yes, yes	
	Participant	[laughs] so you know that's how I've gone through my life there's a right and wrong umm	
	Researcher	because you're searching out truths	
likes right vs wrong and life is not or grays.	Participant	because you're searching out truths yeah exactly erm so I find it quite difficult when there isn't a right and wrong and I try and you know it makes me feel comfortable	recognises life isn't right vs wrong.

'Grey' motherhood.

Journal Article

It was decided to publish in the first instance for Counselling Psychologists in the Counselling Psychology Review. The following article has been submitted, however it has yet to be published.

'Counselling Psychology Review is the Division of Counselling Psychology's peer-reviewed research publication, bringing together high quality research pertinent to the work of counselling psychologists.'

It was decided to publish in this journal in order for Counselling Psychologists to understand more fully how mothers experience postnatal distress and how to support them.

The following pages detail the journal's guidelines and remit.

The British Psychological Society
Promoting excellence in psychology

Counselling Psychology Review
Cover Page

Title: An interpretative phenomenological analysis of mothers' negative experiences and emotions during early motherhood.

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Informed Consent: Informed consent was obtained from the participants taking part in this study. The study's procedure adhered to UWE's Code of Good Research Conduct (2015) and the BPS's Code of Human Research Ethics (2014).

Word Count: 4892/5000 words

Keywords: motherhood, distress, emotions, postnatal, ideologies, pathologise

Abstract (Research) - word count: 250/250

Contemporary ideologies surrounding motherhood do not appear to reflect the experiences of many women. Motherhood is often idealised as a joyful experience, however a large proportion of women experience psychological distress, often receiving a diagnosis of postnatal depression. Current psychiatric systems may not adequately represent mothers' experiences or reflect the range and complexity of emotions experienced. Most psychological research explores mothers' emotions through the lens of a medical model, with a focus on depression; the exploration of emotions beyond depression has been under-researched. This study explored the range of emotions mothers experience during early motherhood. A qualitative study, six women who experienced distress postnatally were interviewed using semi-structured interviews; data were analysed using Interpretative Phenomenological Analysis (IPA). The study found an emotional conflict between the mothers' aspired and idyllic representations of motherhood and their lived experiences; three themes were identified: when idyllic notions of motherhood are not realised; when motherhood is not instinctive; and when prioritising childcare is not easy. Mothers who were unable to live up to the identified notions of motherhood, experienced emotional distress, from resentment and guilt, to feeling broken and insecure. The amalgamation of emotions experienced created a complex emotional landscape they had to negotiate, and their experiences were not represented in the psychiatric categorical systems; they did not identify with having postnatal depression and were left unsupported. This study explored ways counselling psychologists could offer support to this sub-clinical group and viewing their experiences as a normal response to motherhood as opposed to pathologising them.

Background/Aims/Objectives

Motherhood is romanticised, idealised and fantasised (Nicholson, 2001; Parker, 1994; Choi, Henshaw, Baker and Tree, 2005), however these portrayals do not

resonate with many mothers' lived experiences of early motherhood. On the contrary, early motherhood can often induce distress creating a web of emotional complexity and conflicting tensions (Oberman & Josselson, 1996) where resentment towards the infant, fear of criticism or public disapproval and guilt can sit alongside love, joy and devotion. A statistic of up to 85% of mothers experiencing some form of distress (Mind, 2013) would suggest a normal response to motherhood.

Mothers find it difficult to disclose distress in early motherhood (Dennis & Chung-Lee, 2006), possibly because their lived experience contrasts with the prominent idealised sociocultural representations and beliefs entrenched within western society (Nicholson, 2001). Psychological literature suggests that the many deeply embedded ideas about motherhood could be internalised by mothers, and these attitudes, standards and values of others are integrated to form a sense of self (Sutherland, 2010; Walters & Howard, 2009). The women can then use these ideas to inform their understanding of motherhood; any discrepancy between the mother's expectation and experience may have detrimental effects on the mother's psychological and emotional wellbeing (Higgins, 1987; Sutherland, 2010).

Mothers also seem reluctant to seek help (Dennis et al., 2006). If a mother visits her General Practitioner experiencing distress in early motherhood, she is likely to be pathologised as having postnatal depression (PND) (Westall and Liamputtong, 2011); PND is a medical diagnosis where the mother may be seen as a series of symptoms, including anxiety or melancholy (DSM-5, 2013). However, mothers may not identify with depression or with having a mental health condition (Coates, Ayers, de Visser, 2014), therefore pathologising difficult emotions as a mental health condition could shape our perception of what is 'normal' and 'abnormal' (Marecek & Gavey, 2011) thereby stigmatising mothers' experiences further. Psychiatric nosology does not appear to reflect some mothers' experiences (Coates, de Visser, Ayers, 2015) and this study aimed to explore mothers' emotional experiences from a psychological

perspective without the constraints of the medical model; the study of postnatal distress has been an under-researched area within the psychological discipline (Rallis, Skouteris, McCabe & Milgrom, 2014).

