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The developing maternal-infant relationship: a qualitative longitudinal study

Peters, Jane

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**UNIVERSITY OF
PLYMOUTH**

**The developing maternal-infant relationship: a qualitative
longitudinal study**

by

Jane Peters

A thesis submitted to the University of Plymouth
in partial fulfilment for the degree of

DOCTOR OF PHILOSOPHY

School of Nursing and Midwifery

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Author's declaration

At no time during the registration for the degree of Doctor of Philosophy has the author been registered for any other University award without the prior agreement of the Doctoral College Quality Sub Committee.

Work submitted for this research degree at the University of Plymouth has not formed part of any other degree either at the University of Plymouth or at another establishment.


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The developing maternal-infant relationship: a qualitative longitudinal study

Abstract

Aim

The study aimed to explore maternal perceptions and the use of knowledge relating to their infant's mental health over time using qualitative longitudinal research.

Background

There has been a growing interest in infant mental health over recent years. Much of this interest is directed through the lens of infant determinism, through knowledge regarding neurological development resulting in biological determinism. Research and policy in this field are directed toward individual parenting behaviours, usually focused on the mother. Despite this, there is little attention given to maternal perspectives of infant mental health, indicating that a more innovative approach to methodology is required.

Methods

This study took a qualitative longitudinal approach, and interviews were undertaken with seven mothers from the third trimester of pregnancy and then throughout the first year of the infant's life. Interviews were conducted at 34 weeks of pregnancy, and then when the infant was 6 and 12 weeks, 6, 9 and 12 months, alongside the collection of researcher field notes—a total of 41 interviews. Data were analysed by creating case profiles, memos, and summaries, and then cross-comparison of the emerging narratives. A psycho-socially informed approach was taken to the analysis of data.

Findings

Three interrelated themes emerged from the data: evolving maternal identity, growing a person, and creating a safe space. The theme of evolving maternal identity dominated the other themes of growing a person and creating a safe space in a way that met perceived socio-cultural requirements for mothering and childcare practices. Participants' personal stories give voice to their perceptions of the developing maternal-infant relationship in the context of their socio-cultural setting, relationships with others, and experiences over time.

Conclusions

This study adds new knowledge by giving mothers a voice to express how the maternal-infant relationship develops over time. The findings demonstrate how the developing maternal-infant relationship grows in response to their mutual needs as the mother works to create and sustain identities for herself and the infant that will fit within their socio-cultural context and individual situations. Additionally, the findings illustrate the importance of temporal considerations, social networks, and intergenerational relationships to this evolving process. Recommendations for practice, policy and education are made that reflect the unique relationship between mother and infant and the need to conceptualise this using an ecological approach.

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Chapter 1: Introduction to the thesis

1.1 Background to the study

During my professional life, I have seen an explosion of interest in the formative years of childhood, particularly infant mental health within the United Kingdom, reflected in policy and health care practice (Allen, 2011; Leadsom et al., 2013; Department Health, United Kingdom and National Health Service England, 2015; Axford et al., 2015; Public Health England (PHE) 2018; PHE, 2019a). Maintaining infant mental health and protecting infants from adverse childhood incidents is associated with healthy neurological development and health throughout life (Center on the Developing Child, at Harvard University, 2010; Allen, 2011; Leadsom et al., 2013).

The promotion of health throughout the life course begins by encouraging the development of good mental health from in utero, infancy and beyond (PHE, 2019b), with the cause taken up by prominent figures such as the Duchess of Cambridge (Royal Foundation, 2021).

Despite the growing interest in this field, there is little representation of the carers, mothers and fathers of infants who are the most affected by these initiatives. As part of the research journey, I conducted a systematic literature review that asked the question ‘how do parents perceive and utilise knowledge of their infant’s mental health?’ A version of the paper as accepted for publication from the systematic review can be found in Appendix A (Peters et al., 2019). The results illustrated that primarily mothers are the focus of research in this field, in which they are generally treated as research subjects. In addition, the systematic

literature review indicated a lack of longitudinal qualitative research that focuses on mothers' perspectives of infant mental health.

As a result of the findings from the systematic literature review, this research aimed to explore maternal perceptions and their use of knowledge relating to their infant's mental health over time. Using qualitative longitudinal research with a hermeneutic approach to explore the following questions:

1. What are the influences and experiences that help to construct maternal perspectives of infant mental health?
2. How do maternal experiences of infant mental health influence the behaviours and strategies mothers may use with their infants?

Data was collected through oral narratives and researcher reflective field notes, over 15-18 months, between April 2017 to October 2018. During which time, seven mothers shared their stories with me from the last trimester of pregnancy until their infant was over one year of age. As the research developed, it became clear that the nature of the research and the data analysis required consideration of the unconscious influences upon both the participants and my responses and actions within our social worlds. Therefore, I adopted a psycho-socially informed approach to my data analysis.

Before I explain how the remainder of this chapter is structured, I want to give you an overview of the thesis. Chapter 2 explores the theoretical frameworks that have influenced this subject's development, resulting in a dominant discourse or master narrative (Hammack, 2008) that influences infant mental health and maternal care within affluent Western societies and, subsequently, infant care. In Chapter 3, I critique the existing framework for examining the subject of infant mental health, following with a discussion regarding the research on new

motherhood that has been influential in the construction of this study. In Chapters 4 and 5, I discuss the methodology and methods for the research. Chapter 6 introduces you to the mothers that participated in this research, and in Chapters 5 through 11, I present the findings with some interpretation of them using a psycho-socially informed approach, drawing upon the theoretical perspectives that I introduced in Chapter 2. Chapter 12 concludes the thesis with a discussion of the research and the findings, which illustrate how the maternal-infant relationship develops over time. I close the chapter by providing recommendations and actions for practice, policy and education.

For the remainder of this chapter, I will examine the meaning of infant mental health, how this subject links to infant determinism, and the evidence base regarding adverse childhood experiences (ACE) and neurological development in childhood. I will then examine the implications that ACE and neurological development have upon policy development.

Before we go any further, I need to explain the motivation to pursue this topic and its significance for my professional and personal life.

1.1.2 A personal story

The story of this thesis begins with an interplay between my professional and personal life. To tell this story, I need to take you back a few years, beginning with my professional life. I am in my thirtieth year as a Registered General Nurse (RGN). Despite qualifying as an RGN, children and their families have always been the focus of my practice; on completing my RGN training, I considered working in paediatrics, taking a job as a nurse within a regional paediatric oncology and bone marrow transplant unit. Admittedly, I found watching the impact of their child's illness upon the families and the numbers of bereavements challenging

to contend with, and I left after a year or so to pursue midwifery. After training and working as a midwife for around 8 years, I left to undertake a health visiting programme, returning after a period to consolidate my health visiting knowledge to work as a midwife for a Sure Start programme in 2004. The role with Sure Start offered the opportunity to use a combination of public health and midwifery skills and knowledge.

Sure Start was a national initiative set up in 1998 to improve children's services and tackle disadvantages within local communities (Ball, 2002). My midwifery role had a particular remit for young mothers, at that time defined by my employer as including all mothers until the age of 24. In reality, the midwifery team referred mothers to me they perceived as vulnerable, usually related to their social or psychiatric history, as well as teen mothers. I enjoyed the role, supporting both mothers and my colleagues, but there were elements of practice within Sure Start that I found frankly troubling, centring on their perception of partnership working with both colleagues and service users, which was fundamental to the service (Ball, 2002). My concerns regarding service users related to the local Sure Start programme's interpretation of partnerships, a concept central to its ethos (Ball, 2002). In my experience, instead of emphasising consultation and moving toward partnership, the focus was on organisational objectives, leading to some resentment of the establishment by mothers (Peters and Skirton, 2013).

The mothers I supported at Sure Start welcomed me into their homes and were content to work with me; however, they avoided other services, such as career and education advice. When I asked about this, they responded that these services were the same as those offered to children at school, thus displacing their adult status as mothers; as one mother asked me, 'why should I be treated differently from other mothers, because of my age?' Working for

Sure Start brought home to me the political nature of services offered to mothers and their families and my role in accommodating this. Not for the first time, I questioned the delivery of services, but I felt that I needed to pursue this in more depth; my curiosity sparked in the experience of maternal identity and how this shaped mother's perceptions of the services offered to them (Peters and Skirton, 2013). During this period, I was a mother to young children, and I felt a sense of unfairness that, despite the rhetoric that hinted at a consultation (Ball, 2002), this was not happening. By this time, I had started an MSc in Social Research Methods and developed a deep interest in qualitative methodology. After a year, I left Sure Start to work for the University of Plymouth, but the experience had created a sense of dissonance within me, particularly regarding how services are offered to children and their carers, usually mothers, with little consultation. As my dissertation project loomed, I went back to the Sure Start organisation to explore some of these issues with the mothers that attended one of their groups; please see (Peters and Skirton, 2013; Tighe, Peters and Skirton, 2013). I believed that engaging in qualitative research enhanced the quality of public health nursing practice and the services available to mothers and their families. In conducting an ethnographic research study (Peters and Skirton, 2013; Tighe, Peters and Skirton, 2013), the process encouraged me to sit back from my professional role and observe a group of mothers' responses to professionally directed advice, prompting both reflexivity and reflection on my practice (Tighe, Peters and Skirton, 2013). Simultaneously, I felt the research process gave women a voice, encouraged them to ask questions and get involved in delivering services (Tighe, Peters and Skirton, 2013).

While I was completing my MSc studies, the concept of infant mental health gained momentum within the United Kingdom's health and social policy (Allen, 2011; Leadsom et al., 2013). My MSc research findings illustrated the disparity between those organising

services for mothers and their families and the service users themselves (Peters and Skirton, 2013); I wondered how mothers perceived the interest in infant mental health and what the concept of infant mental health meant to them in caring for their infants. In the next section of this chapter, I define infant mental health and discuss the link between this and neurological development in childhood.

1.2 Infant mental health

Recognition of childhood as a particular and special time in a person's life started to emerge in Western Europe between the seventeenth and eighteenth centuries (Hays, 1996). With interest in the child's mind emerging during the mid-nineteenth century, Freud's work in the 1920s became the culturally dominant perspective, eclipsing earlier interest in this field (Shuttleworth, 2010). Freudian theories help set the scene for modern-day understandings of infant mental health, that the experiences of early life have implications for a person's development throughout life (Fitzgerald, Weatherston and Mann et al., 2011). Fitzgerald, Weatherston and Mann et al. (2011) propose that systems theory, an appreciation of the dynamic interplay of relationships between the individual, family, and their environment, alongside the disciplines of developmental psychology and psychoanalysis, are central to what constitutes the discipline of infant mental health. It might be argued that psychology and psychoanalysis help construct how we perceive childhood and parenting. In light of this, these theories are central to the theoretical and conceptual influences that I identify as fundamental to my understanding of infant mental health, as outlined in Chapter 2.

The concept of infant mental health (IMH) is hard to define and contestable given the importance of socio-cultural factors and their impact on the subject's perception. The World

Association of Infant Mental Health (WAIMH) use this definition in their handbook of infant mental health, defining infant mental health:

'as the ability of infants to develop physically, cognitively, and socially in a manner which allows them to master primary emotional tasks of early childhood without serious disruption caused by harmful life events. Because infants grow in a context of nurturing environments, infant mental health involves the psychological balance of the infant-family system.'

(Fitzgerald and Barton, 2000, p. 28).

The definition takes a holistic perspective to infant development and acknowledges the importance of the environment, drawing upon systems theory to highlight how the infant is part of a network of relationships. The concept of positive infant mental health is consistent with the infant developing to meet the demands of their environment. The term infant, in the case of infant mental health, is used interchangeably to refer to children aged between 0-3 years (WAIMH, 2016) or to encompass the antenatal period until the age of 5 years, dependent upon views relating to research and clinical practice (Zeanah and Zeanah, 2009). Despite the holistic nature of infant mental health as adopted by the WAIMH (Fitzgerald and Barton, 2000, p.28), and the recognition that child development is an interaction with social, biological, and neurological systems (Newman et al., 2015), the emphasis upon infant mental health has become intrinsically linked to neurological development.

The emphasis is on growing a healthy brain, acquiring cognitive skills to manage emotions and stress (National Scientific Council on the Developing Child, 2012). More recently, The WAIMH (2016) appeared to condone this perspective publishing a position paper on the rights of infants, after confirming that the United Nations Convention on the Rights of the Child (UNCRC) (UNCRC, 1990, cited by the WAIMH, 2016) did not go far enough in differentiating the specific needs that children aged between 0-3 have. The position paper confirmed the experience-dependent impact of neurological development during this time,

the need to create awareness in parents and professionals, and the use of policy to create supportive environments for infants and their parents (WAIMH, 2016). However, although the WAIMH (2016) acknowledge the importance of neurological development during this time, their position includes a call to consider the distal factors in the environment that can affect health, such as discrimination and socio-economic status (Tomlinson, 2015).

Central to infant mental health are environmental factors, as parenting practices and understanding of child development are shaped by the culture of communities, such as the activities, practices, beliefs, and ecology of the settings in which children and their carers live (Weisner, 1996; Rogoff, 2003). Therefore, distal factors such as socioeconomic status and discrimination are influenced by cultural responses to them, which helps construct how parents choose to care for their children. As Tomlinson (2015) suggests, the preoccupation by the discipline of infant mental health on the dyadic relationship is both a strength, as it has given great insight into the mother-infant relationship, but a weakness due to the neglect of environmental factors that impact the infant's mental health, which then influence parenting behaviours. However, the focus on the mother-infant dyad persists (Peters et al., 2019) alongside the emphasis on neurological development and its implications for infant mental health and development, resulting in a biological focus toward infant determinism.

1.3 Infant determinism

Theories of infant determinism started in Europe during the early eighteenth century, reflecting a belief that infancy is a critical period for human development and that this experience stays with the person for life (Bruer, 1999). The growing focus upon Adverse Childhood Experiences (ACE) and neurological development has moved the focus of early childhood policy away from social determinism; policies aimed at improving the social

conditions and reducing inequalities in childhood towards those of biological determinism (Edwards et al. 2015; Wastell and White, 2017). Biological determinism aims to create the best natural conditions for the child to grow (Wastell and White, 2017). Rather than focusing on the ecological system in which a child grows and structural factors such as poverty, which impact child health and well-being (Tomlinson, 2015; Marmot et al., 2020), the emphasis is upon parenting and parents' actions. In the following two sections of this chapter, I explore ACE and neurological development as these two research areas profoundly impact policy and practice for the 0-3 age group and perceptions of what constitutes infant mental health.

1.3.1 Adverse childhood experiences

The association with intergenerational harm and the long-term implications of adverse childhood experiences (ACE) has led to an increased interest in raising them as potential risk factors for parenting. Despite the growth of research in this area, the topic lacks a consistent definition for articulating the problems of adversity in childhood (McLaughlin, 2016; Steptoe et al., 2019; Lacey and Minnis, 2020). Childhood adversity is a 'construct in search of a definition' (McLaughlin, 2016, p.363). Felitti et al. (1998) developed the ACE study using four categories that reflected various forms of abuse, psychological, physical, sexual, and household irregularity – for example, domestic violence or criminal behaviour in the household. The categories articulated through a questionnaire sent to 13, 494 adults – from which there was a 70.5 % response rate. More than half of this sample reported at least one form of ACE. A graded relationship was found between the number of categories, childhood exposure, and adverse health behaviours and diseases (Felitti et al., 1998). Reporting of four or more ACE was associated with an increase in the risk of alcoholism, drug abuse, depression, and suicide. In addition, there was a graded response to the development of adults' disease, for example, ischemic heart disease, cancer (Felitti et al., 1998).

Further research has confirmed that ACE are linked to reduced mental well-being and life satisfaction, poor health, criminal justice, employment, and educational outcomes over the life course, with the children of those affected by ACE more likely to subject their children to ACE (Mersky, Topitzes and Reynolds, 2013; Bellis et al., 2014). The development of serious disease is more likely to occur before 70 in those with four ACE or more- such as cancer, diabetes, and stroke (Bellis et al., 2015). Four or more ACE increases the risk of violence, mental health, substance abuse, and intergenerational harm (Hughes et al., 2017). There is an increased risk of suspected developmental delay for children of parents who have experienced ACE, with three or more maternal ACE harming development (Folger et al., 2018).

From a critical perspective, ACE are deterministic, and there is a lack of clarity regarding what constitutes an ACE, for example, structural factors such as socioeconomic status. The lack of regard for these factors may lead to stigma and inconsistent use of ACE categories within questionnaires (Step toe et al., 2019; Lacey and Minnis, 2020). Other broader social problems such as poverty, hunger and inadequate housing require further discussion (Edwards et al., 2017). The studies in this field tend to be small and use retrospective data (Step toe et al., 2019). Where there are population-based studies available, these indicate that childhood adversity is standard, with an increased risk of developing a mental health problem over the life course if the individual has experienced ACE (McLaughlin, 2016). The biological mechanisms to link ACE with adult health outcomes are poorly understood; further evidence regarding the timing of the exposure to the ACE is needed (McLaughlin, 2016; Step toe, 2019); therefore, some caution is needed in relating the impact of ACE to the 0-3 age group. There is a lack of evidence about how different population groups respond to ACE

and what may constitute protective factors, with further elaboration required on what may be a normative stressor (Steptoe, 2019; Lacey and Minnis, 2020).

1.3.2 Neurological development

'Bruer (1999), in his book 'The Myth of the First Three Years,' takes the position that 'the myth' gives distinction to the claim that brain development is very rapid and critical during the ages of 0-3 years. This distinction requires that the child has exposure to an environment that can capitalise on this rapid growth in this period (Bruer, 1999). Several authors cite the lack of evidence to support the claim that the first three years of life represent the only period for experience-dependent learning (Bruer, 1999; Rutter 2002; Bruer, 2011; Macvarish, 2016). What we do know is that brain development is responsive through infancy to early adulthood to the environment (Guyer, Perez-Edgar and Crone, 2018), with experience-dependent learning continuing throughout life (Rutter, 2002). Some use the phrase 'neu parenting' (Macvarish, 2016, p.1) to encompass the biologically deterministic approach to promote parenting as means of caring for children in a way that prioritises the child's brain. In doing so, 'neu parenting' encourages parents' overreliance on health and social care professionals to inform them how to care for their children, transforming parenting into a risky business (Macvarish, 2016).

Arguably, the attention given to this aspect of child development is founded on the research that centres upon the impact of institutionalisation and neurological development in infancy, during which time the children may have experienced severe deprivation and privation¹

¹ Deprivation refers to the loss of an attachment figure. Privation is the failure of a child to develop an attachment to an appropriate person/persons (Rutter, 1981).

(Sheridan and Bard, 2017). There is empirical evidence on the effect of institutionalisation upon children from the 1970s, for example, Tizard and Rees (1975), but more recent findings into the impact on children living in environments with severe deprivation and privation have emerged from The Bucharest Early Intervention Project (BEIP) (Nelson et al., 2007) and The English Romanian Adoptee (ERA) research (Rutter et al., 2010). These children who experienced care in Romanian institutions experienced severe deprivation, with very few toys, little interaction from caregivers, were fed an inadequate diet and often washed using a hose of cold water (Rutter et al., 2010). This research is influential in understanding the long-term impact of severe deprivation in infancy and provides a basis for interpreting the direction that infant determinism has taken through the context of Early Years policy; below, I provide a brief overview of this evidence.

1.3.2.1 The Bucharest Early Intervention and The English Romanian Adoptee projects

The BEIP studied 136 institutionalised children randomised to foster care or continued institutionalisation, comparing them to 80 children raised with their own families in Bucharest (Nelson et al., 2007). Children fostered before the age of 2 had improved cognitive development (Nelson et al., 2007). An assessment of the children at the age of 8 demonstrated the importance of maintaining good relationships between the child and caregivers of children to preserve their IQ scores (Fox et al., 2011). Children randomised to the institutionalised arm of the BEIP had problems with reactive attachment disorders² (Zeanah et al., 2005), initially assessed using the Strange Situation Procedure (Ainsworth et al., 1978, cited by Zeanah et al., 2005). This difficulty persisted throughout childhood

² Reactive attachment disorders are defined as an inability to form attachment relationships, despite having the developmental ability to do so (Zeanah et al., 2005; Zeanah and Gleason, 2015).

alongside the development of disinhibited social engagement disorder³ (Zeanah et al., 2005). A reduction in brain activity was also recorded, although the situation improved by the age of 8 if fostered by 24 months (Vanderwert et al., 2010). The evidence suggests that reactive attachment disorder will resolve with improved caregiving and removal from institutions to a suitable environment. However, these interventions do not have the same impact on disinhibited social engagement disorder (Zeanah and Gleason, 2015).

The English and Romanian Adoptee (ERA) is a sample of 144 children drawn from 324 adopted from Romania who had experienced institutional care in that country. The orphans came to England between February 1990 and September 1992. The researchers compared the ERA children with children adopted within the UK by six months, who had not experienced institutionalisation, severe abuse, or neglect, (Rutter et al., 2010). Data were collected at 4, 6, 11 and 15 years of age. The research's early results illustrated that problems associated with institutionalisation were quasi autism⁴, disinhibited social engagement disorder, inattention, and cognitive impairment (Rutter et al., 2010). The research demonstrated that after the age of 6 months of age, psycho-social deprivation resulted in a reduction in head growth into adolescence, with overall growth stalling between the ages of 11-15 years, even though children's growth had responded following adoption. The children did not exhibit emotional problems at the age of 6 years; however, problems appeared between the ages of 6 to 15 years, indicating that children require a level of maturity for these to appear. Difficulties associated with conduct such as hyperactivity were evident before 6

³ Disinhibited social engagement disorder is a situation where a child is indiscriminate in demonstrating affection to adults and fails to stay with caregivers in unfamiliar environments (Zeanah and Gleason, 2015).

⁴ Quasi-autism refers to behaviour that resembles autism a term employed by Rutter et al. (2010) for this study. The ERA children affected had problems with picking up on social cues, reciprocity, understanding of social boundaries and indiscriminate friendliness. But they were socially interested in others and did not use repetitive movements such as rocking. Their behaviour improved between the ages of 4-6.

years and increased over time. Forming successful peer relationships was a problem. The group suffered from anxiety in adult years, stemming from the negative impact of institutionalisation on neurodevelopment resulting in difficulties creating social relationships and maintaining employment (Golm et al., 2020).

The implications for children left in institutionalised care, where they experience sensory, cognitive, linguistic, and psycho-social deprivation at a young age, are far-reaching. This deprivation will impact the development of the brain and subsequent behaviours. However, the mechanism for this is unclear (Nelson et al., 2011, p. 140). The limited data available suggests that removing children from the environment before the age of 6 months is advised to reduce the impact of institutionalisation and provide the child with similar outcomes as if reared with a family from birth (Rutter et al., 2010, Nelson et al., 2011). However, this research applies to infants subjected to severe living conditions but tends to be interpreted by policymakers as a means of illustrating the importance of relationships between caregivers and the infant. This research and that relating to ACE reinforce a dominant discourse or a master narrative surrounding infant development and mothering as translated into policy. As the Commons Select Committee (2018) highlighted, the research into ACE has had a considerable influence on the understanding of the impact of early experience on future development. The emphasis is upon individuals rather than considering the structural and material factors that might result in problems for children and their families.

1.3.2.2 The impact of ACE and neurological development upon the policy context

The influence of neurobiology has shaped policy within the United Kingdom, from policy related to early years, adolescence, and the elderly; these policies tend to indicate that the care of the brain is an individual's responsibility (Broer and Pickersgill, 2015). The media

has echoed this, generally representing early development as centred on caring for the infant's brain, with little or no reference to other factors that may influence development (O'Connor and Joffe, 2013). Knowledge regarding neurological development and ACE has driven the way forward for a policy focus upon early interventions in childhood within the United Kingdom; for a few examples, see the Allen Review (2011), Axford et al. (2015); Public Health England (2018). Examples of early interventions include the family nurse partnership, perinatal mental health services and the healthy start scheme (Perkins, 2019). The United Kingdom now has an Early Intervention Foundation (EIF), a member of the governments 'what works network,' to provide an evidence-based approach to early interventions (EIF, 2021).

Early interventions are central to the Healthy Child Programme (HCP) (DH, 2009); the HCP is guidance that midwives, health visitors and other associated professionals follow within the UK. A public health initiative, the HCP provides universal support for all children and their families (DH, 2009; Axford et al., 2015). Interpretation of the guidance (DH, 2009) varies between the UK's devolved countries regarding emphasis, for example, life or school readiness, number of health visitor contacts, and funding for either early education or childcare (Black et al., 2018). Ultimately though, the HCP views the early years as a priority in terms of developing a good foundation of health for the rest of the child's life, identifying that neurological development and attachment are a priority and that those from disadvantaged backgrounds are at risk of being unable to meet these needs (DH, 2009).

One area of focus within the HCP is supporting parents to provide 'sensitive and attuned parenting,' viewed as necessary due to the rapid neurological development within the first two years of an infant's life (DH, 2009 p. 10). This practice focus aligns with the Centre of

the Developing Child's Harvard University (CDCHU) (2010). The CDCHU (2010) proposes encouraging caregiver-infant relationships to help the child develop secure attachments, promoting brain development and, correspondingly, the infant's physical and mental health (CDCHU, 2010). Schore (2001) suggests that developing secure attachments⁵ in infancy is linked to the brain's optimal development. In addition, caretaker behaviours that lead to secure attachment in an infant promote a healthy stress response, as memories of these experiences are stored by the brain's limbic system, governing our reaction to stressful experiences (Schore, 2001). In fact, we know little about how attachment relationships impact the developing brain (Sheridan and Bard, 2017).

Policies directed at parents and parenting have grown immensely since 2000, first under the Labour government and then with the Conservative-Liberal Democrat coalition (Lewis, 2011; Daly and Bray, 2015). Parenting policy aims to change parents' behaviours using a systematic and evidence-based approach to interventions (Lewis, 2011). While parenting interventions in Europe tend to focus on the family's social and educational well-being, the UK emphasises changing parental behaviours (Daly, 2013) as illustrated by the HCP (DH, 2009; Axford et al., 2015), with little focus upon the broader environmental considerations that might have an impact upon these behaviours. More recently, the Social Mobility Commission (Clarke and Younas, 2017) concluded that there is a lack of longitudinal research on parenting interventions, but that policy in the short term is still an effective means of positively impacting parenting behaviours. Britto et al. (2017, p.98) conclude that for early child development outcomes to improve, an intersectoral approach is required that

⁵ Attachment theory is a psychoanalytical theory developed by Bowlby (1969). Please see Chapter 2 for a discussion relating to this.

focuses on 'nurturing care' to the child, parents and family, an approach congruent with focusing upon the family's social and educational well-being.

The perspectives of infants' families or carers of infant mental health get lost within the policy, practice and research focus as illustrated above and by the systematic literature review (Peters et al., 2019). Therefore, as a result of the findings from the systematic literature review, this research aimed to explore maternal perceptions and their use of knowledge relating to their infant's mental health over time, using qualitative longitudinal research with a hermeneutic approach as introduced in the following section.

1.4 Introducing qualitative longitudinal research

Mothering and infant care is an interpretive social process developed over time, constructed in relationships with others, and influenced by master narratives or dominant discourses fostered within a particular socio-cultural context (Hammack, 2008). The adoption of hermeneutics (Heidegger, 1927; Ricoeur, 1981; 1991a) as a methodological approach explores what it means 'to be in the world' (Heidegger, 1927, p.39). This approach acknowledges that mothers have a 'preunderstanding of the world' (Heidegger, 1927, cited by Ricoeur, 1981, p.17) formed in part by a master narrative that helps guide their interpretations of what it means to be a mother and their perceptions of infant mental health. I adopted a qualitative longitudinal methodology to gather and create a text of maternal stories of this experience over time. The use of qualitative longitudinal research allows the researcher to 'walk alongside' participants⁶ in real-time, as they experience transitional moments in their

⁶ Please note that I use the term 'participant' and 'mother' interchangeably within this thesis.

lives, making this a suitable approach for researching this topic as mothers anticipate welcoming a new baby to their families (McLeod and Thomson, 2009, p.61). I used interviews with mothers to collect their stories of the experience; individuals use narratives to make sense of their lives, and this method reflects the interpretive approach I have taken in this research (Josselson, 2011). The research questions and objectives for the research are presented in Figure 1.

The research questions were to explore:

1. What are the influences and experiences that help to construct maternal perspectives of infant mental health?
2. How do maternal experiences of infant mental health influence the behaviours and strategies mothers may use with their infants?

The objectives of the research were to:

1. Consider how mothers perceive their infant's development and the significance they place on infant mental health and well-being.
2. Explore maternal perceptions of infant mental health; to what extent are these influenced by their personal narratives and societal influences.
3. Explore the extent that maternal behaviours with their infants are shaped by perceptions and knowledge of infant mental health.
4. Reflect on infant behaviour with their mothers and explore how they believe this behaviour is shaped.

Figure 1 The research questions and objectives

As I became engaged in the data analysis of the collected narratives, I realised that participants were affected by the intersubjective nature of the research (Hollway, 2006a). The participants' responses appeared to echo a master narrative (Hammack, 2008) that encompassed the topic of infant mental health, alongside their perceptions of me as the researcher and accounts of themselves as mothers influenced by socio-cultural values. To try and move past this intersubjective element and uncover how external factors might influence

an individual's inner world and perception of reality, I adopted a psycho-socially informed approach to my analysis of the data (Hollway, 2006a). The theoretical and conceptual influences that support the concept of infant mental health are outlined in Chapter 2, and it is these influences that I have used to help interpret my findings in Chapters 5 to 11 within a psycho-socially informed framework.

Chapter 2: Theoretical and conceptual influences supporting infant mental health

2.1 Introduction

In this chapter, I explore the theoretical and conceptual perspectives that influence the development of this thesis and my understanding of infant mental health within a wealthy Western society; please see Figure 2 for a diagrammatic overview.

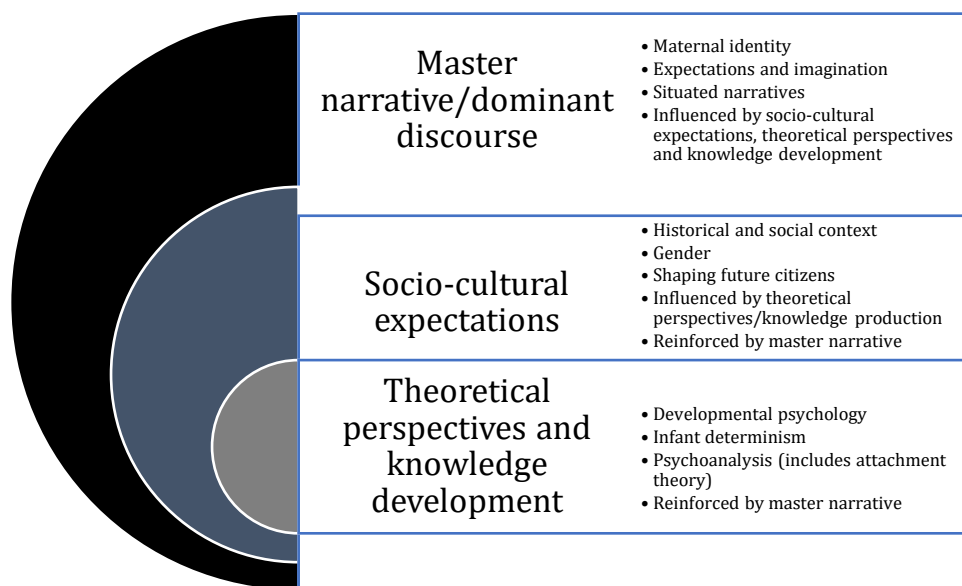


Figure 2 Theoretical and conceptual influences supporting infant mental health (author's diagram)

In the following sections, I will explore the theoretical and conceptual influences as outlined in the diagram (figure 2), commencing with master narrative; master narratives are dominant

discourses within a society that give us expectations of how we should behave, formed from cultural expectations of our roles (Hammack, 2008). Hammack (2008, p.224) goes on to argue that:

'The relationship between a "master narrative" and a personal narrative of identity provides direct access to the process of social reproduction and change.... As individuals begin to construct personal narratives of identity that will anchor the cognitive and social context through which they develop, they engage with master narratives of identity.'

The development of an infant's mental health is a process of 'social reproduction' that evolves within the infant's environment. As part of this process, perceptions of maternal identity formed in part through maternal engagement with dominant discourses or master narratives will influence how an infant is cared for and the carers insight into infant mental health.

The theoretical influences outlined in this chapter, feedback into the master narrative, reinforcing and recreating it. Chapter 1 outlined the relationship between policy and biological determinism, influenced by developmental psychology and psychoanalysis. In this chapter, following my discussion of master narratives, I consider the socio-cultural expectations and theoretical perspectives, except biological determinism as outlined in Chapter 1, that influence the development of a master narrative regarding what it means to be a mother. Considerations of maternal identity will, in turn, affect maternal perceptions and knowledge of infant mental health.

2.2 Master narratives and culture

To understand the role that cultural expectations play in developing master narratives, we need to try and grasp what culture is. Culture is an entity that is central to our existence:

'culture is not just an ornament of human existence but -the principal basis of its specificity- the essential condition of it' (Geertz, 1973, p. 46).

Culture moves us from our purely genetic and biological origins to something that we produce, creating us in the process, influencing our biology, psychologically and social being; without culture, we are 'incomplete or unfinished animals' (Geertz, 1973, p. 49).

Culture is complex and challenging to define; it is an open-ended and extensive concept, as Keller (2014, p.5) proposes in this definition of culture:

'we define culture as values, norms, and beliefs (ideational part of culture) that are shared by people who live in the same ecosocial context consisting of the level of formal education, age at first birth, number of children, and household composition. These dimensions are to be understood not as independent variables that should be statistically controlled for; rather they should be seen as constituting social milieus with particular, norms, values and behavioural conventions (cultural models) that define children's learning environments. Countries can thus- and obviously do- contain multiple cultural milieus.'

Master narratives are those, which reflect a:

'body of anonymous, historical rules, always determined in time and space that have that have defined a given period, and for a given social, economic, geographical, or linguistic area' (Foucault, 1972, p.131).

Our lives are formed through engagement with culture; the interpretation of our understanding of culture is through language that reflects a shared grasp of its symbolism and the need to live reciprocally with one another (Bruner, 1990). Bruner (1990, p.33) identifies this as forming part of a 'folk psychology,' which teaches us how we should act within our own culture, including using language and interacting with others. As I illustrate, this knowledge has implications for our development as individuals, influencing perceptions of maternal identity and infants' care.

2.2.1 Situated narratives

Master narratives provide a social code of how to position oneself or another concerning an entity (Bamberg, 2004), such as motherhood or infant mental health. Individuals form their identity with personal narratives that construct their social and cognitive self, achieved

through engagement with master narratives (Hammack, 2008). Through narratives, we come to understand our sense of who we might be. We construct our sense of self in relationship to the other, considering how others might perceive us and how we view them; as we create our self, we do so relating to situated knowledge and our imagination, experiences of the past, present and our hopes for the future (Andrews, 2014), temporal facets that underpin the experience of motherhood (Thomson et al., 2008).

McLean et al. (2008, p.263) identify the narratives we use to construct our sense of self as 'situated stories,' we begin our storytelling in early childhood and continue throughout life, the sense of self or forming of the self is a dynamic and fluid process that is subject to change in response to situated stories. Situated stories are created from memory to reflect an episode in our lives that we then tell in such a way as to reflect the needs of a particular audience; this audience can be internal or external (McLean, 2008). Therefore, interpreting our socio-cultural landscape is an ongoing process and women in forming their maternal identity and caring for their child will develop their narratives in response to this, requiring a methodological approach to explore this. For a story to get heard depends upon its acceptability to society, stories reflect the political and social landscape, representing power differentials (Plummer, 1995). Narratives are produced as part of an interactive social world, helping us negotiate our activity; they symbolise our socially constructed actions and intentions. Some stories are more accessible to tell than others, dependent upon having an audience willing to listen, reflecting the shaping of stories by power and politics (Plummer, 1995), exposing the dominance of master narratives. In absorbing the master narrative that encompasses mothering, mothers may have expectations of how they will behave as mothers in response to this, suggesting that they will form the stories of their mothering experience in a way that reflects this. If master narratives help create our sense of self and identity, then it

is important to consider how identities are formed. In the next section, I explore the theoretical perspectives that suggest our identity is shaped through an interaction of psychoanalytical, cultural, and psychological factors.

2.2.2 Developing identity

2.2.2.1 Developing identity in childhood

Cultural origins create our understanding of human development and identity (Weisner, 2002; Rogoff, 2003). Human identity develops through childhood and the life span (Erikson, 1959). It is a term used quite loosely to convey something that is, as Erikson (1959, p. 109) describes as 'ambiguous' formed in a complex way and concerned with maintaining a sense of 'self-sameness' while identifying with others. Arguably our life story starts before birth; our parents or future caregivers form a narrative that provides the origins of who we are. The Kleinian theories of introjection⁷ and projection (Klein, 1936; 1946, see section 2.4.1.2.2) help understand identity development. Klein (1936; 1946) hypothesized that we internalize and project out the good and bad in our relationships and context. This process helps the child form a sense of self in relationships with caregivers while allowing him or her to eventually reach out and form connections with others (Erikson, 1959).

Vygotsky (1978) theorised that memory is fundamental to the development of identity, highlighting the role of temporality, as memory enables the child to unite the past with the present. In conjunction with speech, the use of 'signs' helps develop a structure that includes

⁷ Projection is fundamental to the ego, although understood by Freud as a way in which to get rid of unwanted the bad from oneself, Klein moved on to think about projection in terms of good and bad qualities. Whereas introjection was initially understood by Freud to mean absorbing all that was good to help in the development of the ego, Klein moved to a similar understanding as to that with projection. That we internalise both the good and the bad from objects, (Spillius, 2011).

the past, present and future (Vygotsky, 1978, p36-37). Vygotsky does not appear to have a definition of what is meant by signs, but in his book, 'Thought and Language' signs are linguistic, indicating that signs are language or other gestures that might symbolise language cues, which are open to perception by the child or another (Vygotsky, 1986). This concept links to Bruner's (1990) discussion of folk psychology that through our engagement with the social, we learn how to recognise and fit into our cultural milieu if that is what we choose. One implication is that the individual learns to recognise society and seeks to be recognised within it; thus, they absorb the values that underpin that society (Erikson, 1959). This process of ongoing interaction with others forms our sense of self (Mead, 1934), indicating that the development of identity is a psycho-social process.

There are various reasons why individuals might reject societal values and offer resistance against them. For example, when I undertook my research for my MSc, the mothers I interviewed rejected the expectations that Sure Start staff had of their engagement with activities at a group for parents (only mothers attended) and their preschoolers. Instead, they viewed the group as a means of getting out of the house, sourcing local information, not being instructed how to play with their children, and offering resistance by refusing to participate in some of the activities offered to them (Peters and Skirton, 2013). The proposition was that it was important to maintain what they perceived to be a strong maternal identity by appearing confident with other mothers within the group's confines (Peters and Skirton, 2013). This example suggests that maternal identity has the power to shape mothers' activities with their children, and in turn, may influence how they engage with the concept of infant mental health.

2.2.2.2 Narratives and identity

Ideology is a consideration when we think about the development of identity. Hammack (2008, p.231) defines ideology as an 'abstract system of beliefs that develops within an individual, through a discursive engagement with a particular cultural context.' Ideology thus creates master narratives within society regarding the expectations we have for ourselves and others, influencing what it means to mother a child and perceptions of infant mental health. Through master narratives, we create personal narratives, therefore linking ideology and the self. This act helps the individual turn ideology into something that has personal meaning (Hammack, 2008). Arguably, considerations of what it means to be a mother are located within cultural ideologies of the role.

The use of narratives and the development of identity is well documented, for example, Bruner (1986b); Bruner (1990); Ricoeur (1991b); McAdams (2001); Kohler -Riessman (2008); Hammack (2008). The argument is that we use personal narratives to form our own life story, in which we learn from the past and imagine the future, developing our narrative identity (McAdams and McLean, 2013). Mothers might reflect upon their experiences of being mothered, indicating the intergenerational nature of motherhood (Thomson et al., 2008), some of which may not be directly available to them stored in their subconscious (Chodorow, 1999) or of their experience of mothering. Mothers may well envisage how they wish others to view them as a mother, while reflecting on past experiences may help form an imagined self as a mother, helping to direct the care given to her child. Adults can present temporally coherent perspectives of their life stories, which they organise into culturally relevant detail, and may provide causal explanations for events in their lives (Habermas and Bluck, 2000). As adults, we internalise our socio-cultural milieu and use our interpretation to

help develop a narrative that meets our imagined understanding of ourselves (Ricoeur, 1991b).

Maternal identity only forms part of a mother's overall identity, although this aspect of identity may feel all-consuming for a mother with dependent children. Psycho-social factors influence identity formation, and these unite to form master narratives that surround the subject of motherhood. It might be suggested that maternal identity and the factors that influence it are important considerations in maternal perceptions of infant development and infant mental health, shaping maternal behaviours with their infants and directing their interpretations of infant behaviours. The next section of this chapter explores the second element of figure 2, the socio-cultural expectations that influence our perceptions of what it means to be a mother within an affluent Western society and, therefore, possibly influence the maternal identity of an individual.

2.3 Socio-cultural expectations of motherhood in a wealthy Western society

2.3.1 Mothers

Throughout history, symbols of what makes a good and bad mother have been with us (Ruddick, 1989), represented in such a way that maternal individuality disappears behind the child's existence and well-being. The mother has been described as invisible, reflecting the idea that she will be left behind as the child grows, implying that she is insignificant as a person in her own right (Baraitser, 2009). Baraitser (2009, p.7) suggests that a mother is someone whose purpose is to help develop:

'the inner workings of the child, a metaphorical figure used to signify particular representational modes or an individual who engages in a set of socially controlled practices and ideologically driven fluxes of power.'

These representations reflect how socio-cultural perspectives of motherhood influence beliefs of what it might mean to be a mother within a wealthy Western society. As Kristeva (1980, p.304) notes, the onset of motherhood is 'where nature confronts culture,' one can be a mother in a biological sense, but that culture will dictate what is considered the acceptable behaviours and actions of motherhood. The implication is that socio-cultural expectations are powerful influences upon how mothers might view themselves as mothers and, therefore, how they choose to practice mothering their child.

In this section, I explore some of the critical theoretical perspectives that help understand our socio-cultural position on motherhood, including feminist perspectives on motherhood, the idealisation of motherhood and intensive mothering. Furthermore, these theoretical perspectives may help explain the development of maternal identity within the mothers' socio-cultural context included in this study.

2.3.2 Feminist perspectives on motherhood

Caring for children in the West may be an isolating experience as individuals choose to have fewer children and live further apart from other family members (Rich, 1986; Miller, 2005). Sometimes mothers struggle to make sense of the myths surrounding motherhood; they find that the 'natural' and 'instinctive' feelings supposed to accompany it are often missing and are reluctant to admit this, clinging to the moral discourse of a good mother (Miller, 2005, p.138). Mothers who fail to live up to their ideals of motherhood are more likely to experience negative emotions such as guilt or shame (Liss, Schiffrin, and Rizzo, 2013). 'First wave' feminist theory conceptualises motherhood as a symbol of essentialism, a site of oppression within a patriarchal society (Takševa, 2018). The result is that these feminist perspectives resulted in a reduction in motherhood studies, arguing that the definition of

mothering reinforces gender roles. (Takševa, 2018). However, motherhood studies now look to pursue a 'pluralistic perspective' that recognises mothers' individual experiences and 'mothering practices' within differing social contexts (Takševa, 2018 p. 180). The argument is that these first wave theories represented a white middle-class perspective on motherhood, a situation experienced differently from those from differing ethnicities or social groups, in keeping with a third wave approach to feminism (Takševa, 2018). As illustrated in the systematic review (Peters et al., 2019) see Appendix A and Chapter 3, the values of Western, Educated, Industrialised, Rich and Democratic (WEIRD) (Henrich, Heine, and Norenzayan, 2010) societies are very influential upon the conduct of research in infant mental health, childhood and perceptions of motherhood, reinforcing the need to undertake research such as presented in this study that focuses upon the individual's experiences.

Adrienne Rich (1986, cited by Takševa, 2018) challenged the first wave feminist perspective of motherhood. Rich (1986, p.13) hypothesised that there were two ways to think about mothering, both of which are 'superimposed on the other' there is the 'potential' any woman has to her reproductive abilities and her children, and then mothering as an 'institution' which aims that 'women and all children shall remain under male control.' Rich's (1986) work is helpful in trying to appreciate how mothering might be used as both a potential source of power, a position taken by some mothers, for example, in my MSc work (Peters and Skirton, 2013) but at the same time tempered by dominant socio-cultural perspectives on motherhood today, with the mothers in that study very conscious of maintaining perceptions of themselves as good mothers. Rich's (1986) work led to the second wave of feminist thinking about mothering as a basis for power and was identified as such by other writers, for instance, Ruddick (1989) and Hill Collins (2000).

Ruddick (1989) defines mothering as a practice, work, that both women and men can do, which falls mainly to mothers through biological and cultural expectations. As she explains, maternal practice accommodates three potential areas of maternal work, 'preservative love, nurturance and training' (Ruddick, 1989, p.17). Ruddick (1989) acknowledges the ideology surrounding motherhood, suggesting that views which represent mothers as victims of this are oppressive. However, Ruddick (1989) admits that despite mothers' powerful position in their children's lives, professionals, theories, sexism, and ideologies surrounding motherhood undermine this power. Instead of viewing mothering as a space for oppression as suggested by first-wave feminism, she considers the act of mothering as a potential source of power available to women, men, and feminists, who adopt the practice of mothering as a possible political resistance toward peace (Ruddick, 1989). Whereas Hill Collins (2000, p.193) suggests that the development of the community 'othermother' within African American communities in America has led to maternal activism within this group, enabling them to work collectively to confront the racism their children face. These theories present a different perspective on mothering than that primarily reflected in the systematic review (Peters et al., 2019) (see Appendix A), reframing it as a positive undertaking, representing mothering in an empowering way, recognising the potential impact the activity might have on fighting oppression. However, other powerful forces make it difficult for mothering to be recognised as a practice grounded in the individual's experience or as a source of power to be grasped by communities of mothers, centring around the idealisation of motherhood within our socio-cultural environment as explored in the following section.

2.3.3 The idealisation of motherhood

2.3.3.1 Essentialism and motherhood

Patriarchal definitions of motherhood bounded in essentialism continue to dominate Western narratives of good motherhood. The media reinforces these narratives, portraying the ideal mother as a white middle-class woman, usually married, if employed, she is in a good job, or she might choose to be a 'full-time mother' (O'Reilly 2010, p. 7; Rose, 2018). The use of the phrase 'full-time mother' is an odd one, used to describe women who choose to stay at home with their children, not working outside of the house. Any woman who has borne a child will always be what we describe as a mother; it is a biological reality. Whether she chooses to practice mothering, to mother a child is a different matter (Ruddick, 1989). The patriarchal understanding of the mothering role is reflected in the statement, as society does not distinguish the role of being a father in the same way. This distinction is a judgement of how women wish to mother, defining mothers through essentialism, their perceived capacity to reproduce, and caring for a child in a way as recognised by society (Takševa, 2018). It might be argued that essentialist perspectives of motherhood today are reinforced by middle-class values and the media, which I explore in the following section. Maternal perspectives of motherhood embedded in essentialism are described by other researchers of motherhood, such as Miller (2005), signaling that this impacts maternal perceptions of their role and the development of maternal identity. Although I define here the values that underpin a dominant perspective of motherhood, there is a need to acknowledge mothering as an individual experience within Western society, reflecting the complexity of our culture. There will be different experiences of essentialism related to motherhood; for example, some African American communities have an alternative perspective, where a strong mother is viewed as one able to withstand a great deal of personal injustice and pain, a source of potential oppression, as the identity is expected and perpetuated by men within that

community (Hill Collins, 2000). Therefore, maternal perceptions and knowledge of infant mental health need to be explored with the individual within their socio-cultural environment, as undertaken by my study. In the next section, I explore the influence of middle-class values upon motherhood to consider how these perspectives may influence maternal perceptions of identity and maternal care for their infant.

2.3.3.2 Middle-class values and motherhood

Society tends to identify specific groups of mothers as problematic, particularly as they move away from essentialist perspectives on mothering within their given culture. Research linking mothers and their behaviours to poor outcomes for either themselves or their children, for example, teenage motherhood (Robling et al., 2016) and lone mothers (Silva, 1996), or those living in poverty (Morris, 2017). The media tends to whip up prejudicial accounts regarding mothers in minority groups, for instance, stories of migrant mothers scrounging off the NHS (Rose, 2018). Research in human development and psychology focuses on WEIRD societies, identified as White, Educated, Industrialised, Rich and Democratic (Henrich, Heine and Norenzayan, 2010), therefore becoming the source of psychological norms. The literature that surrounds mothering and parenting refers to a view that 'middle-class motherhood' is best, reflecting the master narrative that is situated within the perspective of mothering as defined by WEIRD societies (O'Reilly, 2010; De Benedictis, 2012; Lowe, Lee and Macvarish, 2015; Edwards, Gillies and Horsley, 2015). Despite the focus on 'middle-class motherhood,' the term lacks definition. Texts assume that the reader will grasp what is meant by middle-class within the context of mothering, suggesting that it is ingrained in our understanding of society.

The values that underpin the term middle class in mothering converge with the start of health visiting within the United Kingdom. This nursing profession originated from a concern over the impact of impoverishment upon health reflected in men's inability to participate in the Boer War (Kelsey, 2000). A report issued by The Interdepartmental Committee on Physical Deterioration (1904, cited by Kelsey, 2000) indicated a link between environmental conditions and physical health. A recommendation was made that help be given to assist individuals in improving their health, advising about the situation in which they lived, it was suggested that they have access to 'ladies visiting' with knowledge of infant feeding and a nursing background (Rowntree, 1904 cited by Kelsey, 2000, p. 44). Sanitary inspectors, the precursor to the modern-day health visitor, were employed from the mid-nineteenth century to combat infant mortality rates (Adams, 2012). The government continued to recognise the impact of environmental conditions on physical health, and the regulation of mothers with infants increased in the early twentieth century (Peckover, 2002). The differentiation between mothers of wealth and those living in poverty was marked, with those living in poverty subject to more censure. America saw the rise of middle-class values on mothering during the nineteenth century, with working-class mothers judged unreliable and middle-class mothers wholesome and moral (Hays, 1996). At that time, middle-class women had access to tremendous resources to help with child-rearing, for example, domestic support and staff to care for young children (Hays, 1996). However, the concept of middle-class mothering values holds today. The values imply maternal ability to access supportive resources in information, health literacy, childcare, and groups. While at the same time choosing to lead a moral life, judged by the approach that mothers select to bringing up their baby, for example, infant feeding, choosing to breastfeed over formula feeding (Lee, 2007a; Faircloth, 2010), and the ability to be independent of support from state resources. At all costs, it is suggested that the ideal mother must avoid the moral swamp of a feckless mother who

requires additional support and parenting guidance (Hey and Bradford, 2006; De Benedictis, 2012; Gillies, Edwards and Horsley, 2016). Arguably the media breathes life into this myth, with television programmes polarising stereotypical working-class mothers into reality television shows, representing them in an unflattering way, while portraying middle-class mothers in fictional programmes, leading a 'yummy mummy' lifestyle (Feasey, 2016). Mothers themselves report resenting the lack of diversity and relatable mothers portrayed by television (Feasey, 2016).

2.3.3.3 The media and motherhood

The idealisation of motherhood may be firmly rooted in history, but the narrative continues not only through television (Feasey, 2016) but through all media sources. In 2007 Hardyment, noted in her book 'Dream Babies' that there was now a prolific source of parenting literature, blogs and media consumption. Do a fast forward to 2020, and a search of Amazon tells me that the same is still valid. Ideal motherhood usually comes with a celebrity endorsement or the allure of how to improve your child; for example, Holly Willoughby (2016) 'truly happy baby ...it worked for me,' to John Medina (2014) 'brain rules for baby.' The concept of the 'yummy mummy' exists today (Hardyment, 2007), with Facebook, Twitter, and Instagram providing examples of otherworldly perfectionism in mothering, otherwise known anecdotally as 'clean parenting.' An approach unobtainable for the masses, with photos of glowing children and mothers in scenic surroundings a testament to their success. For example, see 'mother of five boys, living in Cornwall, plant-based diet, home education...' (Gooding, 2020, Instagram) or Jools Oliver 'proud mum of 5' (Oliver, 2020, Instagram). Celebrities and obsession with their lives can permeate perceptions of motherhood, feeding imaginings of what it means to be a mother and to mother.

2.3.4 Intensive mothering

Douglas and Michaels (2004) explore how the media, on the one hand, celebrates motherhood while holding mothers accountable to impossible standards, building on the theory developed by Hays (1996) of intensive mothering. Hays's (1996) theory emerges from her research involving 38 women from various social classes, employment situations, ethnicities, and perspectives on rearing children. Hays (1996) analysed the history of child-rearing and childcare texts alongside interviews and a questionnaire. The concept of intensive mothering has three elements: the mother is the primary caregiver; secondly, her child's needs come first, and she must provide ample time, energy and material resources in looking after her or him. Thirdly, there is no comparison between her child and her work; the child sits outside of that; as Hays (1996, p. 8) describes, 'innocent and pure, children have a special value; they, therefore, deserve special treatment.' Hays (1996) claims that this is the dominant ideology for raising children within the United States. The concept of intensive mothering emerged from all social groups in Hays' (1996) research, but the middle classes were most likely to attain intensive mothering. Ennis (2014) notes that the precursor to intensive mothering was the rising consumerist culture of the 1990s and the neoliberal dropping of social and monetary support for families, with mothers expected to pick up the strain. The ideology of intensive mothering is in evidence today. Ennis (2014) provides real-life examples- mothers being friends with their children's friends, doing homework for their children, and mothers encouraging their children to be in constant contact with them via text/phone/messenger. I would suggest that a preoccupation with intensive mothering substantially influences maternal perceptions of their identity and subsequent mothering practice and care of their child.

The theoretical perspectives and knowledge that I outline in the next section of this chapter have contributed toward our understanding of how we believe young children should be cared for and underpins the development of concerns relating to infant mental health and wellbeing. Mainly, these theories respond to the concept of infant determinism (Bruer, 1999, as discussed previously in Chapter 1). I begin by considering the role of psychoanalysis in our understanding of infant mental health and the potential impact upon perceptions of mothering, with a particular focus on Freud, Klein, Bion, Bowlby and Winnicott. These theories may influence maternal perceptions of mothering and infant mental health and have helped me analyse the data for this research.

2.4 Theoretical perspectives and knowledge

2.4.1 Psychoanalysis

Psychoanalysis is ‘the body of theory derived from Sigmund Freud's work emphasising the existence and workings of a dynamic unconscious’ (Frosh, 2012, p. 6), introducing the idea that young children have a psychic existence. There are disputes within the discipline regarding the theoretical basis for psychoanalysis, but the discipline agrees on the unconscious mind's importance (Frosh, 2012). An in-depth exploration of psychoanalytical theory is not possible within this thesis's confines. However, I explore concepts central to my understanding of infant mental health and ideas that have helped to shape the analysis of the data gathered as part of this study. The psychoanalytical ideas relevant to this thesis are Kleinian Psychoanalysis and Object Relations Theory, with Attachment Theory partly aligned to Object Relations Theory (Frosh, 2012). Figure 3 illustrates the psychoanalytical theories introduced as part of this thesis, linked in theoretical terms rather than chronology.

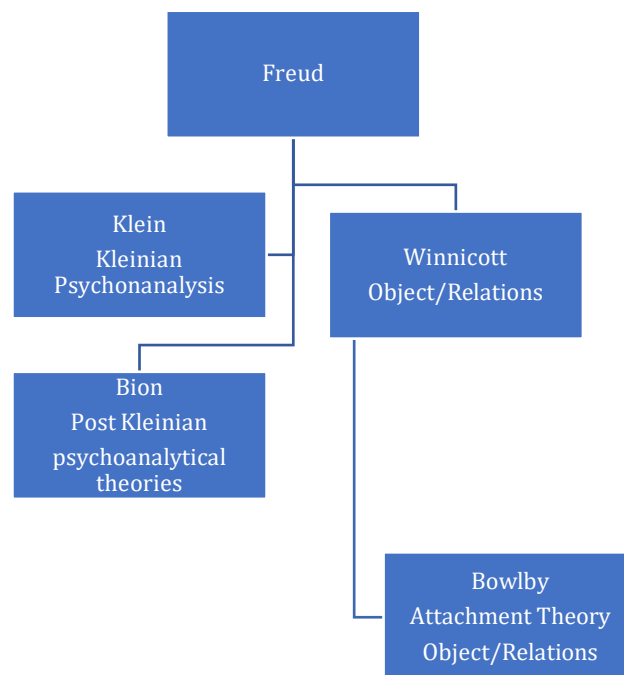


Figure 3 Illustration of psychoanalytical theories: adapted from the writing of Frosh (2012, p.25)

2.4.1.1 Freud

Psychoanalysis begins with Freud. I find Freudian perspectives helpful in understanding the link between our conscious and unconscious selves, and our internalisation of the influences of those around us and our experiences of the social world, in helping to shape our behaviours. For me, this explains how master narratives influence the creation of our identities and behaviours. Freud based his theories on subjectivity and his process of self-analysis (Gomez, 1997). Freud theorised that the mind had three components, the id, ego, and superego and that the conscious and unconscious divide the person's psychic life (Freud, 1923). The ego is the individual's conscious mind, deciding what to repress from our consciousness, negotiating between the unconscious and conscious world; the ego chooses

what we consciously do and internalises our experiences (Freud, 1923; Frosh, 2012). The id is where we hold what we repress; the ego can access the repressed through the id. Freud stated that the ego translates the id's will into action as if it were its own, implying that our intention is not entirely conscious (Freud, 1923). The superego emerges from our biological and historical origins and depends upon the Oedipus Complex outcome. The Oedipus Complex reflects how we handle our lives when given limitations or our ability to cope with loving others that we find difficult to do so (Frosh, 2012). The superego reflects the wishes of society, the internalisation of a harsh paternal voice that controls our behaviours (Freud, 1923; Gomez, 1997). Freud applied developmental phases to childhood, identified through developing sexuality (Gomez, 1997), and theorised how infant life's latent memories resurface and return in adult life (Gomez, 1997; Frosh, 2012). The foundation for our understanding of infant mental health is that early experiences influence the brain's development and that these experiences stay with us throughout our lives (Zeanah and Zeanah, 2009).

Fact box: Freud

- **Claimed a biological basis for his theories.**
- **Theorised that the mind has three components, the id, ego and superego.**
- **The ego represents the conscious mind.**
- **The id is where we store what we repress.**
- **The superego reflects the wishes of society and controls our behaviours.**
- **Developmental phases of childhood are aligned to developing sexuality.**
- **Latent memories of infant life resurface in adult life.**
- **Drives influence our psychology and behaviours.**
- **What satisfies the drive becomes the object.**

Figure 4 Fact box: Freud

2.4.1.2 Klein

2.4.1.2.1 Klein and differences with Freud

Melanie Klein's work led to Kleinian psychoanalysis; an acknowledged alternative to the Freudian approach. Klein considered herself a Freudian, but there were some fundamental differences and similarities with Freud (Frosh, 2012 and Gomez, 1997). Their differences were amplified by her conflict with Anna Freud; Anna Freud was primarily 'ego orientated' (Frosh, 2012, p.23). In contrast, Klein focused on the unconscious phantasies⁸ which emerged from inner drives⁹ and relationships with objects to which the drive is attached. This dispute led to an either-or approach to psychoanalysis within the British school of psychoanalysis (Frosh, 2012).

Klein's focus on drives distinguishes her from being solely an object relation theorist (Frosh, 2012). Although her work started the move towards object relations work, her emphasis was on drives and emotions, such as the infant's emotional life (Klein, 1952). Furthermore, Klein focused on affective states emerging from phantasies; in her theoretical writings, drives are satisfied by predetermined object parts; for example, the mother's breast for the infant and the transference of affective states between people (Frosh, 2012).

⁸ Unconscious phantasies – unconscious mental processes. 'These are a mental expression not only of aggressive and libidinal impulses but also of defence mechanisms against those impulses,' (Spillius et al., 2011, p.3). An innate ability. For Klein phantasies involve 'introjection, projection and relation of internal objects to one another and to the external world.' In short helping us to make sense of the world, (Spillius et al., 2011, p.14).