This study explored the complex emotions experienced during early motherhood and the impact of them on the mother's phenomenological experience. It also explored an alternative to a medical framework of understanding and treating such distress, facilitated through counselling psychologists. Counselling psychology could play an important role in assisting mothers to not only come to terms with their emotions through psychological interventions, but also to normalise their experience and to challenge the prevalent societal norms around motherhood. The research questions for this study were:

- Which emotions do mothers experience during the early stages of motherhood?
- How do these emotions impact on their phenomenological experience or vice versa?
- How do mothers reconcile their subjective experience with their expectation of motherhood?

Methodology/Methods

Interpretative phenomenological analysis (IPA) (Smith, Flowers & Larkin, 2009) was the chosen methodology to capture the mothers' experiences of early motherhood and how they make sense of the world; the potential for valuable insight is a strength of this methodology (Langdridge, 2007). A good understanding of the subjective experience can be used to discern the complexities of motherhood which can then inform how to best support mothers.

Six mothers who found motherhood challenging and experienced psychological distress were recruited, with one pilot interview to assess the feasibility of the

approach. Semi-structured interviews were used to capture the uniqueness of the mothers' experiences (Langdridge, 2007); the researcher used a schedule with specific open questions, however participants were encouraged to express themselves freely, to elaborate on specific points or to digress. The interviews allowed the participants to describe their experience in rich detail and for a dialogue to take place. Before meeting face-to-face, an information sheet about the research was emailed to the participants and on the day consent forms and demographic questionnaires were completed, adhering to the BPS's Code of Human Research Ethics (2014). Interviews were recorded, transcribed verbatim and analysed using IPA (Smith et al., 2009) to gain an understanding of the participants' subjectively lived experience. This was achieved inductively and iteratively through the researcher immersing herself in each transcript and exploring patterns and idiographic content (Smith et al., 2009). Themes were identified within the dialogue and the researcher then carried out the same process on each transcript; master themes were identified across the sample, which best encapsulated the participants' experiences. An overriding theme emerged: *the emotional conflict between mothers' notions of motherhood and their lived experiences*.

Results/Finding

Mothers embarked on motherhood and aspired to mother according to notions that they held of what they believed motherhood 'should' look like, however their lived experiences often did not live up to these notions; this resulted in an emotional conflict between the two with mothers enduring a significant amount of distress. Three master themes were identified which gave further insights into the distress and emotions these mothers experienced:

1. When idyllic notions of motherhood are not realised

The mothers embarked on motherhood with the expectation that they would enjoy it:

> *It's going to be wonderful and we are going to be you know having a fantastic relationship with our children and we'll be best friends […] I thought that I would basically fall in love with my child after giving birth. [Clare]*

Clare used the metaphor of overwhelming giddiness and excitement of falling in love to describe her expectations of motherhood and the relationship she would form with her daughter. This emotive language, with her use of superlatives, demonstrates the idyllic assumptions she made about motherhood. Many of the mothers used hyperbolic language when exploring motherhood retrospectively, emphasising their thoughts and feelings. All the mothers believed that motherhood would be enjoyable, however, the reality was in direct contrast to their ideals.

All the mothers were conscious that their distress conflicted with emotions generally associated with the idyllic representation of motherhood established within society. As a result, they did not discuss their feelings with anyone and found themselves unable to confide in family, friends, or similar others; Ruth and Holly explain why:

> *I think I probably didn't share the way I was feeling because I think there is an expectation that you will love your baby and you'll be delighting in motherhood and I wasn't, and I suppose I felt like there was that was not how it should be. [Ruth]*

> *It's not what you're supposed to think is it? It's not what you're supposed to feel, and I know that there are some people that I couldn't say that to because you know they might never speak to me again. [Holly]*

From these two extracts, Ruth and Holly used 'should' and 'supposed to' implying a specific way to think and feel. When they perceived they were different, or thought that others would perceive them as different, the mothers concealed their emotions and adopted the socially accepted representation of motherhood. They named fear as the dominant emotion behind the concealment; fear of being judged or rejected as Holly suggests above.

The mothers did not perceive other mothers as experiencing distress; when mothers get together the narrative in this study suggests they tend to avoid talking about feelings as conversations turn to practical elements of motherhood, for example, the child's sleeping and feeding patterns. The fact

that they do not perceive others as experiencing distress is not surprising if mothers are adept at concealing distress. All the mothers in this study concealed their negative feelings which served as a fundamental function: to prevent people from knowing their thoughts and feelings because they believed that their experiences of being a mother conflicted with the cultural representation of motherhood and they feared society's reaction to their experiences.

2. When motherhood is not instinctive

The second theme elucidated the belief all the mothers held: that being able to mother, or elements of motherhood, would be instinctive:

> *Everything should come naturally, and you should know how to do everything and um the reality is you don't, and especially as babies don't come with a manual and every baby is different. [Laura]*

Laura believed that the possession of maternal instinct would enable the appropriate care for her infant. Throughout Laura's narratives it became apparent that she wished infants did 'come with a manual' because not instinctively knowing how to mother distressed her. Ruth also thought a 'natural instinct' would be available to her when she became a mother as she explains:

> *You just expect that there will be this sort of inherent like natural instinct [...]I found breastfeeding very difficult and I hadn't that was something I definitely wasn't prepared for and that was certainly something I thought well this is it such a natural this must be completely natural and may be not easy but certainly straight forward and that was so hard and so painful. [Ruth]*

This perception that women possess an innate aptitude to bear and care for children is deeply embedded within western society but the notion that all aspects of motherhood are instinctive was not borne out in the mothers in this study. This is evident when Ruth talks about breastfeeding where she appears to be conflating motherhood being a biologically 'natural' phenomenon with it being instinctive or straightforward ('natural'). Ruth was not alone. The lack of maternal instinct directly conflicted with the mothers' expectations and had a

profound impact on their emotions and lived experiences, as a result they felt guilty, they felt inadequate and a sense of failure.

Guilt was clearly evident in the mothers' narratives and all identified with it; some considered it intrinsically linked to being a mother: 'I permanently felt guilty' [Jane], 'mums feel guilty constantly' [Kate], 'all the time' [Laura]. Guilt was also associated with not being able to draw on intuition, evidenced by this extract from Ruth:

> *Feeling guilty that we were obviously weren't meeting her needs in the right way because she was not a happy baby and so there was obviously not doing something right or there was something we weren't doing. [Ruth]*

Ruth felt responsible for her child's unhappiness because she, and her husband, were unable to fulfil their child's needs, inducing feelings of guilt; she was expecting intuitively to know how to attend to her child's needs. She perceived that she was doing something wrong or neglecting her in some way; implying that if they were attending to her needs in the 'right' way, her child would be happier.

A sense of inadequacy was also prevalent in Ruth's narrative; she perceived that she was not coping well with motherhood and this became apparent when she compared herself to other mothers who, according to Ruth, did not have difficult infants. She perceived that other people's babies were better than her baby; not only did she believe she was inadequate / imperfect, she also perceived that she had produced an imperfect baby. The helplessness she felt for not coping better and knowing how to attend to her daughter's needs led her to feelings of resentment.

These mothers' feelings of inadequacy were rooted in their person; they perceived that they were in some way deficient and not up to the task of mothering. The sense of not being good enough exacerbated the feeling that they had failed. All the mothers identified with failure, usually based on elements of motherhood they assumed and expected to possess. Holly's perceived failure was directed as a personal criticism:

> *It's like the deepest kind of thing inside you like that's what you were designed for and you can't even do that […] like it feels really personal […] basically means you've failed at being a person. [Holly]*

Here, the personal criticism extends to Holly's womanhood and her gender identity is under attack; Holly believes that she has failed at being a person based on her perception that women are biologically predisposed to mother because women are 'designed' to bear and care for children. Holly felt that she was unable to care for her children which caused distress, and this was in direct contrast to the notion of motherhood she was aspiring to: that motherhood would be instinctive. It is evident that guilt, inadequacy and supposed failure appears to be induced when mothers perceive there is a mismatch between their ideal or unique perception of motherhood and their lived experiences; this is apparent by their acknowledgement of what they are 'not' doing.