⁹ 'Drives are thought of as biological forces that are manifested psychologically through the emergence of certain ideas and behaviours,' (Frosh, 2012, p. 55).

2.4.1.2.2 Projective identification

Klein is well known for her work on child analysis, observing play as their means of free association¹⁰ she used interpretation to help children manage anxiety. Klein believed that children were capable of transference¹¹, introjecting objects from infancy that helped form relationships with their parents and that children could express phantasies through play (Spillius, 2011).

I find Klein's approach helpful in understanding the early relationship between infant and caregiver and how we attempt to manage emotions. I intimate that both the mother and infant's emotional responses are fundamental to the developing infant's mental health, as they learn how to coordinate their relationship. It is suggested that we use projective identification throughout life to manage difficult emotions, particularly anxiety and our reactions to other objects (Klein, 1935; 1946). In terms of projective identification, the infant introjects both good and bad objects, projecting them onto the mother, splitting the object, in this case, the mother, into either the 'good' or 'bad breast' (Klein, 1946, p.2). The infant has a fragile ego for the first three to four months of life and cannot assimilate the mother as being both good and bad; therefore, he or she will split the object (the mother), occupying the paranoid-schizoid position (Klein, 1952a), reflecting a primitive level of anxiety (Spillius, 2011). As the infant develops, she or he appreciates that the mother is the provider of both and good and bad; as this happens, the infant then has a greater capacity for introjection rather than the projection of feelings (Spillius, 2011). This ability leads to the depressive position, whereby the infant can experience feelings of guilt for directing bad feelings towards the loved object

¹⁰ Free association refers to the ability of the child to express what comes to their mind, reflecting their phantasies (Frosh, 2012).

¹¹ Transference typically refers to how patients bring aspects of their past lives into relationships with their therapists (Frosh, 2012).

and anxiety regarding the possible destruction of the loved one (Spillius, 2011). As this happens, the child's ego is developing, and at the same time, they are reaching a greater understanding of external life (Klein, 1946). The concept of projective identification leads to our understanding of one person containing another. The mother can take the projected feelings and help the infant manage them, with the unconscious attitudes towards the infant affecting the infant's unconscious emotions (Klein, 1952b).

Fact box: Klein

- Inner drives are important, these are realised by predetermined objects.
- The death drive is fundamental to Kleinian theories.
- Inner drives and the relationship to the predetermined object create phantasies.
- Phantasies result in emotional states.
- Klein had a subjective basis for her theoretical work.
- Known for her therapeutical work with children.
- Children's play is their form of free association.
- Children are capable of transference.
- Projective identification helps us to manage emotions and relationship to objects.
- The paranoid schizoid position is taken in the first few months of life by the infant. The infant splits the object into good and bad.
- As children develop, they are able to appreciate that the object is both good and bad. This results in the child taking the depressive position.
- Projective identification helps us to appreciate how the concept of containment works.

Figure 5 Fact box: Klein

2.4.1.3 Bion

Bion, built on Klein's work, his work is described as post-Kleinian psychoanalysis (Frosh, 2012). Bion (1959) further developed projective identification, suggesting that this was a feature of healthy development in the infant. During infancy, the mother and infant are in an

ongoing cycle of engagement with one another. They communicate on an intersubjective level identifying with each other's feelings, indicating the reciprocal quality of the relationship, giving weight to the relationship's individual nature (Burman, 2017). Bion enables a deeper understanding of the individuality of relationships and acknowledges the role that others have in helping us manage our emotions. Bion's ideas are beneficial within infant mental health for his advancement of the container/contained model (Bion, 1959) and the theory of maternal reverie (Bion, 1962a; 1962b). In the container/contained model, the therapist or mother can absorb the frightening feelings of another while calmly dealing with them and maintaining a 'balanced outlook' (Bion, 1959, p. 313). While maternal reverie means that the mother can take the infant's disturbing projections and frustration, dealing with them emotionally, through her own 'psychical qualities' helping the infant manage these feelings (Bion, 1962a, p. 36). Bion recognised that the mother requires support to provide her with the ability to give this reverie, as her 'psychical qualities' will impact the infant's 'psychical qualities,' reflecting the intersubjective nature of the relationship (Bion, 1962a, p.36).

Fact box: Bion

- **Developed the work of Melanie Klein.**
- **Developed the concept of projective identification, which is integral to the ongoing relationship between the caregiver and infant.**
- **Proposed the container/contained model. This is the ability for another to be able to absorb the agitated feelings of another, in a calm manner.**
- **Maternal reverie. The mother can take the infant's disturbing projections and frustration and help the infant to manage these feelings.**
- **Mothers require support to provide reverie for their infants.**

Figure 6 Fact box: Bion

2.4.1.4 Winnicott

Winnicott was known for devising brief psychoanalytical interventions to help children and families unable to access psychoanalytical treatment (Gomez, 1997). Winnicott was an object relations theorist; this psychoanalytical approach emphasises our need to form relationships with others rather than our response to drives (Hollway, 2006b; Frosh, 2012). I find Winnicott's theoretical perspectives helpful in understanding how important it is for the mother-child relationship to adapt over time as the infant matures. As the relationship changes in response to this, ideally, the mother can provide space for the child to develop a sense of self, helping the infant view the mother as a separate being. Arguably essential for the development of positive mental health and the wellbeing of the carer.

2.4.1.4.1 Parent-infant theory

Winnicott views infancy as a phase when the ego develops alongside a successful mastery of the id; this depends upon the mother's care, with the maternal ego supporting the development of the infant's ego (Winnicott, 1960a). Winnicott's parent-infant theory has two main factors: firstly, the infant's journey from dependence to relative dependence to independence; concurrently, the infant moves from the pleasure principle to the reality principle, from autoeroticism to object relations. The second factor is the nature of the parent-infant relationship (ibid, p.49). The infant's environment is important, and the mother has the role of 'holding' the infant as the ego moves from fragmented to entire, with the infant using the experiences of care given by the mother to form the ego.

Winnicott (1960a) acknowledges the physical nature of maternal care; this is essential to meet the infant's psychic needs. Winnicott (1971) talks of the 'good enough mother' (p. 10) who can adapt to the infant's needs. In essence, in the early days of life, the mother will provide a close interpretation of the infant's needs but gradually withdraw care as the infant matures. In this way, the infant learns that the mother is a separate being as he or she adapts to the maternal failure to respond to her or his needs (Winnicott, 1971). Winnicott (1971, p.55) emphasises that mothers who cannot provide 'good enough care' need care for themselves, suggesting that an appropriate environment will provide this, congruent with Bion's (1962a; 1962b) concept of maternal reverie. Winnicott (1949) acknowledges that mothers are not perfect, that maternal love is balanced with maternal hate, and that the mother will hate the infant for various good reasons, all of which she has to stand without expressing her hatred to the infant. Maternal hate is essential to infant development, as the infant learns to tolerate hate from those who have to do the same with them.

2.4.1.4.2 False Self and True Self

Moving on from the importance of ego development in infancy is the idea of False Self and True Self (Winnicott, 1960b). The development of the True Self starts with Primary Maternal Preoccupation (Winnicott, 1956), which begins in pregnancy when the mother develops a high level of awareness and identification with the infant. For a successful ego to form, the mother needs to meet the infant's omnipotent needs; if she does this in a 'good enough way,' then a True Self will develop. If she is unable to meet the omnipotent needs of the infant, then she is unable to respond to the infant's gesture,' responding with her own 'gesture.' The infant complies with the care, giving meaning to the 'gesture' and a 'False Self' starts to develop (Winnicott, 1960b, p. 145). A child with a sense of a True Self can engage with external reality and appreciate playing and imagination. In contrast, the False Self will grow insincere relationships and introject the characteristics of others who care for him or her, hiding the True Self. The implications for this are that the child is unable to imagine and play successfully, tending to imitate and comply with those that care for him or her (Winnicott, 1960b). Therefore, having problems adjusting to and learning through their own cultural experience, please see the next section.

2.4.1.4.3 Transitional objects

Winnicott (1951; 1971) developed the idea of transitional objects. These are objects that the infant uses to grasp the idea that she or he is separate from the mother, for example, a blanket or a toy. The transitional object provides a space to create something new, a potential space dependent on a trusting relationship with his or her mother. Winnicott (1951; 1971) argues that this space between the individual and the environment is where culture develops and that play is the channel through which we learn cultural experience (Winnicott, 1951; 1971).

Fact box: Winnicott

- **Object relations theorist**
- **Infancy is a period when the ego develops alongside mastery of the ego. The success of which, depends upon maternal care.**
- **The infant's environment is important to development. The mother has the role of 'holding' the infant while the ego is formed. The experiences and care provided by the mother help the ego to form.**
- **As the infant moves from dependence to relative dependence to independence, he or she moves from the pleasure principle to one of reality, from autoeroticism to object relations.**
- **Maternal love is in balance with maternal hate, this is essential to infant development as the infant learns to tolerate hate from those who are having to do the same with them.**
- **True self. For this to develop the mother needs to be able to respond appropriately to needs of the infant. If she is unable to respond to the infant's 'gesture' instead responding with her own 'gesture' to which the infant accepts, the infant will develop a 'false self.'**
- **Transitional objects. The infant uses these to grasp the idea that she or he is separate from their mother.**
- **The use of transitional objects represents a potential space. It is from this space that culture develops.**
- **Play is the space through which cultural development takes place.**

Figure 7 Fact box: Winnicott

2.4.1.5 Bowlby

Bowlby's leading contribution attachment theory falls somewhere between a drive based and object approach (Frosh, 2012). The theory suggests that the desire to form relationships appears from the drive to do so (Gomez, 1997). Bowlby outlined a vision for promoting child infant mental health in 1952, primarily that a young child should enjoy a close and warm

relationship with his or her mother or mother substitute. If a child could not access this ongoing relationship with a mother or mother substitute, it was termed ‘maternal deprivation’ (Bowlby, 1952, p.11). Bowlby extended his theoretical discussions in 1958, publishing the ‘Nature of the Child’s Tie to His Mother,’ an account that explored the need for that first attachment relationship between mother and infant, drawing upon the work of psychoanalysts and ethologists. Bowlby developed his theory further in 1969 with the publication of *Attachment and Loss*; in this book, he developed his theory of attachment in more depth. Initially, psychoanalysis was critical of attachment theory. Psychoanalysts believed it ignored concerns that psychoanalysis dealt with, such as sexuality, drives, unconscious fantasy and used reductionist approaches such as the Strange Situation to classify behaviour (Fonagy, Gergely, and Target, 2007).

More recently, Bowlby’s work has gained a growing acceptance into psychotherapy, and Frosh (2012) places attachment theory near the category of object relations theory due to the need for relationships that attachment theory brings. It is almost an understatement to write that attachment theory is hugely significant to our beliefs of how infants within the Western world should be cared for and impossible to provide all but a taster within this thesis's confines. However, I can provide some examples, starting with the research included in the systematic review (Peters et al., 2019), see Appendix A and Chapter 3, and how this emphasises the importance of the monotropic relationship, a perspective central to attachment theory (Bowlby, 1958; 1969). Attachment theory as an approach to how parents choose to care for their children has a tremendous following with groups and books to support this; for example, see Attachment Parenting International (2021). Attachment theory is associated with the healthy development of the brain, with a secure attachment to the mother or primary caregiver helping the child to develop an appropriate response to stress that will possibly

persist over the life course (Schoore, 2001). At the same time, attachment theory is the recipient of a large body of critique (Keller and Chaudhary, 2017; Vicedo, 2017; Burman, 2017). As a theory, it has a sizeable impact on what is viewed as good mothering, forming a cultural imprint, fostering ideal and intensive mothering (Burman, 2017). Attachment theory demonstrates the might with which a receptive culture can absorb an idea.

Attachment theory emphasises the supremacy of the dyadic mother-infant relationship and the infant's need for monotropy. The mother is judged essential for the infant's survival, with the infant keen to keep the mother close by through the activation of behavioural systems, such as sucking, clinging, and crying. Bowlby (1969) recalls work with primates to compare the human process for attachment. The mother's role is to provide the infant with 'a base from which, to explore' (Bowlby, 1969, p. 208), suggesting that attachment was likely to result from imprinting, meaning that the development has a time-sensitive or critical period. Bowlby (1969) believed that the infant's biological mother was the best person to care for the infant, and his theory of attachment therefore focused upon the deprivation and separation from the biological mother.

Attachment theory itself has extended since Bowlby's original writing. It is now the source of an extensive body of research, with the impact of failing to have secure attachments in childhood related to problems in adulthood (Sroufe, 2005). Sensitive mothering, which is a socially constructed label synonymous with forming the right sort of attachment to your baby, and therefore a symbol of love, influences thinking on neurobiology, policy direction and parenting, in the form of attachment parenting (Faircloth, 2014; Keller, 2014; Macvarish, Lee and Lowe, 2014; Burman, 2017).

Fact box: Bowlby

- **Bowlby developed attachment theory. This theory draws upon work by psychoanalysts and ethologists.**
- **Initially psychoanalysis was hostile to the theory, but in recent years acceptance has grown. The theory draws upon object-relations, but drives are important, in that there is a drive by the child to form relationships.**
- **Attachment theory emphasises the dyadic mother-infant relationship, and the infant's need for monotropy.**
- **The mother provides the infant with 'a base from which to explore.'**
- **The infant keeps the mother close through the activation of behavioural systems, such as crying and clinging.**

Figure 8 Fact box: Bowlby

2.4.2 Developmental psychology

Developmental psychology is a discipline that is not easy to define, as there are competing perspectives about what it involves; as Burman (2017) points out, it is not considered a unique specialism by some, and there is debate around what it sets out to measure. Riley (1983, p.18) suggests that it is where biology meets the social, trying to decipher how a biological entity such as a child turns into 'a social being.' While Bruner (2008) contends that developmental psychology is something that extends across the life span with the cultural aspects that he considers central to human development being present throughout the life course, he defines developmental psychology in the following way:

'What we call 'developmental psychology' is not really just a branch or subspeciality of psychology, but at the very core of human psychology in general. At the heart of all this, of course, is the deeper view that what we call 'reality' is something that we construct – construct it in some deeply sharable way. Where chronologically defined

development is concerned, it is the infant's mother principally who provides the entry port into this domain.' (Bruner, 2008, p., 102).

Bruner's (2008) definition indicates that developmental psychology, like other forms of knowledge, is socially constructed, and in constructing developmental psychology, we do so in a way that reflects societal views regarding what we consider acceptable. As a result, developmental psychology has had a powerful influence on how we view ourselves, children, and our families and is responsible for:

'The comparison, regulation and groups and societies, and is closely identified with the development of tools of mental assessment, classification of abilities and the establishment of norms.' (Burman, 2017, loc.587)

Developmental psychology emerged as a discipline in the 19th century and regulated how children are cared for by society and our expectations for them (Burman, 2017). The interest in children's development in the 19th century was shaped by a dialogue between medicine, literature, and science, with the discussion originating in characters from works of literature, for example, Dickens (Shuttleworth, 2010). Stern (1985, p.14) claims that developmental psychology focuses upon what is directly observable in the infant, while psychoanalysis is a study of the 'clinical infant,' an infant constructed between a therapist and a patient. Hollway (2006b) is critical of this point, reflecting on the work undertaken in real-life settings by Klein and Winnicott; however, their work was underpinned by psychoanalytical theories and the application of these theories. The conjoining of psychoanalysis with developmental psychology is seen in Bowlby's work with attachment theory and Stern's (1985) in the interpersonal world of the child (cited by Hollway, 2006b); however, they are different theoretical perspectives with psychoanalysis focusing on the 'emotional' child and developmental psychology the 'rational' child (Hollway, 2006b, p.448). This suggests a differing

epistemological basis for the two disciplines, with developmental psychology grounded in objectivism and psychoanalysis in subjectivism. Please see Table 1 for details.

Psychoanalysis	Developmental Psychology
Subjectivism	Objectivism
Clinical observation	Scientific observation
Method- free association	Method- measurement
Hermeneutic interpretation	Statistical analysis

Table 1 Differences in the epistemology between psychoanalysis and developmental psychology adapted from Hollway (2006b, pp. 448-9)

Today professions such as health visiting, education, social work and law use the knowledge generated by developmental psychology to inform their practice (Burman, 2017). Currently, developmental psychology influences policy relating to the care of children; for examples, see the ‘Statutory Framework for the Early Years Foundation Stage’ (Department for Education 2017); and the ‘Healthy Child Programme’ (Department of Health, 2009), in turn reflecting our beliefs and hopes for children and families.

In the following section, I give a brief introduction to two developmental psychologists, Piaget, and Vygotsky. Both are relevant to this thesis in different ways; Piaget's work is

evident in some of the literature that forms part of the systematic review (Peters et al., 2019) (see Appendix A), while Vygotsky highlights the interplay between culture and human development, capturing the sensitivity that humans have for their environments, and therefore the individualist nature of development. I then explore the ecological perspective of developmental psychology, particularly the work of Bronfenbrenner and Super and Harkness, a theoretical base that builds upon Piaget and Vygotsky's work to consider the role of systems and settings in child development.

2.4.2.1 Piaget and Vygotsky

The most influential developmental psychologist is Jean Piaget (Burman, 2017). Piaget advocated a stages approach to human development, with development happening in the present, occurring naturally, and speech development a result of thought (Bruner, 1986b). Piaget is responsible for the 'ages and stages' approach to child development (Burman, 2017, loc., 3912). Although misrepresentation of Piaget's work is common to suit ideology surrounding child development, associated with his apparent emphasis upon the standardisation of testing to measure child development when Piaget's favoured methods were semi-structured interviews and narratives. Researchers have tended to ignore this view as it was incongruent with the direction of the discipline, which moved toward objectivity and measurement of units (Burman, 2017). Piaget acknowledged the importance of the socio-cultural environment for child development; however, he believed it was possible to study the individual in isolation, as he was more interested in how children learn (Burman, 2017). Vygotsky (1986) was critical of Piaget's approach, as his observations might be true for the children he observed, but he failed to consider other socio-cultural contexts. Vygotsky (1986) argued that language development depended upon socialisation and that this

happened initially within the child's home. Here describes the complexity of child development, implying that there are many facets or layers to this process:

‘Child development is a complex dialectical process characterised by periodicity, unevenness in the development of different functions, metamorphosis or qualitative transformation of one form into another, intertwining of external and internal factors, and adaptive processes which overcome impediments that the child encounters’ (Vygotsky, 1978, p. 73).

Vygotsky (1978) rejected the biological basis for child development. The most critical moment in a child's development comes when they can combine both speech and the use of tools, ‘practical activity’ (Vygotsky, 1978, p.24). In early development, language and perception connect, and speech is analytical. Vygotsky identified two elements to development: the biological, where the basic processes originate, and higher psychological functions that arise in the socio-cultural. The child cannot develop higher psychological functions without a biological foundation. During infancy, two cultural forms of behaviour appear the use of tools and speech, producing culture. The child internalises higher psychological functions (Vygotsky, 1978). The interpersonal process becomes an intrapersonal process:

‘Every function in the child's cultural development appears twice; first on the social level, and later, on the individual level; first between people (interpsychological), and then inside the child (intrapsychological)’ (Vygotsky, 1978, p.5).

As a child, we internalise cultural forms of behaviour; we recreate psychological processes using signs; we reorganise this and form a new psychological being. Vygotsky's emphasis on the socio-cultural in our development and the internalisation of behaviours that I find useful in understanding how master narratives are sustained and reproduced. As individuals, we exist not only as part of our culture but also as creators of culture. Vygotsky (1978, p. 90) identified a gap between a child's ability to learn, which progresses faster than their development; this space between the two is called ‘the zone of proximal development.’ The

child needs help to internalise the external process of learning, and to do this, support is required from others to work with the child within their ‘zone of proximal development’ (Vygotsky, 1978, p.90). Our ability to learn is collaborative, and at a collective level, we transcend biology and form our history with others. We learn from socio-historical events and make our history, learning about ourselves and what it means to be in the world as we do so (Stensenko, 2011). In the following section, the ecological perspective explains how child development is multilayered, with many factors outside the control of the child’s caregivers.

2.4.2.2 An ecological perspective

By considering the mother as central to the infant’s environment, theories such as attachment theory fail to reflect on the ecological context in which the primary caregivers and infant live (Keller and Chaudhary, 2017). This situation was evident in the systematic review of the literature (Peters et al., 2019) (see Appendix A and Chapter 3); in some cases, although cultural aspects were considered, units of measurement were not always validated for use within that specific context, and there was little regard for individual circumstances. Other models consider the importance of the setting to child development and relationships, using a systems approach - this is more in keeping with the definition and approach to infant mental health, as outlined in Chapter 1 (Fitzgerald and Barton, 2000). One example of such an approach is the developmental niche Super and Harkness (1986).

The developmental niche stresses the intersection between anthropology and psychology in the child's development, ‘it is a theoretical framework for studying cultural regulation of the microenvironment of the child’ (Super and Harkness, 1986, p.552). Super and Harkness (1986) consider the child's growth and development within the social and physical settings they live in, childcare practices and beliefs, and their caregivers' psychology, these factors

interacting with the broader environment and culture. These subsystems all interact, working together as a more extensive system, interacting with the broader culture to facilitate the child's development. As a framework, it is more concerned with the child's microenvironment and the cultural structures than Bronfenbrenner's (1979; 1992) ecological systems theory of human development of child development. Bronfenbrenner views the 'ecological environment as a set of nested structures' (Bronfenbrenner, 1979, p.3) (see Figure 9). At the centre of the structure is the developing child. Bronfenbrenner (1989) drew upon Vygotskian ideas to develop his theory; please see the section above, depicting the concept that potential for human development originates through the intersection of culture with a given time in history. The microsystem of the child interacting with the macrosystem, the macrosystem reflects a culmination of the micro, meso and exosystems, plus the global, political, and cultural context of the time (Bronfenbrenner, 1989).

The microsystem reflects the immediate site of the child's development and the child's relationship with this environment. The mesosystem refers to the clutch of microsystems that the child develops within and the relationships between them, for example, home, school and community (Bronfenbrenner, 1977). Finally, the exosystem is the broader context that will influence a child's development, but which are not directly involved, for example, their parent's workplace (Bronfenbrenner, 1977).

Anthropological evidence provides examples of how vital the child's ecological setting is to their development while critically examining and challenging theories adopted regarding the development of children and their care, extending its analysis to attachment theory (Lancy, 2015). Anthropology is indispensable in understanding how children develop, as developmental psychology mostly confined the assessment of children's development to the

laboratory without a grasp of the reality of the situations in which they live (Bronfenbrenner, 1979; Burman, 1979).

Evidence from ethnographic studies demonstrates that children receive care in ways relevant to their cultural context (Lancy, 2015). For example, attachment theory, as developed by Bowlby, Ainsworth, and other traditional attachment researchers, can be critiqued for failing to respond to criticism regarding the impact of cultural variations upon how the infant attaches to their carers (Le Vine and Norman, 2008; LeVine, 2014; Keller and Chaudhary, 2017; Vicedo, 2017). For instance, infants are encultured into 'virtuous' behaviours by their mothers, meaning that they learn the appropriate ways to attach to others within their community, behave socially, and respond to others' emotions acceptably (Le Vine and Norman, 2008, p. 128). Some examples of this are the Hausa and Gussi people in the African continent (Le Vine, 2014). Hausa mothers do not look or talk to their babies, adopting a 'kin avoidance code,' complying with the code even when breastfeeding their infants, with these interactive elements of infant care undertaken by older women (LeVine, 2014 p.61). While the Gussii infants sleep with their mother and are in direct contact with her body through the first year of life, responsive to their infant's need to feed. Despite this, Gussii mothers are slow to respond to infant demands for eye contact or babbling, prioritising infant growth and calmness through feeding and connection while encouraging passivity by ignoring demands for engagement (Le Vine, 2014). These examples illustrate the individuality of infant care dependent upon their environmental context, that infant care is provided to help the infant 'to fit in' and the need for caution when applying theoretical perspectives to different contexts.

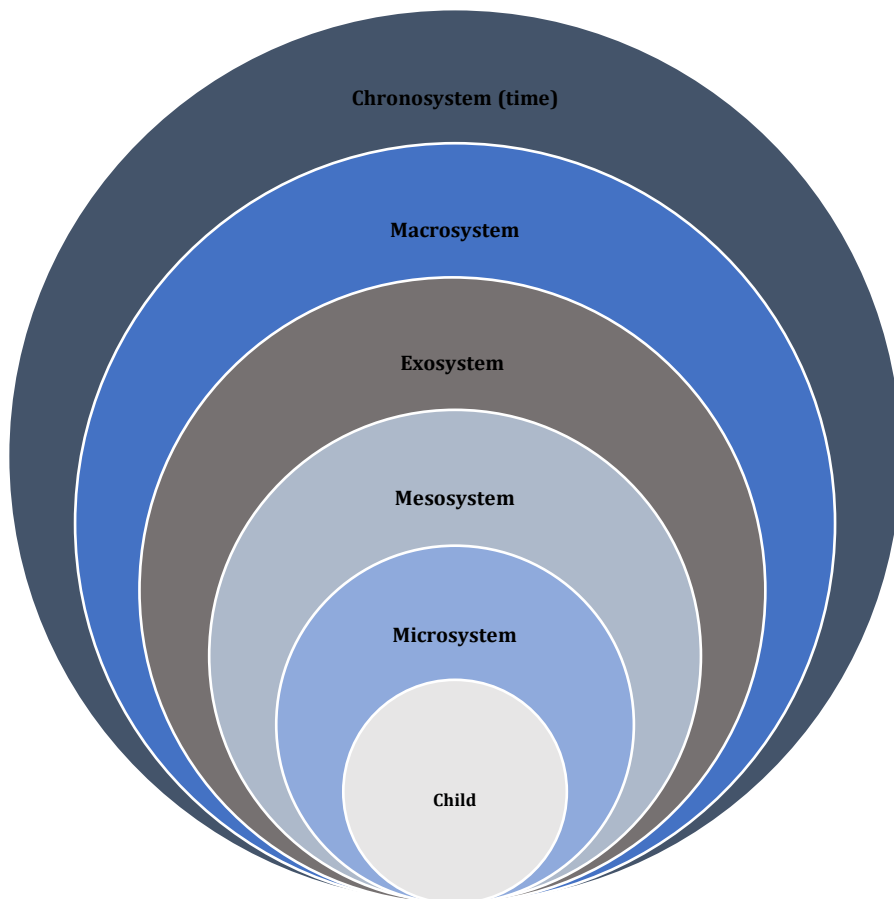


Figure 9 Bronfenbrenner's ecological systems theory of human development, adapted from Bronfenbrenner (1979; 1992)

2.5 Conclusion

In this chapter, I have presented the key theoretical and conceptual perspectives of infant mental health relevant to this thesis. In doing so, I have demonstrated that the care provided to infants reflects the values a society holds and wishes to see replicated in future generations, arguably helping them make the best of their socio-cultural environment (Carlson and Harwood, 2014; Weisner, 2014). Caring for young children is complex and situated very

much within the socio-cultural milieu, where perceptions regarding the role of mothering within that society influence the care of infants.

In the following chapter, I provide a critical perspective of the research relating to infant mental health and parental perceptions and knowledge; this is developed as a result of the findings of the systematic review paper (Peters et al., 2019) a version of which, as accepted for publication can be viewed in Appendix A. I then go on to contextualise this study within the literature on new motherhood.

Chapter 3: Contextualising the thesis within a critical perspective of infant mental health and the literature on new motherhood

3.1 Introduction

In Chapter 2, I explored the theoretical and conceptual influences that support the idea of infant mental health as represented by an affluent Western society and how these perspectives are translated into policy, as discussed in Chapter 1. In this chapter, I start by critically exploring the research in to infant mental health, basing the analysis on a systematic review that we conducted (Peters et al., 2019) (see Appendix A). The systematic review has informed the critical perspective that is developed towards infant mental health in this thesis. I then contextualise the study within the literature on new motherhood, texts that seek to represent maternal perspectives, with research that aims to study the act of becoming or being a mother, and literature that recognises the relational nature of mothering and the impact on childrearing practices.

3.2 The systematic review

As outlined in Chapter 1 little is known regarding parents' knowledge of their infant's mental health; a systematic review was conducted that aimed to explore how parents perceive and utilise knowledge of their infant's mental health. The objectives were to, 1. Identify what infant mental health means to parents, 2. Consider how parents gather knowledge of infant mental health, 3. Explore how parents use their knowledge of

infant mental health, 4. Consider how health and social care professionals can utilise the current evidence to promote infant mental health with parents. Using the guidance provided by the Centre for Reviews and Dissemination (2009) (CRD), a search of the literature was undertaken using both electronic and manual methods to find empirical studies in peer-reviewed English language journals published between the end of January 1992 and December 2017. The search was extended to the end of November 2020 for this thesis; please see Appendix A for full details. The search strategy (see Appendix B) identifies the descriptors used to identify population groups and terms to establish parental perception and knowledge. A total of 4286 records were screened, with 105 full-text articles assessed for eligibility, 16 studies were included in a narrative synthesis; details of these studies can be found in Appendix C. Of the sixteen studies, nine were conducted in the USA, two in Italy, one in the United Kingdom, one in Australia, one in Germany, one in Switzerland, and one in Korea- please see Appendix C for details. Four studies were undertaken using qualitative methods (Dallas, Wilson and Salgado, 2000; Moscardino, Nwobu and Axia, 2006; Degotardi, Torr and Cross, 2008; Kurth et al., 2014). The remaining twelve studies were undertaken using quantitative methods. Of these, eight studies were based on a cross-sectional approach (Harwood, 1992; Stoiber and Houghton, 1993; Harwood et al., 1996; Bornstein, Cote and Venuti, 2001; Keller et al., 2003; Hane et al., 2006; Seo, 2006; Turner, Wittkowski and Hare, 2008) and four were longitudinal studies (Miller and Harwood, 2002; Huang et al., 2005; Donovan, Taylor and Leavitt, 2007; Jessee, McElwain and Booth La Force, 2016).

The findings illustrated that research into parental perspectives, and infant mental health might be categorised into three themes; knowledge and understanding of child development, influences of society and culture and interpretation of emotions and expressions (Peters et al., 2019). The findings demonstrated that it was difficult to fully answer the first three objectives of the systematic review for various reasons, which I explore below.