3. When prioritising childcare is not easy

The third theme related to the priority mothers gave to their children over all other aspects of their lives. Before embarking on motherhood, Clare underestimated the importance of her role:

> *I didn't imagine how important my role was you know [laughs] there's this human being is just looking to me for everything and to understand how to erm interact and and how to behave and erm just her personality traits my mood and my personality and what I do with her all just creates who she is and that that role is massive. [Clare]*

Clare believes that the nurturing she provides to her daughter is implicit in her daughter's development; if she believes she is solely responsible for this then it is understandable why Clare believes that it is such a 'massive' role and this would therefore require complete devotion. In her quest to devote herself to her child, Holly found herself unable to fulfil her child's needs which left her distraught and led her to question whether motherhood was right for her. She was not alone in her deliberations; both Laura and Ruth questioned their decision to start a family.

I guess you just kind of wonder and things you know was this the right thing to do and it's so permanent. [Ruth]

After deliberately embarking on motherhood, to question that decision demonstrates the complex and difficult emotions the mothers experience and this has a profound impact on their emotional distress. Laura went so far as to say that she thought that her daughter would be 'better off with someone else' and reflecting on this made her very upset. The consequences of prioritising childcare and aspiring to mother in a specific way were profound on the mothers' emotions and their lived experiences. Paradoxically, the mothers experienced a significant amount of loss despite supposedly experiencing a significant gain with the addition of a child.

Loss was expressed in many forms in the mothers' narratives; both in the felt sense but also in a functional way, for example a lack of sleep or the neglect of one's own needs. Holly's neglect of her needs led to resentment and feeling broken. She reflected on the compromise she made of her own wellbeing with this small, powerful extract:

To give them everything they needed probably a bit more really umm and then kind of slightly fade away inside myself. [Holly]

Clare felt she had lost her career. She recognised the importance of her role as a mother but by prioritising motherhood she lost her career and feelings of resentment developed:

There was resentment in there because it's like I wanted to get my career going and I wanted to be doing that and now it's got to stop when I've got a child and you know it's sort of not knowing what your future is going to be and how to balance your life now. [Clare]

Clare was finding it difficult to find a balance which enabled her career to be progressed and her infant's needs to be sufficiently met. Two of the mothers reflected that by prioritising motherhood they had lost their lives:

What I have done and it's [life] over basically. [Holly]

I think there was just a lot of like confused feelings and resentment probably about like my life has stopped. [Clare]

These distressing reflections are shocking; both Holly and Clare made the comparison to death after embarking on motherhood. This demonstrates how desperate and unhappy they were with their new mothering role.

Discussion

It is evident from the mothers' narratives that they held particular notions of motherhood. Often these notions emanated from society, but the importance of each idea was personal to each mother and therefore an idiosyncratic template of ideas was established. The conflict between these notions and their lived experiences had psychological and emotional consequences provoking an inordinate amount of distress. For the mothers in this study, distress was endured for months, often years, leaving them trying to reconcile conflicting, often distressing, cognitions with a plethora of negative emotions, without support.

Much of the psychological research exploring postnatal distress is generated looking through a medical model lens, thereby viewing mothers as having a mental health disorder (PND), with symptoms based on psychiatric nosology (DSM-5, 2013). Using this perspective, it is generally assumed that postnatal distress involves melancholy or anxiety (DSM-5, 2013). However, it was evident from this study that women's experiences did not have to include melancholy or anxiety to experience distress; in fact, only two women overtly identified with melancholy or sadness and both experienced it differently.

The range of women's emotions elucidated in this study were far-reaching beyond anxiety and depression and included, amongst others, resentment, feeling broken, lonely, overwhelmed, and inadequate; emotions not captured within the list of symptoms used to describe the mental health disorder in the DSM-5 (2013). It is therefore understandable why three of the mothers did not identify with the disorder. However, it is likely that if they visited their GP describing their symptoms, their distress would have been generalised as

postnatal depression (Westall et al., 2011); the three mothers who saw their GP received the diagnosis. All the mothers expressed a reluctance to go to their GP; those who went, went when their symptoms of distress became intolerable, on two occasions years later.

These emotions were not experienced in a vacuum; the amalgamation of many emotions contributed to the mothers' lived experiences creating a landscape of emotional complexity. It was striking how diverse each experience was and, even if two mothers experienced the same named emotion, the induction of the emotion and the effect it had on the mother were markedly different. An amalgam of uniquely felt emotions created an idiosyncratic experience for each mother adding to the complexity of motherhood.