3.3 A critique of the research regarding parental perceptions and use of knowledge regarding infant mental health

The nature of the themes identified in the systematic review (Peters et al., 2019) illustrated how professional groups primarily from within developmental psychology dominate research in the field of infant mental health. Infant determinism was the focus of the research (Bruer, 1999) represented through the study of predominantly maternal behaviours and actions with their children. Furthermore, the emphasis of developmental psychology in this domain represents an approach to research that considers mothers as research subjects. Therefore, decisions are made regarding how to measure and quantify their behaviours during the research process that represents wider beliefs about the place of mothers and children within society (Burman, 2017). This approach reflects a patriarchal means of understanding what it means to be a mother or mother a child, as explored in Chapter 2, as the subject is explored primarily from the stance of essentialism, mothering in a way that is approved and recognised by society (Takševa, 2018). The following sections (3.3.1 to 3.3.4) explore the limitations of the research relating to infant mental health in more detail.

3.3.1 Limitations of the cultural significance of the research

The findings from the systematic review (Peters et al., 2019) illustrated that the research was primarily conducted in western societies, confirming the dominance of ‘Western, Educated, Industrialised, Rich and Democratic (WEIRD) societies’ (Henrich, Heine and Norenzayan, 2010, p. 61) as a prime source of data for developmental psychology

Arguably, it is difficult to ascertain the relevance of the research presented in the systematic review to other cultural groups, as all but one study, Seo (2006), recruited participants from western societies. However, the research's significance to those western populations included in the research is questionable. Although the researchers conducting the studies acknowledge the complexity of cultural factors, for example, see Haywood (1992); Harwood and Schoelmerich, (1996); Miller and Harwood (2002); and Moscardino et al. (2006), the focus is on the identification of variables. For example, researchers used variables, such as social-economic status or ethnicity, to isolate aspects of culture to be measured and identified. The issue lies in that groupings such as these represent social constructions and interactions between dominant and minority cultures, with aspects of culture, made generalisable to fit the need of evidence-based practice in health care, therefore potentially resulting in stereotypes (Kirmayer, 2012).

Nevertheless, there is a place for this approach in research as it allows the identification of patterns in culture and societies (Rogoff, 2003). While at the same time, it is important to recognise the limitations in using these methods and the scope for research that focuses upon how the cultural milieu impacts our knowledge and choices made related to child development (Weisner, 1996), and subsequently impacting on an

infant's mental health. For example, using research instruments designed to study one population group with another is problematic and may lead to an inaccurate reflection of parenting knowledge and behaviours. A suggested way to improve this is to work from within a culture to produce concepts and research methods distinguishable to them (Greenfield and Suzuki, 1998).

3.3.2 A focus on attachment theory

All but one study (see Dallas, Wilson and Salgado, 2000, which focused on both parents) included in our systematic review focused on the dyadic relationship and the mother's behaviour or knowledge. For example, see Harwood (1992); Stoiber and Houghton (1993); Harwood et al. (1996); Bornstein, Cote and Venuti (2001); Keller et al. (2003); Hane et al. (2006). The emphasis on the dyad and the theory of monotropy suggests that the attachment relationship dominates the focus of research included in the systematic review (Peters et al., 2019). Subsequently, ignoring environmental considerations, failing to capture the intricacy of the infant's social world and the influence these factors have upon decisions are related to childrearing (Weisner, 2005; Keller, 2017), whereas child development theories and concepts emphasise the importance of the cultural environment (Super and Harkness, 1986; Weisner, 2002). Therefore, the instruments used to measure maternal behaviours in most research do not reflect the reality and complexity of participants' everyday lives in which the child's mental health and well-being are located, a situation that anthropology has tried to remedy.

3.3.3 The individualised nature of maternal care, an anthropological perspective

As outlined in Chapter 2, attachment theory (Bowlby, 1958, 1969) has considerably influenced perceptions of how children should be cared for within our society. The emphasis upon attachment theory within the systematic review indicates the impact of this theory upon developmental psychology. Nevertheless, as discussed in Chapter 2, anthropological evidence has provided an alternative perspective on these issues, with ethnographic work, for example, by researchers such as Scheper-Hughes (1987; 1992), who demonstrated the impact that severe poverty might have upon the maternal-infant relationship. Scheper-Hughes' (1987; 1992) work situated in Alto do Cruzeiro, Brazil, a place of extreme poverty, illustrated the critical effect of the cultural context upon maternal care of the infant. The extreme poverty and poor infant survival rate meant that early maternal care of the child was superficial, with the infant remaining unnamed until they were beginning to walk and talk. Maternal care was seen as a poor investment for a child that may not survive and could have perilous consequences for the mother and other family members; this was so strong a perception that other mothers of the Alto de Cruzeiro would admonish a mother for grieving if her infant died. Despite the reluctance to invest in the early months of their child's life, this was no barrier to mother and child going on to form a close relationship, reflecting the multifaceted nature of human relationships (Scheper-Hughes, 1987; 1992). As Scheper-Hughes (1992, p. 411) states:

'A failure to bond at birth should not be taken to mean a permanent rejection of the child by any means. Human attachments are infinitely more complex and variable than are implied in the maternal scripts that begin in the stable and

barnyard and that ethologically oriented bonding theorists use as prototypical models of human behaviour. ’

3.3.4 The mother as a research subject

A feature of the findings from the systematic review (Peters et al., 2019) is that mothers rather than their children have become the focus of research in the field of developmental psychology (Burman, 2017). However, this approach by researchers discounts the active part that infants have in their relationships with multiple caregivers and the individualised nature of their interactions (Tronick and Beeghly, 2011). In turn, this emphasises the gendered socialisation of parenting as something that only women can do (Hays, 1996). The research questions and conduct reflect a master narrative or dominant discourse (Hammack, 2008) surrounding this topic, as discussed previously in Chapter 2. Reproduced through the master narrative is the subject matter of the research, for example, the emphasis given within infant mental health to attachment and dyadic relationships and the decisions to use research tools that reflect socio-cultural beliefs regarding these relationships. The research emphasis in our systematic review is predominately a positivist approach to knowledge production, indicating a biomedical model that uses quantification and simple explanations of human behaviour. For examples see, Harwood (1992); Stoiber and Houghton (1993); Harwood et al. (1996); Bornstein, Cote and Venuti (2001); Miller and Harwood (2002); Keller et al. (2003); Huang et al. (2005); Hane et al. (2006); Seo (2006); Donovan, Taylor and Leavitt (2007); Turner, Wittkowski and Hare (2008); and Jessee, McElwain and Booth La Force (2016). With this in mind, I looked to literature focusing on new motherhood to

look for a more innovative approach to researching with mothers on infant mental health as outlined below.

3.4 A different approach to researching with mothers

In recognition of the individualised nature of the mothering experience, and the complexity of capturing this, there has been a move toward more innovative research methodologies in this field of research. With the focus on qualitative longitudinal methodologies, for example, Oakley, (1986); Ribbens, (1994); Thomson et al., (2011); Thomson et al., (2012); the use of case studies (Ribbens, 1994; Thomson et al., 2011; Thomson et al., 2012). Researching in this way allows the researcher to ‘walk alongside’ mothers as they experience transitional moments in their lives, for example, the arrival of a new child into the family (McLeod and Thomson, 2009, p.61). At the same time, using a qualitative longitudinal methodology provides an opportunity to give mothers a voice in sharing their experiences, thereby helping to redress the balance of knowledge in this field. As Ann Oakley contended, professional discourses have ‘suppressed the knowledge and expertise of women about motherhood’ (Oakley, 1986, p.3). Emerging from this research is the relational nature of motherhood, in terms of the personal relationships that develop intergenerationally and with their child, their wider social networks, and the relationship between being a mother and the social-cultural context in which they live.

3.4.1 Social-cultural influences

One of the first studies to draw upon innovative methodology to explore maternal experiences is by Oakley (1986). Oakley (1986) considered that motherhood was central to all women's lives due to societal expectations for women to mother, whether they chose to or were able to become a mother. Her research recruited 66 women in 1975, whom she interviewed four times during pregnancy and the first few months of life with their child. The research aimed to explore what it was like to become a mother from the experiences of first-time mothers (Oakley, 1986). In conducting this research, Oakley (1986) found that women's experiences of motherhood did not live up to their expectations, a situation not helped by their perception that the phenomenon was romanticised by society (Oakley, 1986), a situation that persists today as discussed in Chapter 2. Oakley (1980) theorised that some of the psychological difficulties experienced by women following the birth of a child might be due to loss of identity. Oakley (1980) believed this loss of identity could be partially explained by the tendency to compare women to animals, perhaps a critique of attachment theory (Bowlby, 1958, 1969), which drew extensively upon ethology in its development. Thus, the implication is that instinct has qualified women for the role without considering the socio-cultural complexity of motherhood and how women perpetuate the relational aspects and expectations of this role.

3.4.2 Intergenerational influences

Bronfenbrenner's (1989) focus upon the interaction between culture and historical time; the chronosystem is reflected in the findings of work by Nielsen and Rudberg (2000). Nielsen and Rudberg (2000) consider the ongoing development of maternal

roles and identity captured in response to mother-daughter relationships studied over three generations and the physical setting in which they reside. The research highlights the changing nature of the role in response to historical social-cultural factors of the time, and the influence of either an urban or rural setting. Interestingly Nielsen and Rudberg (2000) determine a diminishing view of the maternal role by the daughters of the grandmothers, the second generation, suggesting a resentment of future expectations regarding their roles. Perhaps demonstrating how the socio-cultural environment might influence expectations regarding their mothering roles as they develop, and some frustration that their mothers had not done more to progress this. Their daughters (the granddaughters) moved towards an increasing emphasis of individualism, where, unlike previous generations, they vocalised their intention not to allow relationships with men to define their futures. Thus, the relational nature of mothering is seen between mothers and their daughters and in response to socio-cultural developments.

3.4.3 Local social networks

The importance of the social and physical setting in which the caregiver lives and the effects on the childcare practices of mothers are demonstrated by Ribbens (1994). Ribbens' (1994) findings suggested how critical local networks of relationships are to mothers in her 'feminist sociology of childrearing.' Interviewing 24 mothers using a life history approach, she captured the experience of mothers' lives with their children over time, in this instance four years, focusing upon eight mothers for case studies who were interviewed several times. During this research, it was found that relationships between mothers and their children existed not as part of a 'nuclear

family' (Ribbens, 1994, p.190) but as a network of relationships between women and children, including other family members. Mothers wanted their children to be socially adept with others, and considerable effort was spent negotiating contact between the family and others outside of it. Lewis' (2005) social network theory reflects Ribbens' findings, which in contrast to the focus on the maternal-infant dyadic relationship, focuses on the attachments and relationships that the child forms with others; these relationships fulfilling different purposes within the child's life. Despite the similarities in Ribbens' (1994) sample in terms of locality, ethnicity and social class, the research illustrated the individuality of mothers' experiences reflecting their backgrounds and situation. Thus, although the socio-cultural milieu may be important in terms of considering how to care for children, see Oakley (1980) and Nielsen and Rudberg (2000), this interacts with the mother and her family's individual circumstances, reflecting a complexity that the research by Thomson et al. (2011) subsequently identifies.

3.4.4 Acknowledging biographical and historical complexity

Research by Thomson et al. (2011), while acknowledging the historical influences upon child-rearing with a socio-cultural context, takes this one step further by illustrating the complexity and interaction of these factors with other influences within the mother's life. In this way, it illustrates the originality of the system in which a person develops, reflective of Super and Harkness' (1986) developmental niche (see Chapter 2). The Making Modern Motherhood Study (Thomson et al. 2011) used qualitative longitudinal research to consider motherhood from the perspectives of women from the same generation, comparing their experiences with peers and capturing intergenerational

perspectives within families. Thus, reflecting both ‘biographical’ and ‘historical time’ (Thomson et al., 2011, p. 10). To achieve this, the researchers recruited 62 pregnant women from various backgrounds, returning to interview during the first year of their infant’s life, 12 case studies were chosen from the participants, and interviews were undertaken with grandmothers/great grandmothers and others close to the family. The authors chart the impact of the pregnancy and the arrival of an infant into the lives of participants, for example, the effect upon relationships and work, use of resources, such as expert advice and commodities. Exploring how these findings are shaped by many factors, particularly age, social class, and ethnicity, but are also ‘socially and historically constrained’ creating a situation where this is both difference and commonality between mothers, resulting in ‘distinct cultures of childrearing’ (Thomson et al., 2011, p. 269). Thus, childrearing practices are more complex than intergenerational differences and are reflected differently by mothers of the same generation, with mothers both absorbing influences from their cultural context, creating and recreating this culture (Vygotsky, 1978).

Developing the work from the Making Modern Motherhood Study (Thomson et al., 2011), the researchers focused on 6 of the case studies for further scrutiny, whereby they conducted repeat interviews with grandmothers and an observational ‘day in the life’ with mother and child (Thomson et al., 2012, p.186). This further analysis illustrated the individual and dynamic nature of the relationship between mother and child (Thomson et al., 2012). As the authors reflect, child development as a subject area only provides readers with an endpoint for expected development but has little to provide insight into the process of development. By enacting the use of a ‘day in

the life' approach, researchers were able to identify how the child enacted family narratives, reflecting their development within these narratives, and how they moulded themselves into the individual scripts created for them (Thomson et al., 2012). Thus, the child adopted a role within the family, reproducing family meaning; this research identifies the relational and continuous nature of children's development embedded in an intricate web of social and historical complexity.

3.4.5 The case for researching the mother and child in a relational way

Research has neglected the experience of mothers in part due to the perspective taken by feminist researchers that studying motherhood is oppressive as it involves researchers studying parenting 'in the feminine' (Thomson and Baraitser (2018, p.71). As Thomson and Baraitser (2018) identify, a lack of focus on the unique relationship between mother and child leaves a void for motherhood to be devalued and understood unjustly. By researching the mother and child in relationship to each other over time, there is scope to identify how mothering culture affects attitudes towards mothering, in turn influencing the maternal care that children receive- the authors identify this as the 'pull and push' between mother and child (Thomson and Baraitser, 2018, p.80). Through attending to the mother and child relationally, there is the potential to enhance both child and maternal studies. Despite the awareness that research is limited in this field, there is a lack of studies that consider mothers' experiences as their child matures (Simmons et al., 2021). Phenomenological work by Simmons et al. (2021) found that both past and present relationships were influential upon how a mother chose to care for her child. With the mother's evolving relationship with her child, imitating the 'push and pull' described by Thomson and Baraitser (2018, p.80) as mothers reported that

they experienced the development of their own being in response to their child's needs (Simmons et al., 2021). The findings suggest that maternal identity evolves as an interaction with the mothers' past experiences and in response to her child's development. Arguably, master narratives help identify what is expected of a child from a socio-cultural perspective, which influences the mothering and care of the child (Hammack, 2008) (see Chapter 2).

3.5 Conclusion

This chapter provided a critique of the existing framework for examining infant mental health and established some limitations in how research in this field is conducted, particularly in terms of the mother's relationship to the research. The chapter then explored literature that has attempted to focus on new mothers' experiences while acknowledging the complexity of their situation, demonstrating that the act of being a mother and engaging in childrearing is a relational experience. Relational, not only in terms of the interpersonal relationships from the past, present and into the future, but as a result of the interaction between these relationships, personal characteristics and the socio-cultural context in which the mother lives. The literature presented here indicates the individualised and multi-layered nature of the experience, and the ecological nature of development (Bronfenbrenner, 1979; 1992, and Super and Harkness, 1986), how individuals not only represent but produce culture through their interpretation of it (Vygotsky, 1978). As discussed earlier in the chapter, this perspective is underrepresented in research associated with infant mental health (Peters et al., 2019).

To explore maternal perspectives and their use of knowledge in relating to their infant's mental health, a research approach that acknowledged the complexity of the maternal experience was needed. Therefore, I adopted a hermeneutic longitudinal methodological framework involving collecting data from mothers in a setting of their choice over time. The following chapter, Chapter 4, explores my methodological approach.

Chapter 4: Methodology

4.1 Introduction

In the first three chapters, I established that the concept of infant mental health is a complex interplay of a dominant discourse or master narrative that is both established and reinforced through socio-cultural expectations, theoretical perspectives, and knowledge development. The policy and practice guidance directed at this subject tend to reinforce the expectations of the master narrative, with research in this field lacking input from good quality qualitative research, with mothers treated as research subjects rather than participants (Peters et al., 2019). Qualitative methodologies are a group of research methods that focus on the individual's experience of living within their social world (Ellis, 2004). Unlike quantitative methodology, qualitative methodology is inductive and attempts to explore the complexities and significance of the person's experience. Within the paradigm of qualitative research, differing perspectives on knowledge creation exist (Guba and Lincoln, 2008), moving from realism to interpretive and art forms (Ellis, 2004). This research sought to explore the factors that influence maternal perceptions and their use of knowledge relating to their infant's mental health over time.

Caring for an infant is part of a social process embedded within a web of complexity dominated by master narratives on the topic that depends upon interpretation by individuals; this is key not only to how knowledge is produced and reproduced but to our understanding of social life (Hammack, 2008). To try to move beyond the influence of the master narratives that encompass infant mental health and explore the factors that influence maternal perceptions and use of knowledge regarding this subject, I adopted a

hermeneutic longitudinal methodological framework. Qualitative longitudinal research (QLR) is a suitable methodology for researching families, particularly at transitional moments in their lives; the researcher ‘can walk alongside’ participants in real-time as they experience these moments (McLeod and Thomson, 2009, p.61).

By using QLR, I was able to explore the research question with seven participants within their home environment over a period of 15-18 months. I used six sequential interviews to get to know the participants (Yates, 2003) and explore how their perceptions of infant mental health changed as their relationship with their child evolved during the period of rapid development seen within the first year of life. The hermeneutic positioning of the methodology is reflected by the use of narratives, through which individuals interpret their experiences to create texts that are then subject to interpretation by both the creator of the text and the reader (Ricoeur, 1981; Ricoeur, 1991a). This process permitted not only the exploration of participants’ subjective experience of infant mental health but has enabled me as the researcher to consider their experiences within the context of broader influences as discussed within the first three chapters. In doing so, the level of interpretive work and reflexivity required by myself meant that I could only work with small numbers of participants, as it was essential to see the interview as a construction between myself and the participant that was situated not only by time and place but within the context of our individual biographies (Yates, 2003).

In the following sections, I explore the methodological framework for the study in more depth, considering the meaning of interpretivism and hermeneutics, going on to explore narrative and its relationship to imagination and identity, and then qualitative

longitudinal research. I then consider the theoretical approaches that might be used to analyse narratives, focusing on the use of psycho-social approaches. In the final sections of this chapter, I explore the relevance of temporality for this study and reflect on the use of validity and reliability in qualitative longitudinal research, aiming to achieve a work that the reader will find trustworthy (Rolfe, 2006).

4.2 Methodological framework

4.2.1 Interpretivism and hermeneutics

Interpretivism originates from hermeneutics, and one perspective is that it provides the opportunity to acknowledge the research relationship's constructive nature, how the participant and researcher might learn from one another (Alexandrov, 2009). Adopted by postmodern¹² anthropology (Vargus-Cetina, 2013), interpretivism is also open to critique by others for encouraging an authoritative tone and positioning expert knowledge (Geleach, 2013). Individuals view the world differently depending upon their cultural experiences, otherwise known as cultural perception. Cultural perception influences the formation of epistemology, of what constitutes knowledge within a social and historical context, and our representation of others needs to acknowledge this (Rabinow, 1986). Rabinow (1986), exploring both Geertz and Clifford's work, explains how Geertz sought to create an authoritative view of the other using interpretative methods. In contrast, Clifford turns the lens upon those creating the work. My research moves away from the monophonic approach of representation, whereby the researcher

¹² Postmodern refers to the 'fifth moment' as described by Denzin and Lincoln (2008, p. 27). Taking into consideration concerns regarding representation of the other. The researcher no longer separate from the research, the objective observer gone, along with the search for grand narratives.

tells their tale from an authoritative perspective. Instead, I have tried to acknowledge the relational aspects of research in terms of the socio-cultural and historical context and the power generated within the research relationship (Clifford, 1986).

Mothers were expected to co-construct their meanings of infant mental health relative to their experiences, social networks, environment, and interaction with the researcher, a phenomenon that can be explored through the creation of a text. Ricoeur (1981, p. 3) defines hermeneutics as 'the theory of operations of understanding in their relation to the interpretation of texts.' The interpretation of 'texts' is subject to the socio-cultural context in which they are produced. Ricoeur (1981; 1991a) draws substantially upon the work of Heidegger to explain his perspective on hermeneutics; Heidegger was a German philosopher who wrote the text 'Being and Time' (Heidegger, 1927). Part of Heidegger's argument within this text is to understand what Being is, dependent on temporality, and it is our engagement with the past that helps to give meaning to the present (Polt, 1999).

Ricoeur (1981 p.18) explains how a text can provide the means to explore what it means to be in the world; we have a 'preunderstanding' created by our experiences of being in the world within our social-cultural context (Heidegger, 1927, cited by Ricoeur, 1981, p.17). A 'preunderstanding' of the world will influence how mothers perceive or imagine their role, and the person, their child, will become, and subsequently, the care they have given their children. Heidegger (1927, p.39) uses the word '*Dasein*' for Being and Being is about what it 'means to be in the world.'

Understanding what being in the world means is about appreciating the 'everydayness' of being' (Heidegger, 1927 p.43); this is trying to grasp what it means for someone to

exist, what their existence means, Heidegger (1927, p.44) calls this their 'existentials.' Heidegger (1927, p. 10) argues that science is limited in what it can achieve as it tends to 'investigate beings as this or that kind of being,' meaning that science decides in advance how it wishes to study humans, as illustrated for example by the systematic review (Peters et al, 2019) (see Appendix A and Chapter 3). By adopting a hermeneutic approach to the research, I wanted to move beyond this, to explore maternal perceptions and knowledge of infant mental health from their experience of being in the world, creating texts from maternal narratives to undertake this.

4.2.2 Narrative, imagination and identity

4.2.2.1 Structural and hermeneutic approaches to narrative

There are two main approaches to the study of narrative. The structural approach focuses on the arrangement of the narrative (Labov,1972). This approach views narrative as an event and text (Patterson, 2008) and does not encourage understanding of the narrative as a construction of our engagement with social life (Bauman and Briggs, 1990). This linguistic (structural) approach looks inside the text, while the hermeneutic perspective encourages a differing view, which looks outside of the text for as Ricoeur (1991, p. 27) describes 'referentiality, communicability and self-understanding.'¹³ This approach corresponded with my overall objective for the study as I tried to grasp the effect of external and internal factors that influenced maternal perceptions and use of knowledge regarding infant mental health. The hermeneutic

¹³ 'Referentiality' the individual and their 'mediation' between the self and the world. 'Communicability' the individual and their 'mediation' between the self and others. 'Self understanding' is the 'mediation' between the individual and the self. (Ricoeur, 1991, p. 27).

position aimed at a more rounded understanding of the story than that provided by structural analysis (Squire, 2008). The use of phenomenology acknowledges that our experience through stories becomes part of what we know (Squire, 2008). Reading a story completes the text and allows its interpretation in differing historical contexts (Ricoeur, 1991), the interpretation of the text becoming a thing in itself (Heidegger, 1927). When reading or hearing a story, an individual not only considers how the situation corresponds to their experience of the world but brings it to their imagination; I have drawn upon the hermeneutic approach to narrative as outlined by Heidegger (1927) and developed by Ricoeur (1981; 1991a).

4.2.2.2 Imagination and identity

As illustrated in Chapter 2, our socio-cultural environment produces a master narrative of what a good mother should be, helping women to construct an imagined self in this role (Heffernan and Wilgus, 2018). For Ricoeur (1975, cited by Taylor, 2006), the socio-cultural is a domain of the productive imagination, something that is part of a 'utopia,' creating a new reality. Productive imagination aims to do this, but to do so, it has to draw upon reproductive imagination, that is, imagination based on an existing image. Productive imagination goes further, transforming this image into a perceived new reality (Taylor, 2006). Perceptions of our existence are, in part, created by imagination (Ricoeur, 1975, cited by Taylor, 2006), with narrative capturing the 'everydayness of being' (Heidegger, 1927, p.39). To manage the 'everydayness of being' (ibid), I suggest that we rely upon the internal narrative we create for ourselves (Ryan and Irie, 2014). As we continuously interpret our experiences, our memories of events are formed in such a way to satisfy the critical audience of the self; this may help us to create the self we want to be and avoid the self we do not want to be (Ryan and

Irie, 2014). The developing self depends upon temporality, relying upon our ability to interpret the past and present, while with an eye to the future, we consider our hopes and wishes (Bruner, 1986a; McAdams, 1996). Our beliefs about reality may be based upon what we want for the self, formed from societal and cultural expectations and the imagining of our responses (Ryan and Irie, 2014).

Narratives are used to reinforce cultural norms, support change and reproduce society through culturally accepted practices and are central to our development and culture (Miller, 1996). Meaningful social processes form narratives that we interpret and use to help create our identity (Hammack, 2008). Therefore, recounting of stories is used to shape identity, which is influenced by a multitude of factors, the listener, their ability to express themselves within existing cultural frameworks, and the cultural and political situation in which they reside (Rosenwald and Ochberg, 1992). Ricoeur (1991b) distinguishes identity as either 'sameness' or 'selfhood (p.189). Our view of selfhood is constructed through our ability to interpret 'cultural signs,' and we interpret these signs through our interaction with narratives, leading to an understanding of ourselves, illumination in the light of our imagination – 'a figured self' (Ricoeur, 1991b, p.199). When a person tells a story, that story is then completed by the person who receives the story. 'The sense or the significance of a narrative stems from the intersection of the world of the text and the world of the reader' (Ricoeur, 1991a, p. 26). The accounts provided through the narratives collected for this research are unstructured, internal experience, multi-vocal, and dialogical (Josselson, 2011). The speaker is in dialogue with at least one other, and other voices emerge as part of this dialogue (Frank, 2010). Dialogism reflects the context and situation of the communication and the differences between the persons engaged in the dialogue (Clark and Holquist, 1984). Therefore,

mothers might complete narratives consistent with being a good mother (see Miller, 2005). They may interpret themselves considering what they imagine a good mother to be and what they wish the audience to know; how that story is received depends very much on their imagined account of a good mother. A position that, as the researcher, I needed to be aware of, to consider how my preconceptions and those of the mothers might influence the telling and interpretation of their stories.

4.2.3 Qualitative longitudinal research

The creation of texts through narrative inquiry, as discussed above, is one approach to exploring maternal perceptions and use of knowledge relating to their infant's mental health. However, singular interviews I did not think would provide me with insight into the maternal experience of the dynamic nature of the process of the changing relationship between mother and infant during the first year of their child's life, and the interplay between this and their broader socio-cultural context. Given the findings of the systematic literature review (Peters et al., 2019), and research into new motherhood, see (Oakley, 1986); Ribbens, (1994); Nielsen and Rudberg, (2000); Thomson et al. (2011); Thomson et al. (2012) (see Appendix A and Chapter 3), it was important that I conducted the research within the participants' usual socio-cultural context to reflect their 'everydayness of being' (Heidegger, 1927, p.39). I adopted a methodological approach that permitted the collection of data over time, in doing so, potentially providing information regarding their experience during this period of change. Using Qualitative Longitudinal Research (QLR) that was located within the participant's usual home environment is a means of collecting data over time while acknowledging the

ongoing nature of interpretation (Heidegger, 1927) and the personal meaning that this project had to me. As Holland, Thomson and Henderson (2006, p.18) define QLR as:

'open-ended and intentional (i.e., to keep on looking is the key concern); relates to the number of waves rather than a period of time; and to a dynamic research process. i.e., the separation between research design and research process decreases.... the research process comes within the frame of what is recorded and analysed.....It tends to be linked to personal/collective scholarship.'

As discussed earlier in this chapter, QLR is a suitable method for researching families, particularly at transitional moments in their lives. The researcher can 'walk alongside' participants in real-time as they experience these moments (McLeod and Thomson, 2009, p.61). The birth of a new child is a critical moment in family life, representing a period of change, incorporating the formation of relationships, identities, and shift in roles; QLR lends itself to capturing how mothers view the phenomenon over time (Thomson, 2010; Kehily and Thomson, 2011). I collected data in waves over 12-15 months with the same group of participants, following their process of adaptation as they adjusted to the new member of their family (McLeod and Thomson, 2009). I linked the waves of data collection to periods of developmental change for both the mother and infant; for instance, I conducted one interview in the antenatal period, followed by five sequential interviews (Yates, 2003) timed to coincide with the infant's developmental progression, and opportunity for the mother to reflect on her relationship with the infant in response to this.

Narratives were just one form of data collected as part of the research process.

Engaging in QLR and the hermeneutic nature of the research called for researcher reflexivity; I acknowledged the narratives as co-constructed accounts situated in a particular historical time and place, influenced by our individual biographies (Yates, 2003). To account for this, QLR emphasises the significance of the researcher's

experience, field notes, and observations, forming part of the data (McLeod and Thomson, 2009; Thomson, 2012).

4.2.3.1 Qualitative longitudinal research and master narratives

The open-ended nature of Qualitative Longitudinal Research (QLR) connects well to the dialogical nature of narrative, the limitlessness of context (Clark and Holquist, 1984). In turn linking to the concept that interpretation is open to the reader and changes depending upon the historical context in which the text is read (Ricoeur, 1991a). As outlined in Chapter 2, mothering is a construct reinforced by societal and cultural expectations that feed a master narrative. Attempting to get behind that master narrative is an essential step in understanding maternal perceptions and knowledge concerning infant mental health. Societal and cultural expectations are potent factors in shaping our behaviour, particularly with those closely aligned with matters of our identity, such as being a mother and caring for a child, with the evidence base regarding infant mental health embedded in the maternal subject's societal expectations (see Foucault, 1980; Peters et al., 2019). Master narratives may exert power upon how mothers move to respond when asked about the care and expectations they have surrounding their children. For example, it may be considered a positive to view one's own maternal identity in such a way that is located within socio-cultural perceptions of what a good mother is, creating an imagined sense of self within this role to act upon (Foucault, 1980; Ricoeur, 1991b). In developing a relationship with a group of mothers in this study using QLR, I examined the phenomenon of their experience over time within their socio-cultural context. However, to 'get beneath the surface' of this experience and their narratives required a psycho-socially informed approach (Clarke and Hoggett, 2009, p.1). A psycho-social lens allowed me to explore the unconscious

and conscious nature of the relationship between myself and the participants as our relationship developed over time (Thomson, 2012). In section 4.3.2, I explore this in more detail; before this, I need to discuss the differing perspectives of hermeneutics on the interpretation of narratives.

4.3 A theoretical approach to the interpretation of narratives

4.3.1 Hermeneutics and the interpretation of narratives

Ricoeur (1970, 1981) identified two approaches to hermeneutics that are primary forms of interpretive approaches to narratives by researchers (cited by Josselson, 2004). There is no consensus over the process of interpretation. Instead, Ricoeur suggests that there is hermeneutics as 'the restoration of a meaning,' otherwise known as a 'hermeneutics animated by faith' (Ricoeur, 1981 p.xvi). In this version of narrative analysis, the researcher accepts the word of the researched; there follows a discussion regarding the relationship between the researcher and participant and is phenomenological in its approach. It aims to understand the participant's lived experience (Josselson, 2004). Ricoeur (1981, p.xvi) identified the second method as the 'demystification of a meaning,' this version of hermeneutics is 'animated by suspicion.' This second approach is the one that is relevant to my thesis and that fits well with a psycho-socially informed approach to managing the data in my research.

Ricoeur (1970, cited by Ricoeur, 1981) claimed that Freud came from a perspective of suspicion. In developing psychoanalysis, Freud's method viewed the consciousness as false, the aim to interpret the links between symbols and primal instincts (Ricoeur, 1970, cited by Ricoeur, 1981). Approaching narrative analysis from this perspective acknowledges that the participant is part of a broader socio-cultural context, that this, as well as their biography, influences how they recount events (Josselson, 2004).

Considering narratives in this way might appear deceptive, questioning what lurks behind a participant's story; however, we are complex creatures, with narratives honed to appeal to the audience we want them to. As discussed previously in Chapter 2 and earlier within this chapter, our self-identity may emerge from the stories we tell ourselves (McAdams and McLean, 2013). Socio-cultural scripts, a master narrative, influence how we form our narratives and imagination impacts our memory (Ricoeur, 1991a, b; Habermas and Bluck, 2000).

The realisation that I needed to approach my research from a demystification of meaning was a gradual one. As I worked through data collection, I appreciated the participants' position and the influence of a master narrative that dominated their stories. In this sense, narrative analysis is not about accepting the story as told but considering how the socio-cultural milieu in which individuals reside influences their account (Chase, 1996; Josselson, 2004). In taking this position, I appreciated that meaning is hidden and requires interpretation (Josselson, 2004); the narratives contained many layers of meaning and represented differing dialogical perspectives (Josselson, 2011). However, I needed to go beyond the socio-cultural to acknowledge the place of the unconscious in shaping narratives; in doing so, I adopted a psycho-social lens to the analysis of my data.

4.3.2 A Psycho-social approach to analysis

The psycho-social approach to research is congruent with 'the demystification of meaning,' or hermeneutics of suspicion (Ricoeur, 1981, p. xvi). Using this approach recognises the unconscious's role in the formation of our experience, the research environment, and, therefore, research data (Clarke, 2002; Clarke and Hoggett, 2009). Psycho-social methods acknowledge that a structural account interprets how social phenomena occur; however, the structural or social account cannot illuminate how this might impact the individual's unconscious; this is where psychoanalytical theories are helpful. Both psychoanalysis and sociology work together to provide the opportunity to have a more profound understanding of the individual's social world (Clarke, 2006). There is no clinical application of psychoanalysis in this approach; instead, it is a way of thinking about the data. I used psychoanalytical theories to inform my interpretation of data, informing my analysis of the data and exploring my role as a researcher (Hollway, 2015). The researcher's role is central to interpretation and how the influences from the researcher's unconscious form the research environment, yet there is the recognition that social, historical, and cultural elements are essential as these influence the unconscious (Clarke and Hoggett, 2009). The behaviours that influence mothering may be accessible via participants own experiences of being mothered (Chodorow, 1999). These experiences are created within the socio-cultural milieu, helping form a person's psychic constitution and identity, possibly leading to a view of the self as an imagined mother.

The researcher's position is fundamental to psycho-social research, and their subjectivity in the process requires thorough consideration; otherwise, the result might be an

imposition of their perspectives on the data (Hollway, 2015). To caution against this as a researcher, I needed to be reflexive, open-minded to my reactions and observations, and willing to engage with my emotions regarding the research (Elliot, 2011; Hollway, 2015). To do this, I drew upon Klein's (1946) concept of projective identification, whereby parts of the self are projected onto another person, viewed during the research process as 'projective communication.' (Clarke, 2002, p.182). The researcher aware of unsettling feelings during an interview can think about how these feelings might give insight into what a participant may not be able to express in words (Frosh, 2001). The interpretation required for this process goes beyond that imagined by Geertz, critiqued for emphasising the descriptive element of this process, which arguably places it within a positivist framework (2000, cited by Alexandrov, 2009). However, criticism prevails that psycho-social research is viewed as expert-led, as it applies a top-down interpretive framework to participant experiences (Frosh and Baraitser, 2008). Yet, this framework offers a theoretical basis, which is contestable (Squire, 2008). Accepting the limitations of researcher reflexivity and the scope to capture the relationship's nuances is significant, given that the researcher is only ever truly able to acknowledge what is explicit to themselves (Frosh and Baraitser, 2008).

In this section, I have explored psycho-social research's theoretical perspective and the relationship to my study. The following discusses the place of temporality in QLR and psycho-social research.

4.4 Temporality

The essence of time can be challenging to capture in research, and yet our experiences of the past and present and hopes for the future are fundamental to our day-to-day existence (Pearce et al. 2020). Narratives are temporal, helping to configure the past into the present moment, assisting us in reconfiguring our experiences in interpreting ourselves (Ricoeur, 1991a). The temporal nature of narratives helps us develop our identity (McAdams and Mclean, 2013). QLR can capture the temporal nature of human existence as the research is conducted over time, allowing the researcher to revisit the participant and consider how narratives might change or endure over time in reflection to their recent lived experience (Henwood and Shirani, 2012; Pearce et al., 2020). As Adam (2010, p.368) explains, *'just through being in the world all creatures produce futures.'* On consideration of this point, it is arguable that mothers are concerned with their infant's 'future present'. Not seeing the future as already accounted for, but as something to be created, maternal actions will have later implications for their child (Adam, 2010, p.369). In this way, mothers move backwards and forwards in time, considering how the consequences of the past impact the present day and hopes for the future (Henwood and Shirani, 2012). Adam (2010) describes how we might be made accountable for these futures by our present actions. Indeed, motherhood is an area where mothering is held responsible for societal problems (Burman, 2017), a perspective that assumes that the subject is consciously aware of how their actions in the present will have later influence. The psycho-social method acknowledges that our past experiences influence both our unconscious and consciousness, helping to create identity, with cultural norms infiltrating both our conscious and unconscious (Clarke, 2006). Central to this is the concept of introjection, whereby the relationship we have to other objects (usually another) helps us to form the self, illustrated through the research

process and the mother-infant relationship (Hollway, 2008). The use of QLR can help the researcher reveal this through the ongoing relational nature of the research and the space it creates through working with individuals over time, allowing the 'unsaid' to come to the fore (Thomson, 2012; Pearce et al. 2020).

4.5 A note on the validity and reliability of this research

Bruner (1991, p.18) argues that scientific knowledge is demonstrated through gathering of information and replication over time, this knowledge is subject to a process of 'verification.' Yet, it is not possible to apply the same approach to research that studies 'human intentionality' such as narratives. What a person intends to do and what they do are two different things. Therefore, narratives are not used to provide 'causal explanations,' instead, narrative attempts to interpret why a person took the actions they did (Bruner, 1991 p.7). Validity and reliability are terms used in quantitative research; the former illustrates how well a concept is measured in research, whereas reliability indicates a tool's ability to measure an idea consistently (Bryman, 2012). In terms of narrative research, validity suggests that the conclusions from the findings are situated within the data and form logical conclusions, while reliability refers to the 'dependability of the data' (Polkinghorne, 1988, p.176). However, narratives do 'accrue', and it is possible to form an understanding of a shared culture or experience (Bruner, 1991, p.18). Instead, narrative research aims to illustrate 'verisimilitude,' that the findings appear to reflect the truth of the situation (Polkinghorne, 1988, p.176, see also Bryman, 1991, Kohler-Riessman, 2008). Narrative analysis is never complete; the interpretation persists in whoever reads the text, which is open to differing interpretations (Ricoeur, 1991a). On listening to a story, we have expectations regarding

what we will hear (Clarke, 2002), while the teller will reorganise the story, responsive to the audience, to portray events (Ricoeur, 1991a). As storytellers, we want the audience to take away an impression of the self we want to be.

The time that I have spent engaging with the research process has highlighted how qualitative longitudinal research draws together data that is then reinterpreted within a different context, meaning that it can be 'revisited with hindsight' (McLeod and Thomson, 2009, p. 68). Mishler (1986) talks about the 'plausibility of an interpretation,' compared with other 'potentially plausible alternative interpretations.' The interpretations founded on the data will depend on the researcher's theoretical position (Mishler, 1986, p.112). It is challenging to have a generic framework to assess qualitative research against, as it encompasses a broad range of methodological approaches, with the quality of the work resting in the reader's subjective gaze (Rolfe, 2006). Instead, I have focused on incorporating rigour into my research processes by providing a detailed discussion of the study's methodology in this chapter. In the following chapter, I describe the research methods and process in detail, the procedure for data analysis (Mishler, 1986 and Kohler-Riessman, 2008). In the finding's chapters, I align my interpretations of the data with a psycho-socially informed framework, alongside a discussion of the findings concerning this; thus, the reader is aware of my theoretical perspective and the impact upon my analysis (Mishler, 1986). I have acknowledged my positioning throughout this process and the context in which the research was produced through reflexivity (Kohler-Riessman, 2008). The dialogical nature of the narrative is acknowledged, and in my presentation of themes that have emerged from the data, I illustrate the similarities and the differences in perspectives between participants (Riessman, 2008). Thus, I hope to reassure the reader that my

analysis and conclusions are situated within data collected through a rigorous process, using a research methodology appropriate to answer the research aim, questions and objectives.

4.6 Conclusion

In response to the evidence presented in Chapters 2 and 3, this chapter outlined a research methodology designed to capture the individuality of mothers' experiences. Simultaneously, the research methodology acknowledges that the care of an infant and the development of her or his mental health is a social process. Using qualitative longitudinal research that takes a hermeneutic approach in this study enabled me to capture both the individual experience and the social process. The methodology acknowledges the complexity of being and its implications for everyday life by considering the socio-cultural impact on individual perceptions of self and subsequent experiences. In the next chapter, I discuss the methods used to enact this methodology.

Chapter 5: Methods

5.1 Introduction

In the previous chapter, I discussed the methodological theoretical framework for this study, using qualitative longitudinal research with a hermeneutic approach to explore the research aim, questions, and objectives. The research sought to explore the

influences and experiences that help to construct maternal perspectives of infant mental health and how maternal experiences of infant mental health influence the behaviours and strategies mothers may use with their infants. This chapter details the methods I used to collect data during the 15-18 months I spent with seven mothers, as I followed them from the third trimester of pregnancy through the first year of their infant's life and the subsequent process of data analysis.

During the 15-18 months in the field, I collected narrative data using interviews and made field records and reflexive notes of my time spent with participants; using qualitative longitudinal research required that not only did I need to focus my attention upon the participants, but that my experiences were fundamental to the research process as well (McLeod and Thomson, 2009). In considering myself a source of data, I adopted a reflexive approach, contemplating the impact of my position and experiences in a temporal sense. My scrutiny had to extend beyond my working life and took in my understanding of motherhood and being mothered; these experiences were contextualised within time and place, gathered as research data using field records and reflexive notes. I have incorporated a reflexive approach throughout this chapter, especially as I discuss the processes used to collect data in sections 5.4 onwards.

In this chapter, I begin by introducing the research setting and the intended participants. I then explore the data collection methods I used, interviews, field records. I discuss the negotiation of access and ethical approval, participants' recruitment, and their characteristics. My focus then turns to the process of data collection, exploring how mothers and I created a narrative, my experiences of collecting researcher field notes, the nature of sustaining research relationships over time and the ethical considerations

that materialised as a result. I conclude this chapter by exploring the process I used to analyse the data.

5.2 The Setting for the research

The study took place within the participants' local communities, at a place of their choosing, mostly this was within their own homes. In using this approach, I hoped that the choice of setting reflected the usual place of maternal care for their infant, therefore representing as best as possible the usual environment for both mother and child and a place where they felt relaxed. To maintain participants' anonymity, I cannot reveal where the research was undertaken; however, I can give some information regarding the setting's details. I recruited the participants within an 80-mile radius of each other from various locations within the same geographical region of the country. A few of the participants resided in villages, while others lived in towns or a city; the geography of the region is interspersed with wide expanses of countryside and seaside locations. The region is not without its problems; for example, in the city where I recruited two participants, the indicators for child and maternal health between 2017-2019 illustrate that for school readiness, identified as children realising a good level of development by the end of the Reception year and for hospital admission as a result of self-harm in the 10-24 age group that the city is in the bottom 25th percentile as compared to the rest of England (Public Health England, 2021). The region has low numbers of Black, Asian, and Minority Ethnic groups, with 95.4% of the population identifying as 'White, British,' or 'White Other,' in the Census of 2011, cited by GOV.UK (2020).

5.3 The Sample

Initially, and somewhat ambitiously, I had wanted to recruit up to 25 mothers to be in the third trimester of pregnancy; I anticipated that some of the participants would wish to opt-out of the research and hoped that the final number might be between 10-15. I had made this estimate based upon the assertion by Guest et al. (2006, cited by Bryman, 2012) that 12 transcripts were required for data saturation. Given the intensity of the research that I conducted and the waves of data collection that I had planned, which culminated in 41 interviews, I am pleased that I did not recruit these numbers. Below I define the inclusion and exclusion criteria of the participants I wished to recruit to the study.

5.3.1 Defining the sample

The intention was to recruit women who were 34 weeks into a pregnancy. I choose 34 weeks as the point to recruit participants and to start interviews for several reasons:

- Children born at this gestation or after this time would be unlikely to experience health difficulties caused by prematurity (Tommy's 2014).
- Life would be busy after the child's birth, and this gave mothers time to get acquainted with me and some space to think about the research and the implications of taking part.
- It provided an opportunity for me to get an insight into maternal perspectives on the relationship with their unborn child. Thus, allowing me to observe how the relationship developed from before birth right through the first year of life.

Initially, I hoped to use maternity services to recruit participants, giving me access to women from various backgrounds. However, I could not recruit using the maternity services, which I discuss in more detail in section 5.3. For the research to maintain ethical and research integrity, in recognition of the stress that problems a complex pregnancy may bring, the focus was upon recruiting women experiencing an uncomplicated pregnancy from a physical, social, and psychological perspective. Participants' potential vulnerability was considered, with those experiencing pregnancy under the age of 18, mental health issues, and identifiable health and social concerns excluded from participation. Due to a lack of access to translation services, I could not recruit non-English speaking participants. The inclusion and exclusion criteria are available in Table 2.

Inclusion criteria	Exclusion criteria
Female participants aged 18 and over	Under 18 years of age
Ongoing pregnancy at 34/40	Unable to give consent
Live birth of infant after 34 weeks	Unable to speak English

Mother to consent both before and after the birth of her child	A pregnancy where the fetal outcome is considered uncertain
	Expectant mother/family that are of concern to Children's Services
	Fetal loss
	Where there is a known fetal abnormality
	Neonate born with a congenital disorder
	Neonate born with a serious health concern requiring extensive hospitalisation and inpatient care of over four weeks
	Stillbirth
	Subsequent maternal ill health following the birth of her child - resulting in their hospitalisation of more than two weeks
	A diagnosis of a maternal mental health condition

Table 2 Exclusion and inclusion criteria

5.3.2 Negotiation of access to the setting and ethical approval

Initially, to recruit participants, I approached the Head of Midwifery from a maternity unit, providing both hospital and community services and the associated NHS (National Health Service) Trust Research and Development Unit. I anticipated asking midwifery staff to identify potential participants; the Head of Midwifery was supportive and provided introductions to key contacts within the trust, for example, the maternity services hospital antenatal clinic. I applied to the Health Research Authority (HRA) for approval. In June 2016, I received provisional approval from the Research Ethics Committee (REC) REC reference number 16/SW/0163; the committee was supportive of the project. The University granted ethical approval from the Faculty Research

Ethics Committee (FREC) Health Sciences in July 2016. They asked for clarification on a few points; that midwifery staff notified me when an infant was born and the availability of counselling services for the participants post-interview. I obtained full approval from the HRA on September 27th, 2016; see Appendix D for the letter of HRA approval.

In early Spring 2017, I experienced difficulties with recruitment via midwifery services; I discussed widening out the geographical area for recruitment with my supervisory team. The changes did not entail the use of NHS staff, and in May 2017, the HRA confirmed that they did not require notification of this change.

5.3.3 Recruiting the sample

I attempted to recruit participants from three sources, maternity services, social media, and using potential participants local news and networks; each potential source is explored below, with some discussion of the process. I managed only to recruit participants for the study from within the local community. I commenced recruitment to the research in October 2016 and concluded in August 2017.

5.3.3.1 Maternity services

Recruiting via health services, particularly primary care and community midwifery services, is acknowledged as difficult (Jones et al., 2012; O'Conner et al., 2014). I was keen to use maternity services, as this might have given access to a broader range of participants in terms of age, social-economic status, and the number of previous children. I appreciated that despite my obtaining approval from the Director of Midwifery, this was just an official agreement and that the midwives were the real

gatekeepers to participants (Hammersley and Atkinson, 2007). I hoped my previous experience as a midwife would help build relationships, and the initial meetings that I had with midwives went well, and they agreed to promote the research with individuals on their caseloads. Despite this, I did not anticipate the impact of their perceptions regarding the research and the subsequent impression on their views regarding women's suitability to participate.

The midwives advised that I attend their organised antenatal education classes to promote my research. However, during informal discussions with midwives, they reported that the study was of 'no interest' to the women attending their daytime classes. The classes attracted women who were unable to access those offered by the National Childbirth Trust, who had become a principal source of antenatal services in the area. As a researcher, I felt resigned to the situation; I appreciated that midwives were most likely applying judgements regarding the research depending upon a woman's characteristics, perhaps considering that certain social groups were vulnerable, therefore viewing the study as possibly coercive (Miller and Bell, 2012). However, as a mother and ex midwife, I felt disappointed by this but not surprised. I had given up my midwifery registration several years before this; part of the reason stemmed from my perceptions of how women's voices get lost within the need to deliver the service and the positioning and typing of women dependent upon their backgrounds and social class. My experiences of recruiting using maternity services echoed the findings of the systematic review (Peters et al., 2019) (see Appendix A) and the research by (Henrich, Heine and Norenzayan, 2010). With the emphasis on Western, Educated, Industrialised, Rich and Democratic societies (WEIRD) (Ibid.), this research was only considered of interest and appropriate for women from a particular socio-cultural background.

5.3.3.2 Social media

As I worked with the maternity services, I also attempted to recruit using social media through Facebook and Twitter and specific groups such as Mumsnet. I felt this might help the research reach a wider audience. A Facebook page for the study was set up in January 2017, entitled ‘maternal experiences of infant social and emotional development.’ I provided a link to my university page so that interested groups or potential participants could check my credentials. When the page was ready, I started to share with other groups, focusing on local areas and local news items. I had enquiries from one person following local news and interest groups, which did not result in recruitment. I tweeted to some groups and individuals I thought might retweet or respond positively to the research, including childbirth organisations and bloggers focusing on motherhood. Using Twitter to recruit for online survey research has had some success (O’Connor et al., 2014), although this differs considerably from recruiting for qualitative longitudinal research. There were some retweets and more followers due to the campaign; again, I could not recruit.

5.6.3 Local news and networks

On starting the research, I had not regarded the possible participants as under-researched and potentially challenging to reach, but the experience of trying to recruit using the maternity services altered my view. When recruiting for research, local advertising and community news outlets are more likely to be trusted by women as sources of information (Berg, 1999), taking the research directly to their community. Therefore, I decided to recruit using childcare groups situated within the local

community and advertise in local media sources. It was not easy to secure access to childcare groups as initially, it was hard to contact those who had the authority to allow this. A few groups permitted posters, while others did not; however, I managed to recruit two participants from childcare groups. Advertisements in local newspapers and newsletters recruited four participants. The final participant's recruitment was through 'word of mouth' from a mother already recruited on to the research, 'snowballing' (Bryman, 2012, p.202). Table 3 provides an overview of the recruitment source, the interest expressed, and the number of participants recruited through the route. All the potential participants initiated their contact with me using email, I responded with a general outline of the research. If an individual expressed an interest in taking part in the study, I provided them with a full participant information sheet (Appendix, E) with an invitation for telephone follow up at the date and time of their choosing.

Recruiting for studies that require the ongoing relationship between a researcher and participant requires trust; this experience illustrated that this process begins with recruitment. In this context, I managed to recruit seven participants using resources from within local communities using local news and networks to promote the research. In the next section of this chapter, I explore the data collection methods I have used in this study.

Recruitment source	Number expressed interest	Number recruited
Nursery and Playgroups	2	2
Maternity services	0	0
Social media	1	0
Snowballing	1	1
Local news and media	4	4

Table 3 Recruitment source/expression of interest and number of participants

5.4 Data collection methods

This section discusses the data collection methods I used for the research, the interview and the researcher field notes.

5.4.1 The narrative interview

The gathering of mothers' stories regarding their infants' care was central to creating a text to grasp the significance this had for them within their world (Heidegger, 1927). As

Bruner (1986a, p.,153) explains the position of narrative:

‘Narrative emphasises order and sequence, in a formal sense, and is more appropriate for the study of change, the life cycle, or any developmental process.... ‘Stories give meaning to the present and enable us to see that present as part of a set of relationships involving a constituted past and a future.’

Bruner (1986a) emphasises the role of narrative in managing change in our lives.

However, the orderly nature of the narrative is contested, with narrative seen as a way of managing the chaos of subjective experiences, helping us to regulate them (Josselson, 2011). By telling stories, we refine and redefine aspects of our identity in the way we wish to be viewed by others; therefore, any interview is a co-construction between the participant and the researcher (Mishler, 1986; Denzin, 2003) with both engaged in identity work. Each interview creates a world between the interviewee and the interviewer, a performance for each, offering an opportunity for the shaping and reshaping of identities (Denzin, 2003). A narrative is dialogical; it is a dialogue between either one and another, or one and a later self (Bakhtin, 1981). Being dialogical implies that dialogue has many differing meanings dependent upon the context and the speakers; the dialogue is always unfinished (Bakhtin, 1981; Frank, 2010).

The interviews were open-ended and took place within a setting chosen by the participant. I developed a schedule to help guide the interviews (see Appendix F). The interview questions focused on the infant’s social and emotional development, incorporating aspects of life history (Mishler, 1986; McAdams, 1996) and reflected

biographical interpretive interviewing described by Hollway and Jefferson (2013). In attempting to encourage dialogue, open-ended questions were used, for example, asking, *'tell me about your baby, what is he or she like?'* The planned number of questions for the interviews increased between 12 weeks and 6 months to reflect the infant's maturity and hopefully not overtax the participant in the first few weeks after the birth.

The interview schedule reflected the experience's temporal nature (see Appendix F); for example, I designed questions that asked participants about their current perceptions of their infant, at the same time probing about their experiences of the recent past, for instance, by asking about the changing nature of their infant's development. Not only did this type of questioning encourage participants to reflect on the past, but it prompted them to think about how these phenomena were important for their infant's future. In addition, I encouraged participants to reflect on how their own experiences might shape the care they gave their infant; in doing so, it allowed mothers, if relevant, to contemplate how the past may shape their current experiences of mothering. The participants' past experiences were fundamental to understanding the present day, considering how these experiences might influence their perceptions and knowledge of infant mental health and shape their infant's future.

5.4.2 Researcher field notes

Acknowledging the interpretive nature of the research requires addressing the researcher's role as part of the interview process (Ricoeur, 1991a), recognizing my influence in shaping the research. The purpose of keeping field notes and a journal to reflect upon my interactions with mothers and feelings regarding the research process.

In this context, as the researcher, I was part of the research, ‘using the self as a research tool.’ (Jervis, 2009 p.145). How I collected the data depended on my subjectivity and positioning in the research, I felt very much part of the research process immersed in the setting alongside the mother and her child. Experiences shaped how I conceived of and implemented the project, influencing the collection of data and the subsequent interpretation of women’s stories; this research was a subjective, ongoing, and messy process (Coffey, 1999). Dialogical, in that the analysis is never completed (Frank, 2012), with ongoing interpretation depending on the historical, socio-cultural context at the time (Ricoeur, 1991).

The researcher field notes are a reflexive account of my research experiences; this record might be considered a means of enhancing the quality of this study (Rolfe, 2006); reflexivity, after all, is a subjective experience. The concept of reflexivity is a complex one and reflects a way of engaging in:

‘ongoing self-critique and self-appraisal, and that the research product can be given shape by the politics of location and positioning. The research project not only has the right to assert the interests of those studied but it is unavoidable that our interests are incorporated into the inquiry.’
(Koch and Harrington, 1998, p.888)

I tried to take a reflexive approach throughout the research process as a means of also examining my ‘pre-understanding’ created by my experiences of being in the world, informing my own experiences of mothering, motherhood and the perceptions that I formed of participants (Heidegger, 1927, cited by Ricoeur, 1981, p.17). The use of reflexive field notes helped me to ‘properly enter’ the hermeneutic circle (Ricoeur, 1981, p.232) in that the data collected using these field notes added to the overall interpretation of the research issue. However, as my knowledge developed over the research journey, I realised that reflexivity, although critical to this study, requires

Careful consideration as my use of psycho-socially informed approaches to the data analysis illustrated the role of the unconscious in the creation of these texts, a point I discuss in more detail in section 5.5.3 (Walkderine, Lucey and Melody, 2001; Clarke, 2006; Nicholls, 2009; Clarke and Hogget, 2009; Hollway and Jefferson, 2013).

5.5 The process of data collection

Data collection was inherently reflexive, and I have acknowledged my positioning as an individual with a health care background and a mother throughout, considering how my experience and situation shaped this process. Data collection took place between April 2017 and October 2018; all interviews were digitally recorded with participant consent and later transcribed verbatim. Please see section 5.6.2 for details regarding consent. In addition, I recorded my observations and experiences of the data collection process in my researcher field notes.

5.5.1 The timing and organisation of interviews

I planned six interviews; one participant, Hanna, joined the study at the first postnatal interview and completed five interviews. The other interviews' timing corresponded with periods of infant development during the first year of life (Rose and Aldgate, 2006); see Table 4 for details regarding the timing of interviews and the number of mothers who participated. There was flexibility regarding the organisation of interviews to accommodate maternal lives; this was especially required at the final interview, as most participants had returned to work by the time their child was 12 months of age. As a result, I spent between 15- and 18-months collecting data depending on when we undertook the first and final interviews.

After the initial phone call, we arranged a date and time to meet to conduct the first interview, which I confirmed by email. Please see section 5.6 for details regarding maintaining research relationships, ethical issues, and consent. Table 4 illustrates the timing of interviews and the number of participants that completed each interview. Interviews were at a place of the participant’s choosing, mostly at their home. With Natalie, our interviews were conducted in my office, using Skype and in one instance (when Skype failed) via the telephone. I intended interviews to be between 30 minutes to one hour. The interviews lasted between 45 to 90 minutes; timing varied depending upon the participant. However, a home visit lasted anywhere between 90 to 120 minutes, contingent upon informal chat and sometimes the mother and baby expected that I would stay and play following the interview. Engaging in play with the baby and chatting to the mother as I did so was pleasant; I felt it reciprocated for all of the attention and time they were giving me as part of the interview process. Building a qualitative research relationship is reciprocal (Coffey, 1999), demanding time and consideration.

Interview 1	Interview 2	Interview 3	Interview 4	Interview 5	Interview 6
34 weeks gestation or above	Infant aged 6 weeks	Infant aged 3 months	Infant aged 6 months	Infant aged 9 months	Infant aged 12 months plus
6 participants	7 participants	7 participants	7 participants	7 participants	7 participants

Table 4 The timing of interviews and the number of participants

5.5.2 Creating narratives

5.5.2.1 The dialogical nature of interviews

In transcribing interviews as part of the research, the intention is to create a text for others to read. The interpretation of which happens as the reader engages with the text (Ricoeur, 1991a). Mothers presented themselves as they wanted to be viewed by someone who was not only a research student but a woman in her 40s with young adult children and who had worked all her adult life in either health or an academic health-related role. Aware that I was recording their interviews, they wanted to shape a view of their maternal role, which tallied with their perception or imagined perception of self as a mother. Engaging in that dialogical process with mothers encouraged me to think about my identity, what type of self was I trying to present, how might this influence the research process and the type of data collected. It is challenging to control perceptions of self by another; the assessments they made of me were situated within their socio-cultural framework and experiences that only they could access.

Nevertheless, there was a potential space between this assessment and their first engagement with the researcher to manage perceptions through dialogue and actions. My contact with them reflected a cultural 'borderland' (Rosaldo, 1993, p.26). Although we had similarities, such as gender and motherhood, we also had differences in our life experiences, for example, educational and professional backgrounds. My perceptions of the participants were just as important as those they formed of me, as I considered their influence upon data collection and subsequent data analysis.

5.5.2.2 Managing perceptions of the self as an interviewer

Situating myself within the interviews caused some internal conflict. My professional life meant that there were expectations regarding the role, such as making decisions for others. My position as a health visitor had stressed the importance of encouraging a partnership approach, and in that position, I tried to work alongside clients to contribute where required to identify their health needs. However, despite assurances that the health visiting service promotes universalism (PHE, 2018), my experience is that families view the profession as synonymous with safeguarding. Certainly, most participants expressed ambivalence towards the health visiting profession, linking the service to safeguarding. Not helped by many of them reporting a fragmented health visiting experience due to the pressure that the service faces.

Considering how others might see us is an essential realisation for any health care practitioner and health researcher. Sometimes I wondered if the interviews were a source of disappointment to mothers, I think some mothers had assumptions regarding what I might offer them given my professional background. I felt they saw contact with me as an opportunity to express concerns or seek information regarding their child. During an interview, mothers would routinely tell of child health queries or concerns or look for confirmation that they were following a correct course of action with their child. Initially, it was difficult to balance responses, I did not wish to be in their homes as a health professional, but on the other hand, I could not escape that part of my identity, their need for information, and the social requirements of us forming a sustainable relationship between participant and researcher.