There was only one emotion that was shared by all the mothers: guilt. Guilt is now considered an intrinsic constituent of motherhood (Seagram & Daniluk, 2002) and yet is not named as a symptom of postnatal depression (DSM-5, 2013) which again, questions whether the categorical approach reflects women's experiences. Guilt was experienced differently by each mother and experienced in all aspects of motherhood, whether that was for the negative emotions experienced or a perception of not being able to fulfil their child's needs. When exploring guilt with these mothers, it was apparent that they felt the emotion if they perceived something was lacking or they had not lived up to their mothering ideal. This finding is supported by the psychological literature (Sutherland, 2010; Higgins, 1987; Doucet, 2000). Specifically, Higgins' (1987) self-discrepancy theory, which suggests that a discrepancy between a person's lived experience and their 'self-guide', for example their aspirations, induces emotional discomfort, particularly guilt and shame.

Shame was only specifically named by one mother: 'quite ashamed of how badly I was doing' [Holly]. Guilt implies doing something wrong, either an act or behaviour (Sutherland, 2010), whereas shame is induced by fear of public disapproval or when the esteem of others is at risk; they are, however, often conflated (Tangney & Dearing, 2002). Shame is therefore not apparent in the

mothers' narratives, however, stepping away from the data, it seemed important to explore shame. In the broadest sense, shame plays an important part in mental health difficulties (Orth, Berking, Burkhardt, 2006; Tangney et al., 2002) and all the mothers in this study identified with distress. Shame in particular is identified as the emotion caused through aspiring to live up to be a 'perfect' mother (Liss, Schiffrin & Rizzo, 2013) and can be produced by feelings of inadequacy or failure (Scheff, 2000) which the mothers in this study also identified with. Shame is described as the 'social emotion' (Scheff, 2000) and is inextricably linked to relationships (Higgins, 1987; Liss et al., 2013); the nature of shame is to conceal experiences from others, which are thought to be 'incommunicable to others' (Kaufman, 1980, p.vii) or induce 'public disapproval' (Sutherland, 2010) and this is evident in the mothers' narratives.

None of the mothers in this study recognised that their inability to disclose difficult emotions was perhaps due to shame; this is not surprising when shame is often conflated with guilt (Tangney et al., 2002) and all the mothers identified with guilt. This mismatch suggests that shame is perhaps a terminology clearly defined by those studying it but is not generally understood in this way within society. However, shame could explain why all the mothers felt a need to conceal their emotions and act as if all was well to society. If a mother feels 'different' and has deviated from social and cultural norms she may feel stigmatised fearing public disapproval (Kitzinger, 2006) and this impacts on whether they seek help (Dennis et al, 2006; Halter, 2003). All the mothers found it difficult to seek help; shame proneness is a predictor of reduced help-seeking behaviours and depressive symptoms (Dunford and Granger, 2017). It therefore could be considered that shame is a contributory factory to mothers' distress despite the apparent absence in the mothers' narratives in this study.

Conclusion

This study revealed three master themes; all three explored notions mothers held and aspired to during motherhood. It was evident that these notions were rarely achieved or achievable and as a result there were repercussions including emotional and psychological distress; this emotional conflict between the mothers' notions of motherhood and their lived experiences became the overriding theme for the study. The themes elucidated a plethora of negative emotions experienced during the early stages of motherhood. This study therefore contributes not only to the understanding of mothers' experiences, identifying a number of different emotions not previously identified as distress during the early stages of motherhood, but also identifies a potentially large group of mothers whose distress is unidentified within the current western culture of diagnoses and medical discourses and who, as a result, are largely unsupported.

Idealised versions of motherhood deny any difficult aspects of motherhood (Craig & O'Dell, 2009) and appear to cause an inordinate amount of distress. This is an area where mothers can be supported by counselling psychologists; the provision of a space to explore ambivalent or powerful negative emotions where emotions can be normalised, held and detoxified may be beneficial. It also seems important to understand a mother's perception of her role and the importance she places on societal norms and expectations around motherhood. The identification of the notions of motherhood she holds and the modification of self-concepts and/or questioning the legitimacy of self-guides would prevent a conflict between representations of motherhood and mothers' lived experiences (Higgins, 1987). This would induce realistic expectations (Liss et al., 2013) and serve to protect mothers from the detrimental emotional effects and alleviate distress (Higgins, 1987). The aim would be to reduce risk factors and enhance protective factors. Encouraging this subclinical group to come forward and offering them early psychological intervention is therefore important not only for the benefits of the infant (e.g. Bowlby, 1997; Winnicott, 1964) but also

for the mother's enjoyment of motherhood and her own emotional and psychological wellbeing. Until mothers feel able to disclose their feelings openly without feeling vulnerable and exposed to judgement for not conforming to society's representation of motherhood, motherhood idylls remain unchallenged and the paradoxical nature of motherhood remains intact.

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