5.5.2.3 Forming relationships with participants

Forming relationships with the participants depended upon reciprocity (Coffey, 1999); the participants expected something in return for their time. I adapted to this in various ways; for example, if a mother raised a concern, I listened to the problem and asked how she had dealt with the issue, agreeing if appropriate or prompting where they might seek further support if required. That is the very least that I could do for them, wanting to maintain a professional footing and nurture the research relationship if the situation posed did not present an ethical or professional conflict.

Mothers asked about my personal life; they were interested in my children and the research's progress. How did I manage to juggle family, research, and work? Questions I have asked myself throughout my children's childhood, and for which I have no ready response. Like much in life, reality is complex and challenging to convey quickly. I reassured those who asked that my children were older now and making lives for themselves and that part-time PhDs took several years for a reason. Keen to keep the interviews as relaxed as possible, it was essential to engage in some informal personal talk, but I did not want my anxieties, of which there were several regarding the PhD to cloud the space between us. In this way, I presented a version of self that was not necessarily true but important for participants to see, someone who was managing the PhD process and the other demands of her life.

5.5.2.3.1 Conducting the interviews

The interviews all followed a similar process. When I arrived, the participants and I would chat informally about their lives over the last few weeks and months, and they would ask how the research was progressing. Participants were often keen to share, and I had to avoid getting through the interview before we officially started. Whoever was

hosting the interview would make a drink, and we would settle somewhere, such as a sitting room or around a kitchen table. It felt cosy and relaxed. I would ask participants if it was 'okay' to go ahead with the interview and start the digital audio recorder. At this, I felt a shift in mood, the most awkward moment of the interview. The bright, chatty conversation I was greeted with drifted away; a formal tone crept in as the realisation sunk in for both of us to the real reason for my visit. No matter how much I tried to glide into the moment of starting the interview conversationally, I could not detract from the need to receive verbal consent for the process to continue. I mostly used the interview schedule as an aide-memoire - a way of checking in that we had addressed the research aims and objectives. I attempted to encourage dialogue; open-ended questions were used, for example, *'tell me about your baby, what is he or she like?'* Where possible, I avoided asking *'why'* using instead something like- *'how did you respond?'* When seeking clarification, I used the participants own words and phrases to do so; here is an example with Tess in interview 3 regarding the qualities she wanted Georgie to develop. I am prompting Tess to explain, to understand her position:

Interview: *'yes, so you said about, wanting him to be happy, content, learning about, learning about things really...'* this works, as she goes on to explain, Tess: *'Yes. I'd like him to be kind of empathetic to other people, so kind of nice that we've got, we've got friends, or I've got friends that have children the same age. So, he can learn to interact with them. And hope he learns some social skills. And I kind of try and – when we're eating at the table, and he kind of sits with us to eat at the table. I think it's quite a nice thing to do....'* A story then follows about wanting Georgie to have better social skills than his father, explaining the why without asking, illustrating how we constructed a joint narrative responsive to the developing relationship formed as part of the research process (Mishler, 1986).

5.5.2.3.2 Managing vulnerability

Appreciating participants' vulnerability was an essential aspect of interviewing; some questions or topics might be difficult for mothers to explore (Hollway and Jefferson, 2013). Alternatively, how I, as a researcher, asked a question might unintentionally harm participants. Participants were aware that they could discontinue an interview at any time or that I would offer to cease the interview if they became distressed.

Interviews varied as expected, dependent upon the participant and me and our mutual situations, continuing to be a feature of change throughout the research (Scheurich, 1997, cited by Fontana and Frey, 2008). The longitudinal nature of the research illustrated how as a researcher, I stepped momentarily into someone's life and then would be gone for a few months; in that time, life continued for both myself and the participants, our situations changing in the meantime. On occasion, I felt myself reacting to my work and home life, and as much as I tried to keep this to one side when interviewing, occasionally these feelings would creep in; perhaps I rushed an interview more than the mother wanted or failed to follow a lead that a mother threw down during our conversations. Writing after each interview in my research journal was a means of acknowledging and exploring these feelings.

Now and then, I would walk into an atmosphere within the home that I could not comprehend, and as the interview progressed, the nature of the trouble would appear; for example, Mary became upset during our final interview. I sensed something like anger when I entered the home and some hostility toward me; her responses were shorter than usual. As an interviewer, I found it tough to know how to tackle an undercurrent like this. I tried to take as usual a gentle and friendly approach, but

reflecting now, I wonder if I should have addressed the situation by asking something like: *'you appear troubled today, Mary, is there anything I can help with? Do you want to continue or just chat?'* As we progressed through our interview, Mary suddenly became very upset, bursting into tears; here, an excerpt from my researcher field notes records the experience but lacks at this point any awareness of what I might have done differently to manage the situation:

'Mary thrusts her baby at me and rushes out of the room and up the stairs. What is happening? It takes me a moment to realise that she is sobbing loudly. Why had I missed the cues? I hear a door slam. I look at Harry; he is crying loudly now, clearly upset by his mother's unusual display of emotion. What should I do? She wants to be left alone. I prioritise Harry. I experience a range of emotions very quickly. What if I cannot settle him? He does not know me that well. I have a quick panic. She is already upset; I do not want to make her distress worse. There is nothing more stressful than hearing your baby upset. I rock Harry for a bit, and he begins to quieten. Distraction is key here, I think – luckily, this room has an ample supply; I choose some toys and begin to play with Harry. The tears leave him, and he begins to interact with me. He starts to smile. After a while, Mary returns to the room, to a smiling Harry - I feel that at least in that aspect of our interaction I have not failed, but what I wonder how did it go wrong?'

As she later related, the problem stemmed not from the interview but that she had left Harry at nursery that morning for a 'settling in' session. The session had not gone well, Harry became upset, and the nursery had emphasised this to Mary. It was challenging to unpick for sure what was happening, but Mary had fears about returning to work and leaving Harry. With hindsight, having studied her interviews in detail, it is evident that despite her strong relationships with 'mum friends', these relationships encouraged peer pressure, a form of mum competition, measured by who could manage the trials and tribulations of motherhood, rather than offering her the reverie she required (Bion, 1962a; 1962b). Mary seemed to have difficulty finding someone who could contain her anxieties, and these transferred onto Harry; the nursery was instrumental in escalating

her fears rather than helping her manage the process. I remember feeling irritation toward the nursery during this interview; Harry had not seen me for over three months, yet it was easy for me to distract him with toys, and by the time his mother came back into the room, he was playing happily. Reflecting later on this interview, I acknowledged that this was our last meeting and wondered if the uncompromising finality of the research relationship intensified the experience for us both. Although I thought it might have done, I lacked insight into the changing nature of her world and was too keen for the final interview to end on a positive note; I had failed to question the underlying current of her mood when we met on that last occasion. Mary, having to deal with a return to work, was perhaps made more symbolic by completing her involvement with the study.

5.5.3 Researcher field notes

Throughout the experience, I created researcher field notes; initially, these would be in 'rough' form as soon as possible following an interview; sometimes on the train home. I have terrible handwriting even I find it difficult to read; therefore, I transcribed my reflections onto a computer file from memory and my rough jottings. I attempted to use my digital recorder to record the experiences, but I think best through writing, sitting at my computer screen. Sometimes it was difficult to type up these records immediately after an interview; often, work would get in the way, I would feel tired, or I just needed time to consider the interview, my thoughts, emotions, and reactions. The process was ongoing throughout the research, echoing the continuing nature of qualitative longitudinal research (Holland, Thomson and Henderson, 2006); I added new insights to my records as I engaged in data analysis, as I became more conversant with psycho-social approaches to research and as I sit here writing up this thesis.

I reflected on all aspects of the process, the difficulties of achieving the Health Research Authorities approval for the study to go ahead, the ongoing and what seemed at times a futile attempt to recruit participants, my responses to initial telephone conversations with participants, the interviews I conducted with participants, their reactions to their child and myself, the mother-infant relationship, and their child's reaction to me. I used my senses in this experience, particularly hearing and sight. I recorded my thoughts and emotions and tried to view the mother, infant and myself as embodied beings engaged in a mutual dialogue (Yates, 2003). As Sharma, Reimer-Kirkham and Cochrane (2009) point out, as qualitative researchers, we are often caught up in the content of what is being said, rather than paying attention to how it is being said, forgetting that speaking is an embodied act. For example, what were the mothers' bodily reactions when engaged in the interviews, how did they respond to the interview itself or specific topics? For instance, all participants shifted their bodily response as I started to audio-record our conversations from relaxed to a more formal tone, reflected in posture, and they would 'eye up' the digital recorder. How did I respond to them? What were my bodily reactions? In the entry from my research journal below, I note how a room's staging can affect how bodies are situated and make it challenging to communicate. This entry recalls my experience of recruiting participants with the maternity services; I must admit that I was starting to find the situation hopeless; my despondency was reflected in the tone. The note provides insight into my positioning as a health professional, the judgements I made regarding the provision of services, and how the move toward daytime provision makes it more difficult for partners to attend:

I consider the set up for the room, chairs in a circle focused on a television screen. I wonder what has happened to antenatal care. As a practitioner, I had provided antenatal classes of an evening in a community hall without a TV in

sight. Five women attend today's class without their partners; they all sit in their chairs, barely making eye contact with each other, let alone the midwife or me. The midwife stands at the front. I feel awkward and intrusive.

This next excerpt from my research journal is from an interview with Georgie and Tess. At this contact, Georgie is 6 months old. When I reflect on this interaction, it feels like my bodily responses are in tune with Georgie, was I experiencing the countertransference of his frustration here? (Hollway and Jefferson, 2013). It also demonstrates my lack of tolerance on occasion as an interviewer and the self-reproach I feel for intruding upon their busy lives. I am making a quick succession of judgements about what I perceive to be the influences of an intensive approach to mothering (Hays, 1996) which I contrast with my own experience of mothering, my children at the time of the interview aged 19 and 20, in some ways feeling both guilty and justifying my approach at the same time. The bodily experience heightened the experience and my emotions:

'Georgie is upset. He is tired, attending a group this morning; he has come home to this. His mother occupied talking to a stranger. Tess tells me he finds it hard to nap during the day, and she partly blames the lack of routine; they are always out doing stuff. I ask her if she wants to stop for a bit, she says 'no,' we carry on with the interview. I find it difficult to focus; there is children's music, a nursery rhyme I think, continually playing in the background. My head is spinning too much noise, I have a headache, and I feel exhausted. I reflect Georgie's life is an endless round of activity and noise; no wonder he is grumpy. Georgie is protesting; we work at distracting him with various toys. Tess tries to avoid feeding him; she knows this would settle him but does not want to use the breast in this way. I wish she would feed him. It would calm him, and he might sleep; it might give him the breather he is looking for; I am selfish- it is not good to have him rely upon this for comfort, or is it? It is OK to breastfeed your child for large parts of their childhood, but not to let them use the breast for comfort. How is a baby supposed to appreciate the difference? I find it confusing, so what about him? I wonder how we should respond to a tired and fed-up child. I try to remember what I used to do with mine; I took them for walks. I would certainly put on a TV show they enjoyed. Tess does not like using the TV; she views this as bad parenting. I think the term she used is 'lazy parenting.' If only she knew, she would probably lose any respect that she might have for me. I was a less than perfect mother, of that I am aware, working and studying all the time, and trying to meet their needs. But as a health professional, what should my stance be? We

live in a busy world; Tess is returning to work. Why do mothers have to do it all? Do mothers need to be permanently engaged with their infants during their waking hours? What room does this leave the child for their growth, learning how to distract and comfort themselves? To be themselves, to tune out from the endless round of activity and being moulded. A person under construction. I feel helpless to do anything useful. Tess remains calm; she can chat through the noise and the distress, coping with me; her valiant efforts to meet both mine and Georgie's needs are impressive; she has endless patience. On the other hand, I struggle to listen attentively to her.... she talks quickly, I work to maintain my focus; eventually, she gives in and feeds Georgie – I breathe a sigh of relief. Georgie instantly calms. Nevertheless, I feel guilty; Tess is trying to help with this research, something else for her to manage.'

In common with Elliot (2011), I was in a situation whereby I was interested in documenting participants' experiences of motherhood and not my experiences emerging from my own culture of motherhood. However, appreciating the hermeneutic nature of the research meant my past experiences shaped my perceptions and formed part of the process. Therefore, participants experiences and mine were bound together, and in being so, I worked through this, acknowledging the difference in our socio-cultural and historical context.

Researcher field notes can only provide an insight into understanding from the researcher's perspective (Emerson, 2001). To counteract this, I reflected on what I might have missed that was important from the participants' perspective, where, for example, had I interrupted or glossed over a question? I considered situations that had made me feel uneasy during interviews. A participant might introduce a topic that I avoided, a common situation for interviewers (Walkerdine, Lucey and Melody, 2001), adopting the position as Hollway and Jefferson (2013, p.154) describe of the 'defended researcher.' As I listened to interviews, reread the interview transcripts multiple times, and reviewed my research field notes, my strategies emerged; for example, I tended to steer around signs of participant

relationship difficulties, particularly with their partner. Although a parental relationship might be fundamental to an infant's mental health, I had to engage with the whole family when present, and I think reflecting on this, I was concerned that it would align the research with conflict and become unpleasant to the participant. Also, I felt duplicitous if I engaged in this type of talk and concerned that my motivations might centre more upon getting a good story (Conquergood, 2013) rather than considering the actual benefit for the research. The nature of this research encouraged participants to divulge aspects of their lives in a way that they might not necessarily choose to do. In managing this, as the researcher, I had to question my motivation for both exploring topics and those that I might avoid. The need to reflect and document researcher reactions and responses through field notes is a continuous requirement of this research that persists in writing this thesis.

In this section, I have explained the process of data collection and reflected on some of the decisions I made as the journey unfolded. I now want to consider the complexities of maintaining research relationships within qualitative longitudinal research, the ethical considerations arising from this research method, and the ongoing relationship with the participant.

5.6 Maintaining research relationships and ethical considerations

5.6.1 Creating a rapport

5.6.1.1 Acknowledging the importance of personal characteristics

Relationships with participants had to last for over a year; in some cases, the relationship lasted for 18 months; given the frequency of the interviews, I had to form a genuine rapport with the mothers. There is an assumption that sharing characteristics with participants might help develop a connection. To some extent, this is true; I often discuss the research when engaged in teaching a research module to student nurses; when we consider interviewing, I ask them to imagine how they might respond as a participant who is a mother to someone like myself or my 19-year-old car-mad son. Acknowledging that these preferences exist within us is a good starting point to consider the interview from a participant perspective and how our assumptions and the nature of our research shape the type of participant who wishes to join a study. Although I am a woman and a mother with vivid memories of caring for and living with young children, the participants in this research were interested in comparing the minutiae of their experience with other mothers in a similar situation. My professional background, the experience of health and education were more of a draw to the participants I recruited, we were similar in that respect, and they entered the research with a desire not only to give voice to their views but to learn more about themselves, to consider the development of their child, and to help with research.

5. 6.1.2 Personal characteristics as a strength and a barrier

My characteristics, for example, professional background, available for participants to view on the information leaflet (see Appendix E) formed a possible barrier to recruiting

a more diverse group of mothers. Based upon my experiences with health care delivery and the reaction of the midwives when trying to recruit to the research, there is the potential for quite different experiences of interactions with health workers and health care between groups of women based on socio-economic status, age and ethnicity. However, I managed to recruit to my MSc research (see Peters and Skirton, 2013; Tighe, Peters and Skirton, 2013) from a group of mothers with more diverse characteristics, such as educational attainment, social-economic and employment status. I had shared some similarities with these participants, which made it more comfortable to relate to them as we got to know one another at their 'stay and play' group. These characteristics were part of my 'backstage' identity (Goffman, 1959, p. 129), perhaps easier for participants to see in a group setting over some time; this was an identity that I mostly hid from the participants taking part in this current study. I felt more relaxed with the participants that I worked with during my MSc; I found it more straightforward to relate to their lives and backgrounds, maybe this reflected the type of clients that I had worked with most recently or the context in which I had grown up in, it is difficult to tell for sure. In my years as a practitioner and a researcher, I have realised that a genuine interest in others and their experiences are fundamental to establishing a rapport and maintaining relationships with clients or participants. The difficulty was maintaining the role of a researcher without tipping over into friendship or therapeutic intervention.

5.6.1.3 Keeping the relationship research focused

Establishing a rapport as researcher and participant, rather than therapist or friend, was crucial for the participant's wellbeing, as lack of clarity regarding roles can encourage participants to reveal more than they are comfortable with during an interview (Duncombe and Jessop, 2012). I found that the interview schedule helped me to be clear regarding my role and the purpose for my visit; although I encouraged participants to share their stories as they wished, it meant that I focused on the research questions and objectives of the research, which is what mothers had consented to. Explaining, in part my reticence to follow participant leads on specific topics, such as difficulties with personal relationships. I found it challenging to balance the need to reciprocate with participants to share some of myself without creating a relationship that effectively coerces participants into imparting information. Despite efforts to maintain distance, some participants found the research supportive, and therefore potentially difficult to leave the relationship. For example, Ella felt the interviews were *therapeutic*, while Mary became upset as the interviews' cumulation possibly symbolised changes to her life.

Given the research's longitudinal nature, I wanted to be available to participants between the interviews if needed but remain unobtrusive; therefore, I tried not to disturb participants unless they contacted me. These mothers were busy and did not need an added drain on their time and energy (see Reay, 1995). Participants varied in how they liked to organise dates for further interviews; some mothers wanted to arrange a future date at the interview, while others wanted contact nearer the time. After an interview, all mothers received a follow-up email that thanked them for their time and encouraged them to contact me if required. Participants received reminders through email a few

days before the date of their next interview; they were aware they could cancel the interview to rearrange as they wanted.

5.6.2 Consent

All participants completed a written consent form on joining the research at the first person to person contact and the first postnatal interview. All participants were contacted via email before each interview and had the opportunity to decline involvement. Each participants was asked for verbal consent prior to commencing the digital recording of every interview. However, the nature of consent in qualitative longitudinal research (QLR) is complex and ongoing (Thomson, 2007). Despite the regular communication and options to decline their involvement in the research, this does not capture the reality of the implications that participating in QLR may have. It is unclear if participants can fully appreciate that the research's longitudinal nature may result in them revealing information that usually they might not choose to.

The data in QLR has a cumulative impact, the unintended consequence resulting in an intrusion to their privacy (McLeod and Thomson, 2009). The interpretive nature of the research is something that we discussed in completing the consent forms and an item that formed part of our catch up at the start of each interview. Although the purpose of the research was made clear to participants, it was difficult for me to be sure how participants imagined the outcome and foresee how the study would progress. The process of QLR is complex and challenging to control, for example, researcher-participant relationships and the shaping of the data. Therefore, the concept of consent at the beginning of the research is unclear (Miller and Bell, 2012). If consent becomes the focal point of each interview, there is a danger that this will inhibit the rapport

between interviewer and participant (Duncombe and Jessop, 2012). However, I continued to check with participants on arranging a further interview and, before commencing an interview, that they wished to continue with the research. At the beginning of each visit, I spent time with the participant just chatting, for around 15 minutes, which was not recorded, and I hoped that the mother would express any concerns regarding the research before we moved on to the interview. I would recall observations from our previous interviews during interviews, allowing the participant to correct my interpretations and reflect on her experience. Each interview, creating a new layer to our co-constructed account. In truth, some ethical aspects only become apparent amid data analysis, and reflexivity was vital in confronting these issues.

5.6.3 Infants as contributors

Infants were active contributors to the interview; they might be unsettled, chatty, wanting to feed, or wishing to engage in play. Even if they were not present, they were very much a presence as the research depended upon maternal perceptions of their care and development. Maintaining research relationships were contingent on getting along with the dyad. I worked with the infant and read their signals and responded accordingly. A baby may look to engage and play or chat; I might play a game with them while talking to their mother; favourites included building blocks, hiding objects, finding them, and playing peekaboo. Sometimes, I wondered if a baby resented my presence as an intrusion to the relationship with their mother, a previously content baby, mother report, would not wish to soothe during the interview. Perhaps the presence of a third unknown person requiring maternal attention influenced the relationship dynamic. Whatever the cause, it was important that infants felt included, and I viewed the interviews as a conversation between the three of us.

5.6.4 Management of confidentiality/anonymity and storage of data

The participants' information leaflet (Appendix E) explained the management of confidential information through the research. All participants received a copy of this. Each participant had a number assigned at the start of the study to identify audio recordings; after downloading each recording, I destroyed the audio recordings from the digital recorder. The audio recordings were downloaded onto a university computer with an encrypted password and then destroyed after transcription. Each participant received a pseudonym, and personal details such as the area in which they live and relatives' names were either changed or removed in the transcripts to maintain their anonymity. Any personal information, such as addresses and telephone numbers, was kept on a university computer with an encrypted password; and later deleted. Participants gave consent for their midwives, health visitors, and general practitioners to receive a letter detailing their involvement in the study.

5.7 Data analysis

In this section of the chapter, I consider the approach used for data analysis in this study. In analysing the data, I sought to construct the experience regarding their perceptions and knowledge of infant mental health for all participants. I looked across the cases to identify patterns in them, which I identified as themes (Josselson, 2011) woven throughout the data, and a sense of the experience from a psycho-social context. The following sections detail this process of identifying the themes; I then discuss the construction of two individual stories from their narratives.

5.7.1 Identifying the themes- managing the data as a whole

5.7.1.1 Managing the data – thinking about NVivo

I began data analysis in November 2018. I had a mass of data that mutually overwhelmed and delighted me that the participants had contributed so much to the research. In managing the analysis, I had to find a way of dealing with the study's longitudinal nature and the quantity of data. In essence, I had 41 transcripts, each of about 8000 words, which sat alongside my researcher field notes. My supervisory team were keen on the use of a computer programme NVivo, and I spent several months working with this approach; however, I found it reductionist and challenging to use with both the longitudinal nature of the research, the number of the interviews, and the detail included in the interviews; a view echoed by other researchers of narrative inquiry who caution against coding with this type of data (Clandinin and Connelly, 2000; Yates, 2003; Kim, 2015). It created a superficial and descriptive picture of the data and highlighted just how much maternal perspectives were dominated by the master narrative surrounding perceptions of the mothering role and care of the infant within our socio-cultural context. As I was busy wrestling with my dilemma and the data, a new supervisor with experience in qualitative longitudinal research and psycho-social approaches to data analysis joined my supervisory team.

I wanted to work to reveal a possible meaning to participant narratives, a 'demystification of a meaning' (Ricoeur, 1981, p.xvi), accepting that narrative is not a direct reproduction of events or reality. However, it is co-constructed with a particular audience in mind, framed within a specific historical, socio-cultural context, and

interpreted by others. To achieve this, I used a psycho-socially informed approach to data analysis, as introduced in Chapter 4. Initially, I used reflexivity to manage my ongoing engagement in the research process and my relationships with participants, illustrating a psycho-socially informed approach to thinking about my data and its construction. (Thomson, 2009; Hollway and Jefferson, 2013). Reflexivity, practiced in this way, acknowledges what the researcher adds to the construction of knowledge, mostly through recognising researchers 'emotional responses'¹⁴ to the intersubjective relationship between the researcher and participants (Hollway and Jefferson, 2013, p.159). I engaged in debriefing with supervisors, particularly concerning situations with participants that I found difficult to reconcile. The computer programme NVivo illustrated the influence of dominant discourses /master narratives (Hammack, 2008) on the data, so engaging in that process helped demonstrate the impact of these on the construction of participant narratives. I discussed the situation with my supervisory team. We agreed that I needed to find a way of 'getting underneath' what mothers said; Clarke and Hoggett (2009, p.1) describe this as getting 'beneath the surface' of the data. I had to reconsider my whole approach to managing the data, which I explain in the next section, but in approaching the data analysis, I decided to apply a psycho-socially informed lens to interpret maternal narratives; otherwise, the result might be an imposition of my perspectives on the data (Hollway, 2015) (see section 5.7.1.3 for the process of data analysis). A psycho-social informed approach to the interpretation of

¹⁴ Hollway and Jefferson (2013, p.159) use 'emotional responses' as an alternative to the terms 'transference' and 'countertransference' which can create some confusion in application to psycho-social research. Hollway and Jefferson (2013, p.158) define transference from psycho-social research perspective as 'feelings, more or less available to conscious awareness, when confronted with emotionally redolent situations that trigger previous experiences, these may be projected onto others.' And countertransference as the situations where these feelings, 'may be felt and identified or disidentified with.' The two processes are dependent upon each other.

narratives provided me with a way of incorporating psychoanalytical and psychological theory with sociological theory, trying to grasp the influence of how our inner world helps to construct our perceptions of the outside world and the influence that this outside world may have upon how we construct the inner world (Clarke and Hoggett, 2009; Hollway and Jefferson, 2013).

5.7.1.2 Thinking about the data as a whole

Wanting to reveal the meaning of a body of data that included the narratives and researcher field notes, I had to consider how to approach the data as a whole without losing the substance of the individual experience. The hermeneutic circle consists of individual experiences considered in relation to the experience as a whole (Squire, 2008; Josselson, 2011). In common with a dialogical approach, the hermeneutic circle never closes, and the interpretation is never complete (Squire, 2011; Frank, 2012). Beginning the process, I read the narratives several times, seeking to develop my understanding of each participant's experience. I made notes and created a case profile (Henderson et al. 2012) for each participant and wished that I had done this from the outset of data collection. As I created the case profile, I read and reflected on my field notes, noting my observations of the participant and our reactions to the interviews. Creating the case profile helped me construct an overview of the participant's changing experience over time (McLeod and Thomson, 2009, Pearce et al., 2020a; Pearce et al., 2020b). I added further dated records of my observations regarding the data; with some distance from collecting data, it was easier to see aspects of my behaviour that I had not recognised at the time. For example, did I try and distance myself from participants by failing to explore aspects of their stories to protect myself? The

‘defended researcher’ (Hollway and Jefferson, 2013, p154). Below is the process of data analysis that I followed.

5.7.1.3 The process of data analysis

- **Reading:** I read the interview transcripts and field notes several times. I tried to be open-minded, observing my feelings and preconceptions as I went (Lieblich, Tuval-Musiach and Zilber, 1998). I made a record of these. Members of my supervisory team read some of the transcripts, and we discussed our perceptions of the interviews at supervisory meetings.
- **Creating case profiles:** A method used by Henderson et al. (2012) to manage qualitative longitudinal data. I made a case profile for each participant; the case profile helped identify individual changes across the interviews, identifying cross-cutting emerging themes. Please see Appendix G for Hanna’s case profile. On the case profile, I recorded the following: identity, mother-infant relationship, infant development, relationships, emerging themes, and researcher reflexivity. I looked for emerging themes by identifying stories within the interview; for example, this might be an action, a point of view, or an interaction (Saldana, 2016). I shared the case profiles with my supervisory team for discussion at our meetings. The case profile provided a means of comparison between the participants.

- **Creating memos:** as emerging themes appeared, I made a detailed record of each – a memo.
- **Creating summaries:** I summarised each participant’s story, highlighting similarities and differences between each story. Simultaneously I considered the researcher field notes and noted any similarities/differences in my observations or reactions to participants. See Appendix H for an example of summaries from Natalie and Fran’s interviews. As I developed the themes, I made a cross-comparison with the participant summary.
- **Comparing emerging narratives:** initially, I identified these using the case profiles and then compared the memo created for each. I colour coded the emerging themes and returned to the transcripts, going through the text and colour coding the sections to represent the emerging themes. I noted any sections of the transcripts that were not a good fit with the emerging themes. I then reflected on the themes and amended them as required, moving between the data and the themes, continuing until I had exhausted the process. I discussed the process and progress with my supervisory team at frequent intervals. I reflected on the researcher field notes, considering my influence on developing these themes and recording new observations as they occurred during the process.
- **Bringing the narratives together:** I cut and pasted data aligned with each theme; there was considerable overlap between the themes, making it difficult to discuss one without the other. A sign that the work is thorough, the themes should reflect human life's complexity and multilayered nature (Josselson, 2011). Four main themes emerged, but as I worked, there were areas of similarity between them, and three themes emerged ‘evolving maternal identity,

‘growing a person,’ and ‘creating a safe space.’ I developed a more detailed memo for each and related data to each, Appendix I, is an excerpt from the developing theme ‘evolving maternal identity.’ I did a cross-comparison of these with case profiles and participant summaries. I discussed these themes with my supervisory team, providing them with evidence to consider data saturation. These themes are presented in Chapters 9, 10 and 11.

- **Writing:** is not just an ongoing part of the research process; it forms a method of never-ending data analysis. As I write and rewrite throughout the research process, my insight into the research, the participants and I, as the researcher, has deepened. Writing sparks connections and enables me to think more deeply about the data. Behar (1997, p. 16) calls for writing to reflect the researcher's vulnerability, where appropriate. Although not relevant to all forms of ethnographic writing, my research's methodological foundation and premise ask for reflexive thinking about the process. Knowing how to temper this information, I found the most challenging aspect of writing, deciding which parts of my story are relevant to share.

Having spent so much time with this research, I sometimes wonder where the research and I separate, if at all. McLeod and Thomson (2009, p. 68) talk of ‘living a qualitative longitudinal research study’ and the difficulty in separating the researcher from the researched. Indeed, I feel that this is given further emphasis not only by the nature of the research but in that it is a doctoral study programme that I have lived with for the last seven years. This study has witnessed not only changes in the participant’s lives but that of my own, children growing, bereavement, getting older, it is all there. As well as this, the

significance of the past creeps in as my familiarity with psycho-social research methods grow and a developing introspection as I reevaluate my motives for embracing this subject. Alternatively, are my new insights a result of a search for identity that is being changed and reimaged through the PhD studentship and engagement with differing discourses and perspectives (Richardson and Adams St. Pierre, 2008). In this way, writing has encouraged me to consider the self in relationship to the subject, examining my social context and past in developing my analysis (Richardson and Adams St Pierre, 2008).

5.8 Conclusion

In this chapter, I have described the methods and processes used to conduct my research and the ethical implications of undertaking qualitative longitudinal research. I have given readers a sense of how the research process impacted me and the decisions I made due to this. In the following chapter, I introduce the participants who took part in this research before moving on in subsequent chapters to present the research findings.

Chapter 6: An introduction to the participants

In this chapter, I give a brief overview of each participant and their situation, summarised in Table 6. The focus of this study is on the individual and their socio-cultural situation. I have provided details of some salient aspects of their lives, information on the family and social supports available to participants, child-care choices, and their work situation. These were aspects of their lives that appeared consistently during our interviews. Although the participants share similar characteristics in terms of education/professional backgrounds, they all had different approaches to childcare and the support they received from both family and social networks. Please note that terms regarding family relationships such as ‘married’ or ‘husband’ reflect how participants described their relationships throughout; I, interchangeably, refer to them as either ‘participants’ or ‘mothers.’ As discussed previously in section 5.5.1, all the participants and members of their families have pseudonyms, which are used throughout this chapter and for the remainder of the thesis.

At the end of this chapter, I introduce the two individual narratives that I focus on in Chapters 7 and 8 and my rationale for choosing these particular stories to tell.

6.1 Fran

Fran resides with her husband John and son Toby, aged 2. Jessica is Fran's second child. Educated to a postgraduate level and a primary school teacher, currently working as a teaching locum, Fran was interested in my subject and had responded to an advert in the local news. She remembered researching her MSc and was keen to help with my research; she was particularly interested in attachment parenting. Fran sought employment and work as a carer, returning to work by the time Jessica was 9 months, which suited her childcare arrangements. Her mother provided childcare for both children; she was the only participant to rely solely on family support for childcare and moved back to her childhood town after Toby's birth for support from her family. Fran chose to breastfeed for as long as possible and was breastfeeding Jessica at one year.

6.2 Ella

Ella lives with her husband Frank and daughter Claire, aged 3. Ella works part-time as an ambulance technician. Living in the area since birth, Ella has family and established social contacts nearby; many of her friends now have older children. When we first meet, she is anxious about how Claire will adapt to the new arrival. Ella breastfeeds Isaac, choosing to cease at 6 months, reporting that she is delighted to have her 'body back.' Ella returned to work when Isaac was 12 months, working one shift per week

over a weekend, as Frank is available to care for the children at this time. Ella's parents live close by and require support from Ella. Ella's mother is unwell and needs help from Ella with managing her home. By the time Ella returns to work, Claire has started school; Isaac will follow Claire in attending the same nursery that adjoins the school every Monday to allow Ella respite. Ella needs time to recover from her weekend shift and to provide clerical support for Frank's business and undertake household chores.

6.3 Mary

Mary lives with her husband Sam and son Joshua, aged 2. Mary works part-time as an occupational therapist. Neither Mary nor Sam have family close by, and they do not depend upon them for day-to-day support. Mary is close to a group of 'mum friends,' with whom she shares a busy social life, choosing to breastfeed Harry for as long as she can, sustained by the reported peer pressure within her group of friends. Mary is breastfeeding Harry at 12 months but wants to reduce the feeds significantly. When Mary returns to work, she intends to place Harry in the same nursery as his brother Joshua. Establishing Harry in the nursery is a source of distress for Mary.

6.4 Natalie

Natalie resides with her husband Hugo and son Jacob aged 4. Natalie works full time as a postdoctoral researcher. Jacob is about to start school as Freya arrives, and Natalie is delighted to be taking maternity leave at that time to help with his transition to school. Natalie chooses to breastfeed Freya for the first 6 months of her life, deciding to cease

breastfeeding when she returns to work. Neither Natalie nor Hugo have family living locally to them. Hugo's family are Eastern European and reside in that part of the world. Despite the physical distance between them and their families, both Natalie and Hugo view them as supportive, with Hugo's father coming to help the family when Natalie makes a trip abroad for work. Natalie has good social networks from Jacob's early years, relying upon them for socialising, but family for advice and support. Natalie has returned to work by the time Freya is 9 months. Freya attends the same nursery as Jacob did, and Natalie feels reassurance in this.

6.5 Tess

Tess lives with her husband, Mike. Georgie is her first baby. She works full time as a receptionist when we meet; after the birth of Georgie, she moves to part-time work. Tess is breastfeeding Georgie at 1 year and continues as she returns to work. She goes to some effort to express breast milk at work, as it takes most of her lunch hour to access the facilities to do so. In her pregnancy and throughout the first year of Georgie's life, Tess spends time finding and maintaining friendships with other mothers. Tess and Mike's families live close by and offer support. Her mother is keen to help and offers to care for Georgie when Tess returns to work. She is eager to maintain her independence from her family and believes that Georgie will benefit from a nursery; therefore, Georgie attends nursery for one day a week, spending the other day Tess is at work with Tess's mother.

6.6 Ruth

Ruth lives with her husband Matt and son Noah aged 2. Ruth works part-time as a civil servant, working both from home and commuting with overnight stays at her workplace every few weeks. Neither Ruth nor Matt have family living close by and judge their parents to be too elderly to provide support. Ruth has two sisters with whom she discusses baby and childcare; however, she places a higher value during the early months of Isla's life on the support she gets from her 'mum friends.' Ruth intends to breastfeed for as long as she can and continues as she returns to work. Isla attends nursery on a part-time basis with Noah when Ruth returns to work when Isla is around 12 months.

6.7 Hanna

Hanna resides with her partner Charlie; they get married during the study. Hanna is Eastern European by birth, living in the UK for some time now, and works in marketing. Freddie is her first baby. When I first meet Hanna, she is on maternity leave; after working full time, she intends to return to work on a part-time basis. Hanna's family live in her country of birth, and they have a close relationship; she communicates with them frequently using WhatsApp, and they visit each other regularly. Charlie's mother lives nearby, and when Hanna returns to work, she helps with childcare, while Freddie attends nursery for some sessions. Hanna is breastfeeding Freddie at 1 year of age and continues on her return to work, having stopped some of the feeds, with Charlie's mother bringing him to her at work so that she can breastfeed if Freddie requires it. Hanna does not wish to express breast milk.

Table 5 on the following page, provides a summary of each participant's details

Name	Age	Education	Parity	Social supports	Baby	Employment
Fran	32	Postgraduate	2	Married lives with husband John and son Toby aged 2.5	Jessica	Part-time (Locum/temporary work)
Ella	37	College	2	Married lives with husband Frank and daughter Claire aged 3	Isaac	Part-time
Mary	37	Degree	2	Married lives with husband Sam and son Joshua aged 2	Harry	Part-time
Natalie	38	Postgraduate	2	Married lives with husband Hugo and son Jacob aged 4.5	Freya	Full- time
Tess	28	Degree	1	Married lives with husband Mike	Georgie	Part-time
Ruth	34	Degree	2	Married lives with husband Matt and son Noah aged 2	Isla	Part- time
Hanna	35	Degree	1	Lives with partner Charlie	Freddie	Part- time

Table 5 Participant details

6.8 Identifying two individual stories to tell

The purpose of this research is to understand maternal perceptions and knowledge of infant mental health from the position of mothers experiencing life with their children during this particular point in history and within the current socio-cultural context and give voice to individual stories regarding the phenomenon. Therefore, as well as presenting three themes that emerged from the collective data (see Chapters 9-11), I also present two individual participants' stories in Chapters 7 and 8. Although the data analysis identified aspects of collective experience as reflected through the themes, there are differences between first and second-time mothers' experiences. Deciding on the stories to tell and their representation is part of the hermeneutic process (Vargus - Cetina, 2013), this research is 'partial, selective and contestable' (Bochner and Ellis, 1996, p.21) the presence of which depends upon the representation provided by me as the researcher. Tess and Ruth, whose stories are presented in Chapters 7 and 8, are not represented as typical of the whole; instead, I am re-telling their experience as a first or second-time mother over time (Clifford, 1986). In this way, I can hope to illuminate their experience and give voice to a group with little representation within this research field. Choosing the stories was, in part, both a practical and reflexive experience. Tess was the only first-time mother who participated in all six interviews. Her desire to create a robust maternal identity and the implications for her perception of infant care and development was fascinating. Ruth told her story with clarity; her experience appeared embedded in the life and narrative of middle-class parenting values. Both Ruth and Tess echoed the master narrative surrounding mothering practice and within their perceptions of the mother-infant relationship but demonstrated ways of shaping

this narrative to meet their own needs, presenting resistance at times in their stories to the pull of these master narratives. In Chapters 9 through to 11, I present all three themes, representing the individual experience within each, portraying both similarities and differences between participants. Nevertheless, for now, in the next chapter, I begin by telling Tess's story.

Chapter 7: Tess's story

7.1 Introduction and overview

Tess, responded to an advert from a newsletter to participate in the study when she was around 12 weeks into her first pregnancy; she was excited about becoming a mother and keen to help with the research. During her pregnancy, I maintained casual contact with Tess as she wanted, finally meeting her in person six weeks before her baby's expected date of delivery.

Tess's story takes us from the end of her pregnancy through the first year of motherhood. As far as possible, I have arranged the content below in chronological order¹⁵, the passage of time illustrating how Tess's relationship with her infant developed, there was an interaction between her emerging maternal identity and how she chose to care for Georgie. The mother-infant relationship between her and Georgie is one of co-construction of mutuality to their mental health and wellbeing. Her narrative is one of hope both for herself as she developed her identity as a mother and for Georgie, for whom she imagined a bright future.

7.2 Taking control, becoming a mother

At 28 on joining the study, Tess was the youngest participant and full of optimism for impending motherhood. Married to Mike, she graduated from university with a degree in Geography but had difficulty finding work in a related field ... *I would ideally like to*

¹⁵ There is some overlap of events in places.

go into town and country planning because of the way cities and development are built can really impact on the environment and lifestyle.’ Tess felt that she needed a master's degree to progress in the field and had taken jobs in retail and administration; her emphasis was upon developing Mike’s career, ‘he’s doing really well, to be honest at the moment. He’s quite ambitious. Not like me, really. I think he’s got this idea of what he wants to do, whereas I’m a bit more float along.’ Instead, she focused intensely on becoming a mother, particularly birth. Initially, her information came from the stories that ‘friends and friends of friends’ shared. The telling of birth stories is a standard practice within many cultures and is associated with the development of maternal identity (Carson et al., 2017).

‘I’ve not heard many people say, “yes, it was fine.” You just don’t really hear that, so it’s quite nice to change your own expectation of what it can be like rather than thinking it’s going to be this horrific, traumatic ordeal, and it actually doesn’t have to be, or it’s not for everyone.’

7.2.1 Doing her research

Determined to create a different narrative for herself, she read and researched widely. Nevertheless, maybe she felt denied of information about home births until it ‘*was too late*’ becoming distrustful of midwives:

‘I have read a lot of journal articles, NICE guidelines, and the AIMS¹⁶ website it’s an awful website of really interesting articles on it, so that’s been interesting to read about how statistics are swayed. We all know statistics are swayed but not necessarily taking everything; you’re told at face value. It has made me a little bit cynical of the midwives, to be honest, not necessarily in hospital, but I think I would feel more confident in questioning something and asking them to back up what they’re telling me with evidence rather than just accepting it.’

¹⁶ NICE refers to the ‘National institute for Health and Care Excellence,’ while AIMS refers to the ‘Association for Improvements in the Maternity Services.’

Tess sought positive stories of birth and those that emphasised a natural approach, she was fascinated by the idea of hypnobirthing, as well as reading related texts, she used social media to try to learn from others' experiences:

'On Facebook, I've joined a couple of pages around hypnobirthing, and people have put their stories up. If you had questions, people post on there for advice from other people who have been through the same thing but with similar expectations from the labour. There's a website called Positive Birth Stories which you can read because most of the time, all people tell you is when things go wrong.'

7.2.2 Taking control of the birth

Tess developed strong beliefs about what she wanted from her birth. Having choice and control over the birth experience is related to a positive birth experience (Cook and Loomis, 2012). These beliefs appeared to result in some resistance toward health services and services delivered to women. Controlling the birth experience seemed important to her, but she appeared to acknowledge the possibility that the situation would be outside her agency, raising conflict (Bruner, 1990). To remedy potential conflict between her agency and a situation outside of her control, she seemingly created a narrative illustrating her resistance to the potential conflict. If the birth did not go to plan, it would be at the behest of forces beyond her control:

'My midwife, when I go for the birth plan meeting, is not going to be very pleased. I am a bit of a control freak, and I would like it to be as natural as possible. I've been reading up a lot about hypnobirthing. I think you spend your whole pregnancy avoiding eating things, drinking things, any drugs at all, and then you get into the delivery room and from what I've heard, and it is only what you hear from other people, I think a lot of people are very keen to tell you their horror stories a lot of the medical staff in hospital seem very intervention happy. I would like to avoid that if possible.'

Tess emphasised the narrative of risk that pregnant women are subjected to, the moral duty of taking responsibility for another represented in maternity care. Towards the end

of her pregnancy, midwives raised concerns for Georgie's growth, but Tess's sense of self-belief remained firm, and she had a natural birth in a water pool, just as she hoped:

'The end was so quick, it was a bit of a shock, really. Then trying to pick up your baby floating around in the water...I think I was just a bit; I think I was in denial – he came out, and I thought, "I'm just going to have a baby." I don't know; I think I just expected someone to pick him up and hand him to me. So, I wasn't really expecting to have to fish him out. I just think it was a little bit of relief, probably, just a bit of shock that that bit was so, so fast. But it was lovely, it was a really nice, calm experience, yes. Yes, that was really lovely.'

7.3 Adjusting to a new life

7.3.1 The reality of early motherhood

The delight Tess took in Georgie's birth contrasted sharply with her experiences in the days that followed. She was keen to breastfeed, but Georgie, lethargic after the birth, refused to do so, and they were discharged home without him having fed:

'We came home, and we saw my parents and Mike's parents, and we just kept trying to feed him, and I couldn't feed him at all. And he was quite calm until probably about ten o'clock and then he started getting really frustrated. And it's not very nice when he was really crying, but there was nothing we could do to calm him down. So, I kept trying overnight, and then I was trying to hand-express and syringe it into his mouth. We were getting no sleep, and he wasn't very happy, and we weren't very happy. So, I ended up sending Mike out to buy a little bit of formula because we phoned triage, and they weren't very helpful.'

She and Georgie were readmitted to the hospital a few days later to see a specialist infant feeding practitioner. Within a few days, Georgie was exclusively breastfeeding, but it was not easy:

'We did struggle a little bit with the feeding just because I find it painful. But it took about three weeks. We only used the formula for about four days. And then we're exclusively feeding. But I was still struggling a bit, but yes, just like three weeks probably to get it right.'

There was much for Tess and Georgie to learn in those first few weeks. She created a narrative for them both; they were in this together, both new to the experience, and it

had a shared meaning for them, the mutuality of the situation helping to deepen their relationship:

'I didn't know what I was doing, and he didn't know what he was doing, and it takes you both a while to get it. And then it was no problem; it was just getting him to open his mouth. And, yes, getting him to stop getting his hands in the way. Yes, stop sucking your hand (to Georgie). Now, he's quite happy.'

7.3.2 Seeking reverie

Tess spent the early weeks of Georgie's life trying to establish a routine for themselves as a new family, a challenge as they were still getting to know Georgie. She created a positive character for Georgie, defining him at 6 weeks as *'quite placid and chilled out.'* I wondered if this was the baby she imagined and wanted to create, as she immediately went on to fashion a juxtaposition of his personality with a story about Georgie being *'gripey,' 'unsettled and not much of a sleeper.'* Meaning that Georgie experienced both good and bad emotions when in his mother's presence, and at this early stage, he could only attribute both emotions to her (Klein, 1959). Finding a resolution was a complex undertaking. Tess and Mike were incredibly anxious, as explained previously (see section 11.3.1), regarding the possibility of cot death, they were engrossed in Georgie, *'well we were always interacting with him,'* I wondered if some of this need to interact with him constantly originated from their fears regarding his wellbeing. With no obvious source of containment, the projective identification (Klein, 1955) coming from both Georgie and his parent's anxieties may have produced a state of high emotion for all concerned. Their concern may have made it challenging to provide the reverie that Georgie required (Bion, 1959; 1962a; 1962b). Although Tess was beginning to feel that she could identify *'what he wants a little more,'* working to manage Georgie's distress before he *'got to the point of really crying,'* some of the concern also, therefore,

appeared to stem from her feelings of responsibility for Georgie's emotions and wellbeing.

Tess recognised that she needed to find help during the early weeks of mothering.

While Tess had a mutually supportive relationship with her mother, she declined to take what she called '*unsolicited advice*' from her. Tess was determined to become the mother that she wanted to be she sought support from women with whom she had attended antenatal classes:

'I'm quite friendly with three other ladies, it's quite nice, all their children are from two weeks older than him up to a month older than him. So, it's quite nice to be able to say, "Oh, what do you think, what have you done?" And have a bit of advice from someone who's going through the same thing at the same time.'

These relationships continued to be necessary to Tess in the first few months of Georgie's life in helping her adjust to her new identity as a mother and caring for Georgie, more so than her family or professional involvement. When Georgie was 3 months old, they appeared to provide her with affirmation that she desired:

'I guess they're always positive; it's not – there's no kind of criticism there, it's not judgemental. Yes, I think we've probably got a lot in common. We've got similar backgrounds and similar kind of education and yes. So, we're about the same age, and so it's kind of fresh in your mind what they're doing – whereas kind of when I speak to my mum, she can't really remember what happened when.'

After the initial few weeks of adjusting to life with Georgie, Tess's sense of agency was re-emerging. She was becoming more confident and took Georgie out every day to engage in mother and baby activities. Tess seemingly appreciated that their distress was mutually dependent, with both projecting their anxieties (Klein, 1955):

'I don't like him getting bored and fed up. And I think it's, as I say, it's easier to stimulate him when we're out and about. I just find it a lot easier, and I don't get frustrated – sometimes here, if he's crying, you can get quite frustrated because it's quite claustrophobic. But when you're out, it doesn't feel like that.'

Tess's contact with the groups provided a form of reverie, where she found help to translate and manage difficult emotions and provided respite from the dyadic relationship and their mutual dependence (Bion, 1962a; 1962b), perhaps helping to maintain both Tess's and Georgie's mental health. As reportedly the feelings of being the one responsible for assisting Georgie to manage his emotions were, at times, overwhelming:

'I kind of think he's trying to communicate something, even if it's that he's just not very happy, and it might not be about there's anything wrong with him. I kind of want him to know that his cries – we will react to them, and we will respond to them. Yes, I want him to know that we are listening to him and trying to respond to him. But it is hard to know sometimes what, what they want.'

7.4 The person yet to be

7.4.1 Imagining a child

Tess had an expectation regarding how her baby would be, what he would be like from our first interview. Tess created a story of how Georgie would be within their lives and the parents that she and Mike would become. Her narrative appeared to reflect her socio-cultural understanding of what it meant to be a good parent, which was further signalled by the actions taken, such as getting their home ready, attending antenatal classes, and considering how they would care for Georgie when he arrived. As Bruner says, 'we live publicly by public meanings' (1990, p. 13), and Tess took care to 'display' the actions of a good parent (Dermot and Pomati, 2016, p. 129). Societal influences were significant in caring for Georgie and her future perceptions of his development and wellbeing. Arguably Tess used her imagination's reproductive element to create a productive element, imagining a new reality from a preconceived idea of how her child would be (Ricoeur 1975, cited by Taylor, 2006). She imagined her child

and what he might do, *'a little boy. My husband's quite excited to get to kick a ball about and fly a kite and get muddy in the garden.'* Tess imagines the memories they will create, reflecting the self as the mother she wishes to become:

'Lots of cuddles and being held, and I don't really think there's such a thing as a baby that's cuddled too much or held too much. I think it's nice to be able to spend a lot of time with them and spend time as a family, which is why we're trying to push on with the house now, and we're having lots of late nights now because we want to get that out of the way for when the baby's here so we can do nice things at the weekend and we can spend time together as a family after Mike goes back to work. Just lots of cuddles and lots of play together and lots of day trips out. I don't really think you have to spend a lot of money you can just go for a walk or go to the beach and pick up shells.'

7.4.2 Creating the social baby

It was important to Tess that Georgie grow up a sociable person who could get on with those around him. By the time Georgie was 6 weeks of age, she was modifying her behaviour to help Georgie's development:

'I like him to have good kind of social skills as he gets older. I'd like him to kind of have good – be able to talk to people and kind of be polite and well-mannered. We talk to him a lot. I kind of just – I'm used to talking to the cat – he's over there – talk to the baby. So, I just kind of talk to him all day about a load of rubbish, really. And so yes, he's used to being talked to, and I try and leave little gaps – as a conversation, to try and encourage, especially when he is awake and kind of making noises.'

Tess found it easier to get out of the house as Georgie matured; most days, she had at least one if not two excursions planned. She showed me several photos of Georgie engaged in activities, for example, at their baby sensory group when he was 12 weeks, *'I would say he was kind of fascinated, kind of got transfixed. And we had like Jingle Bells then, and then we were doing this with the balloons and bubbles and the parachute that was going up and down.'* These groups not only relieved their mutual *'boredom and frustration,'* but intended to encourage him:

'To be kind of empathetic to other people, so kind of nice that we've got, we've got friends, or I've got friends that have children the same age. So, he can learn to interact with them. And hope he learns some social skills.'

As Tess started to plan her return to work, she thought about the options open to her. She continued to place importance on Georgie's social development and imagined situations that were well into the future; in planning for his future, she appeared to be trying to contain her anxieties about it; attending school was a particular feature for her:

'Although I don't want him to go to nursery, at the same time, I think it will be easier for going to school; it will make that transition easier. And I'm sure he probably will enjoy it, actually. He loves other children. Kind of he's fascinated with other babies at the moment.'

7.4.3 Allowing Georgie to develop a sense of self versus intensive mothering

When Georgie was 6 months of age, Tess acknowledged that *'he's got his own little personality now. I think you really kind of see, start to see their temperament and see what they're interested in and see what they're not fussed by...'* To some extent, she drew this conclusion from observing Georgie alongside other babies, recognising that he liked interactive play in comparison to others that played independently. At 9 months she was still very much involved in his play, although was now able to sit back a little *'I guess play time's a little bit more independent in the fact that, although I play with him, I'll sit back and let him take the lead a little bit more and see what he wants to do.'* Tess, keen that Georgie *'learn to play and be a bit more creative,'* had a fear of being accused of *'lazy parenting,'* which she attributed to parents that used the television as a source of entertainment for their child. In Tess's narrative and the time, I spent with her and Georgie, it was possible to see the influences of an intensive mothering culture (Hays, 1996) and master narratives regarding mothering and infant care upon her. These idealised how she would act as a mother and Georgie's responses,

illustrating how the need to be a ‘good’ mother in response to societal pressures can impact infant care, development and wellbeing.

7.4.4 Learning from the past

By the time Georgie was 9 months old, Tess had expressed what she wanted for Georgie in life and how her actions might achieve this. Sending him to nursery early on was fundamental to this plan, and a means of helping him to develop positive mental health, as she explained here:

‘I think it will just serve him well in life and make him a happier person. I think if you’re kind to other people, other people are nicer.... I suppose better quality experiences and life experience and I’d like him to be confident and independent enough ... Like I wanted to teach him to be his own person, I suppose. And feel comfortable being away from us and being away from me and know that he will come back when we get him, but he can still have a nice time away from us.’

It emerged that Tess was trying to rewrite her own story, the temporal nature of her narrative becoming clearer throughout the research. Remembering her past was helping her to create a future that she wanted for Georgie; she tried to help Georgie construct a self that would be different from her (Andrews, 2014):

‘I never went to nursery as a kid, and I was really shy, and so I think that’s probably shaped my perception of the fact that if he does learn those social skills earlier, he might have an easier time I’d just like him to feel, be more confident, have more confidence than I did as a child.’

7.5 Renegotiating relationships

7.5.1 With Georgie

As Georgie grew, Tess had to face the challenge of him wanting to exert his own will; at 6 months of age, she believed that managing his emotions were her responsibility,

relating to the socio-cultural influence of intensive mothering (Hays, 1996) and her sense of expectation regarding her identity as a mother:

'I don't know whether it's just kind of a natural kind of inbuilt reaction to hearing your baby cry. Once you hear your baby cry, it is kind of a trigger almost, and if you can't make it right quickly, it can be – I find it quite stressful. I think you just want your baby to be content, and you want your baby to be happy. And I think I feel it's my responsibility like I feel his happiness – like if he's upset, it's kind of, I'm responsible.'

Alongside this, Tess's desire to 'get out of the house' had a downside; she felt that Georgie became 'overtired', and it was 'kind of my fault because I haven't got him to sleep.' She balanced this by the joy she felt at attending classes with Georgie, as 'it's nice to see him enjoy himself and kind of – (to Georgie) you get all excited, don't you? Asking rhetorical questions of Georgie as he matured was a narrative device that she often used during our interviews. A way of not only including him in our interviews but using dialogue to help frame his experiences, assisting him in making links between the 'interpersonal process' of attending the groups with what how it made him feel inside, the 'intrapyschological' experience (Vygotsky, 1978, p.57). In this way, she tried to create a positive emotion for Georgie associated with peer learning and social activity, thus possibly promoting this as an activity that he might continue to enjoy.

As Georgie's personality and sense of agency grew, Tess acknowledged that she could not maintain his happiness all the time. She was aware that his behaviours would be judged by others apart from herself. When Georgie was 9 months of age, she recognised that her desire to shape him into the child she wanted him to become resulted in some unhappiness on Georgie's part.

'If there's something he wants, and he's not allowed it, then he does kind of get frustrated, and he'll kind of clench his fists and go red, and you growl, don't you? Sometimes. (Addressing Georgie). He kind of goes, Grr.... He's got to learn that he can't have his own way all of the time. Because in real life, I don't want him to

be spoilt. I don't want him to throw tantrums when he gets - I know he will to some extent, but I don't want him to be like pandered to all of the time.

Georgie was now able to express a variety of emotions through vocalisations, gestures, and facial expressions. She translated these and responded accordingly to his emotions, interrupting what was shaping his emotions through his behaviour and trying not to reward emotions she did not want him to show:

'If he's sad, then that's, we always try and give him a cuddle and comfort him. Frustration's a bit different, I think. I guess it depends why. If he's frustrated because he's not getting his own way, I do tend to leave him a bit longer or distract him with something else. Rather than kind of give in to letting him have his own way. Or kind of go straight in for a cuddle.'

At our final meeting, Tess articulated that she was best able to help Georgie by maintaining a sense of 'calm' perhaps reflective of Bion's (1962a; 1962b) concept of reverie while acknowledging the having to deal with some complicated feelings of her own (Klein, 1946):

'I try not to get too emotionally, not involved, but kind of worked up, as I kind of think it's all a bit confusing for him. He's still trying to work everything out and understand it, especially when he's kind of angry or frustrated. I don't think it's good to get angry or frustrated with him. Or really, I mean it's fine to say 'no.' But I think if you get too worked up and it is hard sometimes because sometimes it's massively frustrating for you too. (Addresses Georgie - Don't we? We try and stay calm and talk through it.) I kind of, yes, think if you kind of get caught up into ...it's only going to be more, even more confusing. Whereas if you stay calm and just try and share some of that calm, it might help.'

7.5.2 Returning to work

As Georgie moved toward the second year of his life, Tess had to negotiate other relationships that impacted her relationship with him. She decided to return to work; this was 'more of a financial decision' to pay for 'luxury things like holidays,' her perspective concurred with the narrative of intensive mothering, where maternal work is subordinate to the main role of being the breadwinner (Hays, 1996). Although for Tess 'I hate being stuck in the house' was a narrative that persisted throughout, she resented

the return to work. However, her strong narrative around motherhood and immersion into the role resulted in a rewarding experience that work could not compete with, *'it's not like I'm going to go to work, and I'm excited about going back to a career because it's not a career.'* She *'would much rather be at home with Georgie.'* Her work, though, allowed her mothering role to come first, as she explained that *'at the moment it's kind of ideal because I can do my work and come home and not have to think about it. I can just switch off,'* but she recognised that she might not find it easy to return in the future if she so wished if she did not do it now. Tess, Mike, and Georgie found the transition to nursery *'traumatic.'* When I saw her for our final interview, the situation had started to improve, but it was still hard, with Mike being the one who dropped Georgie off for nursery:

'he's been a bit more content and realises that we are going to come back and get him. But it was worse because I don't see it, it's not so bad for me. But it's not very nice for Mike having to like leave him. He's like a little monkey and holds on; you have to prise him off.'

7.5.3 With her mother

As Tess navigated her return to work, she had less time to spend with her other mother friends. She used a social media group to maintain contact with them, and they remained a vital source of support for her; but she started to look toward her mother, acknowledging the influence on her approach to mothering, *'I probably have learnt a lot from my mum. Like how she was. Just kind of getting out the house and doing things and being busy.'* Tess still perceived her mother as outdated when it came to her child development knowledge. However, she recognised and accepted the love her mother had for Georgie and that she still knew how to challenge him:

'I chat to my mum about kind of what he's doing. She can't really remember; she kind of remembers roughly like the big things. But I think you do. It goes so quickly. Like even now, I can't remember exactly when he did everything. So, yes,

she's always saying, "Oh, he's so clever, he's so clever." So, yes, I probably wouldn't ask for advice, but we do chat about what's going on and what he's doing, and mum has him one day a week, so she sees him a lot... She's quite good with kind of doing different activities with him to help, like bring him on. And she would like maybe think of doing different things that I wouldn't think of.'

Tess admitted that she felt her mother's influence in managing some of Georgie's behaviours, this presence often unrecognised at the time. However, she appreciated that her experiences as a child were in her subconscious, coming to the fore in her mothering, illustrating the influence that previous generations may have upon an infant's development and wellbeing. Tess was more accepting of this, a change from our first interviews where she was determined to be quite different from her mother.

However, she was anxious by how little control she had:

'He's started biting.... with the biting I did kind of, have been a lot more kind of firm about it.... Actually, I think it's like my mum coming out in me, which is a bit scary. And just as though if he's just been doing something that he really should be but wouldn't know. He's just investigating I'd say just like "no" and move him away. But with the biting, I did say it almost shouted. "No" - like a lot more firmly.'

7.5.4 Reaching a conclusion

As we neared the end of our interviews, Tess felt that although her antenatal reading had made her feel more confident to cope with labour, it had not prepared her for the reality of mothering:

'I don't really think any book can really tell you anyway.... You think it's going to be something, and it's actually completely different. And there's just no right answer. There's no right way of doing things. You've just got to do your best, what's best for your family really. That's all you can do, I think, is do your best.'

Finishing Tess's story in her words, she reflected on a year gone by, optimistic and full of hope for the future yet to come, ending as she had begun:

'I am really proud of him. I know it's normal. I know, I know it's like not child genius spectacular, but it's still lovely to see. I really enjoy, I think it's amazing how much they change. Go from being this tiny, helpless baby, doesn't really have

a clue what's going on to being a little person. Like a self-aware little person who can tell you what they want, and they like, have likes and dislikes and their own little personality. I think that's really lovely to see. I feel quite lucky I don't have to go back to work full time, so I do get to see it. And I don't have to miss out, and we can make lots of memories together and do lots of nice things together.'

Chapter 8: Ruth's story

8.1 Introduction and overview

My first meeting with Ruth was at her home, with her second child expected in six weeks. Ruth working from home, met me during her lunch hour, her toddler Noah at nursery. Although cheerful, Ruth looked forward to her second baby's birth with some disquiet, having had problems with placenta previa with her last pregnancy. Noah, now aged 2 was born at 35 weeks the day after they moved into their home, *'we drove to hospital in the removal van, so that was fun.'* The pregnancy this time around was *'straightforward,'* and although Ruth's main concern was for *'a healthy baby,'* she hoped for a birth that is *'a little more natural in a way.'*

Ruth's narratives emphasised her experiences with Noah, a commonality that all of the multiparous women shared. Most pressing was the development of the relationship between two siblings, the acceptance of the new arrival essential for the emotional wellbeing of all concerned. Ruth's story has four elements, all of which recall the past, influencing the present, to form the future. Toward the closure of this chapter, we get a sense of an ending and of new beginnings as Ruth started to consider putting aside old relationships to think of the future. The chapter begins by focusing on Ruth's desire to create a close sibling relationship between Noah and Isla, continuing with her need to instil a sense of calm within herself and with her children. I then move on to consider Ruth's belief and need to keep her children close, concluding to consider how Ruth decided to mother and the influence that this had upon the subsequent care of her children.

8.2 Relating to Noah

8.2.1 Imagining life with a sibling

Noah's birth and subsequent life were constant sources of comparison for Ruth's forthcoming child's arrival. Her recollection of events leading up to his birth was vivid *'everything that could have gone wrong went wrong basically, but it doesn't matter because he's here and we're fine.'*

Ruth was trying to prepare Noah for the new arrival:

'In a way, I don't think he knows; I don't think he quite understands the reality of it. He understands the concept. He knows the baby is coming to live with us and he's very funny about some days he thinks it's a boy, and sometimes he thinks it's a girl, and he talks to it a bit. This morning he was telling the baby off for kicking Mummy, saying, "you don't kick, we don't kick baby!"'

To prepare him, she created an imaginary world for Noah of what life might be when the baby arrived. Ruth crafted stories regarding the baby's characteristics or where he or she might sleep; in doing so, she was helping not only Noah but herself to contemplate the 'everydayness of being' with the new member of the family (Heidegger, 1927, p.39). Narratives, helping them both to interpret how the baby would be within their world, providing a means for Noah's reproductive imagination to think about what this might mean (Ricoeur, 1975, cited by Taylor, 2006). In this way, she was beginning to construct her expected child as an individual; despite all of this, Ruth reflected that she did not '*think*' Noah:

'Is prepared for the reality of it, but then how can you, even adults, don't understand. I'm trying to encourage more days where we just potter around at home, and he plays a bit, and I'm trying to encourage a lot more playing by himself, but it will all change when the baby's here, I'm sure. I'm not sure there's much I can do.'

8.2.2 Noah, a young apprentice

In the aftermath of Isla's arrival, Ruth felt that '*Noah is doing pretty well; he has been lovely with her and has adapted really well.*' She encouraged Noah to help in caring for Isla. Ruth encouraged Noah to learn through experience, teaching him to respond to Isla how she wanted, working to develop their relationship.

'He likes stroking her head, and he has started if she cries, he will talk to her like I talk to her, so I have been in a different room, and I have heard him saying I'm here Isla, I'm here it's OK don't cry and patting her head and things which is really nice.'

Ruth was keen to ensure that Noah had a crucial place in Isla's life. She developed a scenario involving pretend play; Noah was the only one who could communicate and interpret Isla's need to feed. The use of pretend play engaged Noah in the social rules of how to behave as Isla's big brother (Vygosky, 1967):

‘And we have a funny joke that she only says “whah” and whah means milk, so I say oh “Noah, what is she saying? And she is saying whah and what does she mean and what shall we do?” Usually, “give her some milk, mummy.” So, we kind of have a fun game like that, and he pretends that he can understand her. He tells me “oh she wants some milk, or I think she is sad now.”’

Ruth created a narrative for how she imagined Noah and Isla’s relationship developing, again providing a reproductive element for his imagination. Theoretically helping him move towards a situation where he might envisage the relationship that she wanted for them both, but it would be something new, something that came from his productive imagination (Ricoeur, 1975, cited by Taylor, 2006).

‘I tell Noah that he makes her happy, and I think occasionally he does come over, and he puts his face against her face and she kind of turns to him a bit, and I think she is going to absolutely worship him. I think there is going to be big brother worship going on I think he makes her happy.’

8.2.3 Isla asserting herself

Ruth continued to promote Noah’s and Isla’s relationship; to do so, she felt it was important that Noah perceived that both he and Isla experienced the same parenting relationship.

‘We’ve started saying things to her like, “oh, no, you don’t, no, don’t do that.” But actually, that’s more for Noah’s sake, because if she pulls his hair or something, I think he needs to see that we’re telling her not to do it because if he pulled her hair, he would be told not to do it. So, that’s quite interesting. And I don’t, you know, I don’t think she responds to it at all at the moment. But she will, as she gets older, she will have that element of discipline around her. Because there needs to be the same rules for her as for any older, for her brother as well.’

Ruth wanted Noah and Isla to interact and encouraged them to do so. Nevertheless, she appreciated that for both of them, it had difficulties; she illustrated her ability as a mother to mentalise regarding how this might feel for Noah (Fonagy, Gergely and Target, 2007):

‘She particularly loves Noah talking to her or playing with her, which is quite funny because he likes to kind of, you know, lie on top of her and be a bit rough and I’m there saying, “No, gentle, gentle, don’t lie, don’t squash her, don’t

squash her.” And obviously, she’s just laughing at him and really enjoying it, so it’s a bit confusing for him, I think.’

When Isla was around 9 months of age, Ruth felt that she was *‘starting to assert herself a bit more as well.... if her brother comes and starts hassling her, she will screech until it stops. She’ll just do a little scream.’* She perceived Noah’s actions as *‘just being very affectionate,’* and Isla was now starting to be able to stand her ground with Noah; she left them to some extent to negotiate their relationship:

‘He’s picked up on the fact that she’s a bit more robust. So, he plays with her a bit more robustly that he’ll kind of grab her arms and wave them around or he’ll give her quite a vigorous hug. Or try and kiss her when he’s wearing his bike helmet and bash her and – I think she gets annoyed with him. She kind of does an “AAAAAH” shout of “leave me alone.” And when he takes things away from her, she’ll shout at him. But, at the moment, if he gives her something different, that’s the rule – if he takes a toy, he has to give something back to her. Then she’s still placid enough to just accept whatever has been given to her.’

8.2.4 A lasting friendship

Ruth reflected that her sister’s children:

‘Fight all the time; they really don’t get on. They just fight all the time, and they’re quite close; in a way, they’re quite intensely close. They’ve moved quite a bit, so they spend quite a lot of time together, the children. But they do fight a lot; they’re real rivals.’

She was resolute in trying to prevent the same for Noah and Isla and continued with a narrative that focused on the positive aspects of their relationships: *‘I like to think that they’re friends. And Noah says to me sometimes, “Isla is my friend. She’s my best friend.”’*

When I visited Ruth for our final interview, Isla had what she felt to be a robust relationship with Noah, the sibling relationship more significant than that of the mother-child. However, I question now if a comment regarding being *‘too much part of the furniture to have a name’* signified a part of her that did not recognise Isla as separate from her. Alternatively, perhaps she felt the need to moderate her position within the

family—reflecting the invisibility of mothers that society bestows upon them (Baraitser, 2009).

'Her and Noah's relationship has just been – we couldn't have asked for it to be better, mainly because Noah has been so lovely about it. He just adores her to a fault, you know, I have to tell her, tell him, "Get off her, just leave her alone, she's trying to walk somewhere, and you're hanging off her legs. Please put her down or get out of her face." I have to say that quite a lot, you know. But she, she really likes him, you know. She says, "dada" for my husband, and she calls Noah "baba". She hardly ever says "mama" because obviously, I'm too much part of the furniture to have a name. But she's, you know, she's very – she had a little sound for him quite early on. She really enjoys seeing him, and she, you know, will sometimes – they will just be sitting together, and she'll just give him a kiss. And it's just so nice, it's lovely.'

Isla had become a more active participant in her relationship with Noah; she moved from dependence towards 'relative dependence' as an individual (Winnicott, 1963, p.87) and illustrated that she appreciated the need for reciprocity in relationships:

'At bedtime, she always blows raspberries on Noah's tummy because he thinks it's hilarious. She always puts, you know, she'll be reaching to the bed and wanting to sit on it because – and blow raspberries on him, because that's what she does every night, and she thinks it's hilarious.'

The friendships that Noah had, Ruth felt, were essential for Isla's development as she started to form relationships with Noah's friends and their younger siblings. Isla was starting to develop peer relationships. She looked toward the future and the relationship that she hoped Noah and Isla would have:

'I hope that she and Noah stay friends as they grow up. I'd love them to stay as liking each other as much as they do now. I suspect that it won't quite happen like that. But, you know, I'd quite like them to, as adults, be friends.'

8.3 A sense of calm

8.3.1 Reflecting on past experiences

Noah's birth and first year of life created a source of comparison for Ruth to measure her experience with Isla. She wanted this experience to be different:

'I think I've talked about Noah quite a lot, and I think that is because I don't have the second baby yet. So, you may come back after we've had this baby, and I will laugh my head off and say, "do you remember all those wonderful things I told you when we met before well, that was a load of rubbish". I'm trying to be prepared for the fact that everything will go out the window, but I also am hopeful that I do have more perspective this time of the fact that well, I think firstly to trust what we're doing and just stick to our guns and trust our instincts with it. I think my attitude is more relaxed about going with the flow of things, but we'll see.'

Ruth found Isla's birth and the experience of being a second-time mother a positive one in comparison to her first time, a state she seemingly introjected, with the resulting security in her role as a mother, feelings that she projected to others and Isla (Klein, 1946; 1952):

'I've got a lot of friends who've got two babies or who have had two babies, rather. And I'd say the majority of them have said their second baby is easier in terms of more content to play by themselves, that they are a bit calmer—all those kind of things. And we've, you know, I've discussed with them the fact that because we, as mothers, are calmer as well...So, I think there's a bit of that. You know, what you're doing not in a, not completely know what you're doing, but you're probably not going to kill them, kind of thing. But yes, some of it is probably because Noah felt very precious because we'd had a hard time with having him.'

She felt her more relaxed attitude toward Isla was a bonus and resulted in Isla being a more relaxed child; she viewed this as a positive for Isla. Isla, having the space to play by herself and develop as an individual (Winnicott, 1971):

You know, he (Noah) was a bit; we probably fussed over him a lot as well—much more than over her. I wouldn't say I wouldn't use the word. I don't think I fuss over her at all. "Do I? I ignore you?" [Addressing Isla]. I think one of the things I say to her a lot is, "oh poor baby, and you just got plonked in that chair again, didn't you?" I think it's fine because I think she has; it does build a bit of ability to play by themselves and not to require attention all the time.'

8.3.2 Dealing with conflict

As Isla matured, she was able to express how she was feeling, not always liking what Ruth had planned; car journeys were a particular problem. Ruth focused on finding

ways to deal with Isla's emotions. Avoiding conflict was important to her; she acknowledged the environmental influences upon her:

'I would try not to, you know, shout at her or be rough with her in any way because my experiences of being brought up and watching other parents and, are that that's not a nice family atmosphere.'

Isla, when she became upset, would project this distress onto Ruth (Klein, 1946). Ruth attempted to manage her feelings positively, in a way that reflected Bion's maternal reverie (Bion, 1962a; Bion, 1962b), through trying to reframe her emotions into something less difficult for Isla. However, it was not always possible to manage Isla's emotions positively, as she reflected here on dealing with Isla's distress:

"'Oh dear, that's a horrible noise,' or something like that. Just a kind of calm, 'well, I'm sorry, but I have to take the cotton wool packet away.' And just chatting to her. I think in the car if it's stressing me out if she's shouting at me in the car and I'm just tired, and I don't want to be, I don't want to hear that, I think I probably am a bit less calm about it. I probably, you know, am calling back to her, 'that's enough now; I don't want anymore; can you please stop screaming.' That kind of thing. I try not to raise my voice back to her. It's hard sometimes. Sometimes you just have to go, 'aargh. Please be quiet.'"

Maintaining Isla's sense of calm depended upon Ruth working out what she wanted, *'I think most of the time I get it right because she's not an unhappy baby. She doesn't spend long periods of time crying, which I think is partly her. And partly being able to judge what she wants reasonably.'* Finding activities that met Isla and Noah's needs was a challenge and something that she felt was essential to maintaining a sense of calm at home. The right activity resulted in time well spent together and encouraged them to enjoy each other's company. Ruth felt this cared for everyone's sense of wellbeing. She demonstrated the ability to consider how Isla might feel about an activity, in effect mentalising (Fonagy, Gergely and Target, 2007):

'We actually took her to nursery rhymes at the library the other week, which was something specifically for her. But her brother came too. And he really enjoyed taking her, and I enjoyed the fact that we were doing something for her rather than something for him that she came along too. Or something for me that she

just gets carted around for. And she enjoyed it. She was kind of looking at the other babies. You know, you could almost imagine she's thinking, "Oh, there's other people the same size as me; this is something for me." Yes, and she, she was, you know, she was quite happy during that. She enjoyed the songs, you know, she was looking happy and watching the music and engaging with it. And yes. So, it's partly for her, it's partly for me, it's partly for her brother, partly just to get us all out of the house.'

8.3.3 Acceptance

Ruth continued to build on *'the experience of having looked after a child through babyhood into being a young child, as he is now, has given me more confidence in looking after her.'* Having Noah to compare Isla, too, meant that she felt *'that my instinct is right, that if I think she's okay, she's all right. And if I think something's wrong, it probably is.'* As a result, she was a *'bit kinder'* to herself and *'bit kinder to her.'* By being a *'bit kinder'* to herself and Isla, she talked about managing her expectations of herself and Isla, particularly concerning Isla's physical development. Now, she could draw upon what was usual for her children and contain her anxieties regarding their development. It is suggested that child development occurs within the child's particular socio-cultural context (Rogoff, 2003; Weisner, 2002; 2014) and that the initial environment is the relationship between the infant and their first carers.

Having this knowledge gave Ruth more confidence in her mothering:

'I think it's marvellous that she doesn't crawl; it makes my life much easier. Whereas with Noah, I was really anxious about him not crawling, and other people would say, "Are you worried that he doesn't crawl?" And I'd say, "Well, a bit." And then it would make you think, "yes, why doesn't he crawl?" Whereas I know I was pretty sure she wasn't going to crawl because babies in our family just don't seem to crawl.'

This confidence in her abilities may have provided Ruth with the space to help manage Isla's more challenging emotions, as she reported the ongoing need for patience in helping Isla overcome her frustrations; at just over a year, she was keen to walk but unable to do she was heavily reliant on Ruth, with implications for their relationship:

She's worked out that I will always walk around with her because that's what she wants to do. And I'm her slave. So, I think it's important for her, you know, she won't learn how to walk independently unless she does all the practising of walking with a person. But it does mean she's probably a bit more fractious with me because that's all she wants to do. She won't sit and calmly play like she does with other people.

Ruth seemingly felt it was necessary to manage life by accepting situations; her behaviour toward Isla imitated this. Isla was able to project her frustrations onto Ruth (Klein, 1946) and Ruth appeared able to provide maternal reverie for Isla (Bion, 1962a; 1962b), potentially helping Isla maintain a sense of wellbeing. By the time our interviews came to a close, Ruth had determined that she wanted her children to be *'kind of content with things that you have.'* Ruth felt that this resulted in happiness. As she elaborated:

'The most important thing is that you can be happy with what you have or content with your current situation. And not always be trying to change things or look for what's going to happen in the future to make things better. That actually being happy, like, yes, being content and being able to make the best of a particular situation is quite important, I think. And I think that's how me and my husband live, is that we, you know, we are aspirational, but we are quite good at making a situation work for us. We'll just say, "Oh well, this is fine, this is fine, we can do this, we can work with this, we don't need extra things to make this work."'

8.4 Being close

8.4.1 Thinking of the future

Ruth kept her children physically close as babies, viewing this as essential to the development of their wellbeing. At our first interview, she explained how this had worked with Noah; although not easy, it was worth the effort:

'Lots of hugs and cuddles and them being able to come and have that physical closeness whenever they want, which has its downsides – I spent at least an hour and a half in Noah's bed last night because he wouldn't go to sleep without me in his bed. There's that physical closeness which I think is really important in making you feel loved and then I suppose there's a kind of trust as well which I think is probably important, of a child knowing they can come and either when they're old enough have a little chat to you or before that that they trust you'll always be there to look after them or pick them

up, whatever they need. That's something that I remember quite a lot from Noah is getting to the point where I felt like I hadn't had any kind of physical break from him for weeks and weeks and weeks. Which can be really hard, I think, you can feel quite shackled to them in a way, but it's not forever, and the benefits are absolutely huge, and most of the time it's wonderful.'

Ruth continued with this practical approach in the first few weeks of Isla's life; *'I think they should be cuddled and rocked and fed to sleep at this age.'* Ruth linked close physical contact with security, her approach affiliated with attachment theory (Bowlby, 1969) and mentalisation (Fonagy, Gergely and Target, 2007) illustrated by her ability to think through how Isla might feel. In turn, she felt her actions would lead to Isla becoming the child she wanted her to be:

'I want her to feel secure, that she gets milk whenever she needs it and cuddles whenever she needs them and that we have that kind of physical closeness, and I carry her in the sling quite a bit, and she is very happy in that. So ideally to kind of foster that sense of security for her and that she is safe and warm and loved and that can only lead to good qualities in her.'

Ruth felt pleased that she managed to get Isla to sleep without feeding her by the time she was 3 months; however, continuing to maintain physical contact was important:

'I actually fed her and then put her down awake, and she did actually go to sleep with me lying next to her. She likes me holding her hand, which is really sweet, it's very sweet. So, it's, you know, I can't be annoyed with her as she's holding my hand, or she just wants the hand on her cheek.'

Ruth believed that Isla's biological needs were fundamental to feeling secure. Meeting these needs would result in Isla's emotional well-being. However, Ruth's future goal was the relationship she desired with her daughter:

'I think that's quite important for her to feel that there's someone there, you know, to look after her if she needs it... Having that physical closeness as well. So, you know, her sleeping in the bed close to me. She gets carried around in the sling quite a lot. Probably use the sling a lot more than the pushchair. Yes, I think that kind of encourages that security of you know, you're always physically close. On just a physical or a biological level, babies need to be close to their mothers to protect them. So, I suppose it's that very kind of basic natural feeling that if you're physically close, then they're safe. I mean, it does mean that I'm now stuck standing up, swaying, holding her while she has asleep, but you know, I can deal

with that. Cuddling a baby is not the end of the world. So, it's very nice. You know, I have got friends who say that their babies are not cuddly. Where it's usually when they get a bit older, I suppose that their toddlers don't, won't cuddle them or won't come and sit on their laps or come for hugs and things, and to me, that feels very sad. I've got an extremely cuddly toddler which gets a bit annoying sometimes, but most of the time it's really lovely.'

8.4.2 A mutual need for comfort

Isla's ability to go to sleep without physical contact at 3 months was short lived; as Ruth's return to work beckoned, she focused on finding a way to get some sleep and cope:

'I think we're managing; I think we're all tired, but most of the time it's completely manageable. We've actually just bought another cot, a second-hand cot, to put in our bedroom. She's in her own room, but we just go in and out of it all night. It was the spare room, so it's got a bed in it. So, we spend quite a lot of time lying on the bed with a hand in her cot because she likes to hold a hand or something.'

Ruth felt there was no other option but to find the situation 'manageable,' it was what she needed to do for Isla. At times though, it did become too much:

'Occasionally, it's quite stressful. And occasionally, I get fed up. And to a point of, "I don't want to be dealing with this anymore; this is ridiculous." And we had one night where we let her cry, and she cried for about an hour. My husband was in there with her, but I just said, "She doesn't need feeding; just go and be with her." And she cried for about an hour and went to sleep.'

As Ruth and I got to know each other throughout the interviews, she appeared to feel more able to confide in me about her needs, as illustrated in our penultimate interview. As this interview excerpt below appears to reflect how Ruth's feelings regarding her need for comfort seemingly projected onto Isla (Klein, 1946), perhaps to manage her emotions regarding what it meant to be alone:

'I think it's comfort. I think she likes to be around people, and she's used to having reassurance at night that someone's there, I think, which is completely understandable. You know, I always think I sleep in bed with my husband because it's a nice comforting thing to be together. Why should I expect my children to sleep in an isolated room without reassurances that their parents are there? I know I get fed up, and although I think it's a bit annoying, and she, you know,

should really be sleeping better, but I don't like that idea of that she should be doing something, and she needs us through the night.'

When Ruth returned to work, she expressed being pleased with the child Isla was becoming. An affectionate relationship was developing between them as she hoped.

She described how Isla related to her as she collected her from nursery and her reactions to other family members:

'Then she kind of cuddles into me, and then she'll kind of pull back and look at my face and pats my face a bit and then cuddle in again. She's just, she's just so affectionate and delighted that I'm there. So that always makes, almost makes it worth leaving her. So that's, you know, I think, I think she's a very, she is cuddly, she is affectionate. And she's always pleased to see someone she hasn't seen for a while. So, when my husband gets home, she'll shout 'dada'. And shuffle towards him if she can or lift up her arms for a cuddle.'

8.5 Determining how to mother

8.5.1 Mothers

Establishing social networks with other mothers appeared essential to Ruth. On expecting Noah, her two older sisters who had six children between them had *'talked a lot about the people they've met since having children and how important it is to have other people around that you know.'* Despite the sisterly advice, she did not view either them or other family members as prime sources of support in those first early months with a baby, as their advice was considered outdated. She was keen to establish relationships with other mothers, and for Ruth *'one of'* her main worries about moving when expecting Noah was the fear of isolation *'I like having people around me: I'm not very good just by myself.'* Encouraged by her sisters, Ruth found the details of a National Childbirth Trust class on a Saturday, to which she and Matt drove down for as *'it would be great to know a few people in the same position as us before we moved.'*

When I met Ruth, the relationships she had established with some of the mums she met at this group were essential to managing any anxieties regarding mothering:

'I have been asking everyone what the most useful thing for them was when they were in labour because I didn't do labour last time, I don't know what it's like, and lots of them have done it twice. So that's an example of what I would ask them and just because it's lots of different people who have had lots of different experiences of labour that's quite useful and I trust them.'

These mothers were the people she turned to in the first few months when she had concerns regarding Isla:

'I had forgotten about the battle about trying to get them to go to sleep in their Moses' basket rather I just remember that I suddenly had this flashback of hours and hours of putting them down and them crying and you pick them up and they go to sleep, and you put them down, and they cry, this kind of thing. So, I did the "WhatsApp" Group, and I sent out anyone got any good tips for how to do this because I can't remember how I did it and got lots and lots of ideas back – a few of which we tried, and which are working quite well.'

8.5.2 And others

As Isla grew, Ruth turned her attention to the different parenting styles that her children required. She distinguished between 'bigger things' – and what she considered minor aspects such as weaning:

'You don't necessarily choose how you're parenting. You just react in every situation. You know, I don't, it's not as planned as thinking, "ah, I'm going to say this now," or "I'm going to pick them up now" or "now I'm going to do this." You know, there are some bigger things that obviously you would plan, like how you're going to discipline them.... when they're weaning, how are you going to do it? Are you going to do purees, or are you going to give them sticks of food? You know there are bigger decisions.'

As Ruth considered the 'bigger' aspects of caring for a child, she acknowledged the influence that others had upon how she chose to care for her children:

'I've seen other people parent and other things I've seen people do and thought, "oh, I don't want to do that. Or that looks like it works really well, or I really agree with that kind of thing." And it's not, and that's what I mean, it's not always going to work for your child.'

Ruth felt that she wasn't always aware of these *'influences...you don't even really notice you're taking on until you're trying out different things with your own children.... I don't really choose how we parent. A lot of it is instinctive. Just responding.'* Ruth's upbringing and her mother or father's influence was not a significant part of her narrative. However, she acknowledged unconscious influences in her story, reflecting how she might have internalised childhood experiences, which played out in her relationships with Isla and Noah (Chodorow, 1999).

8.5.3 Being an expert

As Ruth settled into mothering two children, she emphasised her autonomy in deciding how to care for them. Although she looked toward her friends for support, it became imperative for her to illustrate that she was different and not a follower of trends:

'I'm not extremely against particular things or extremely for particular things. It's just kind of a, well, everything in moderation. And you know I think things like weaning, I suppose, I had a friend, a few friends who were, baby-led weaning is the only way you do it. You never give them purees. Everything has to be finger food. And then other friends who were, "oh, well, they just have Ella's pouches the whole time and whatever." And actually, they all end up eating, you know. It's not; it doesn't seem to me to be massively different. And I was talking to my sister about it the other day, and she said when she had her first two children ten years ago, the fashion was purees, and then when she had her third and fourth children, the fashion was finger food. And, she said, "it's just fashion."'

Interestingly the NHS (2020) has up to date weaning guidance for parents; however, Ruth's perspective reflects the array of information available to mothers from other sources and the problems associated with the constant comparison between mothers in their childcare practices. This behaviour may reflect the need for mothers to demonstrate expertise in their child's care, consistent with other research in this field (Miller, 2003; Miller, 2005).

Ruth felt that mothers could *'only be an expert on your own child, and so you have to just do what is, works for them and not, and try not to get too wound up or stressed about it.'* She wanted *'to do what's best for her (Isla) and try and ignore. Or not ignore advice. I don't mean ignore. I meant not to try and be too strict about following a particular regime or fashion.'*

As Isla matured, her behaviour impacted others besides Ruth. Unencumbered by the worry of caring for a new infant, she was able to direct her attention to the *'bigger'* issues. The stuff of mothering that interested her was how Isla's behaviour *'affects other people:'*

'If she pulls her brother's hair, it hurts him. If she takes something that another baby was playing with, that baby will be sad. I suppose basically it's, it's down to that. It's being you know, not, not negatively affecting other people. So, that's probably how I would make a decision about it. If she's doing something and it's not really affecting anyone else, and I don't care if she's doing it, I'm not going to tell her off for it, which is, yes, it's a principle that I, I suppose I – it's a bit unconscious.'

Ultimately, others' perceptions of Isla were a concern for her. Ruth was concerned with maintaining both her and Isla's performances in the *'front stage'* aspects of their lives (Goffman, 1959, p.129). These perceptions perhaps reflected her ideas of Isla's legitimacy as a person within her socio-cultural context and how others, as a result, might perceive her behaviours and actions as a mother. Here she described the qualities she wanted Isla to have:

I suppose that's what I think of as kindness, of being a good friend or a good sibling or being a positive person is, is having a positive impact or effect on the people around you. I probably think about people and relationships quite a lot. That's probably what I'm interested in.

As well as wanting Isla to have positive social outward behaviours (Goffman, 1959), although Ruth wished for Isla to be an individual, she wanted her to have collectivist socialisation goals, the ability to accept and value others (Park, Coello and Lau, 2014).

8.5.4 A sense of an ending

At our final interview, Ruth recognised the support and influence she received from her sisters. However, she accepted that as her children grew, she had more in common with them and felt that her mum friends' relationships might someday be no longer relevant to her life. Whereas her sisters were an ongoing relationship, and they shared a past:

'I talk to my sisters quite a lot. Both of them have children who are older, but, as my children get a little older, I think I have more, I think I have more to talk to them about. I think the kind of baby stage is very specific to itself, as is the toddler stage. But then probably, when you're past that into the kind of child bit, I may, you know, be completely wrong, but I feel like the things that you focus on are more similar if you've got a four-year-old or an eight-year-old. I have found I can relate more to what my sisters are talking about with their children now that certainly one of mine is a little bit older or out of that kind of baby/toddler bit.'

I sensed the beginning of an ending and the start of something new emerging. Ruth and I were looking to the future, with transitions ahead of us both, me to subsequent steps in my research, she, to the next stages of her children's development and the significance for her life and relationships. In our last interview and Ruth contemplated how the meaningful relationships she had taken such pains to develop with other mothers might conclude as their mutual need abated:

'Whereas there's certainly lots of people who, our friendship is just because we have children the same age and we go to the park together and – and it's lovely. But quite aware that those friendships will disappear as you get new, new relationships, you know when they start school or meet new people. You can't fit everyone in your life, can you?'

Instead of defining relationships on her terms, Ruth realised them for what they brought her children. She developed friendships to meet both her, Noah and Isla's needs as she navigated their childhood and imagined the new relationships they would foster in the future. Ruth's attitude brought home the all-encompassing nature of motherhood encouraged in our society, Hays (1996). Nevertheless, as Adrienne Rich, back in 1986,

pointed out, becoming a mother is only one aspect of a woman's identity, 'we need selves of our own to return to' (Rich, 1986, p. 37). I could not help but think about what Ruth's future might bring as her children grew and moved away from her.

In the next three chapters, I present a thematic analysis of the data, with each chapter reflecting a theme. Integrated through each chapter is a discussion of the findings situated within a psycho-social framework. In the following chapter, Chapter 9, I outline how the findings and discussion are organised and then present the theme of evolving maternal identity.

Chapter 9: Findings and discussion

9.1 Introduction

Throughout the following three chapters, I present the thematic analysis of my study. I discuss the three themes identified during the data analysis separately, starting in this chapter with ‘evolving maternal identity’, ‘growing a person’ in Chapter 10 and finishing with ‘creating a safe space’ in Chapter 11. The findings emphasise the developing maternal-infant relationship and the significance to both maternal and infant wellbeing. Fundamental to this developing relationship was the socio-cultural context where the mother and her child lived, alongside existing and emerging social networks. Given the hermeneutic nature of the research, I have presented the results alongside my interpretations using a psycho-social framework; these theories are introduced in Chapter 2, outlining which ones I will use at the start of each theme. A discussion of the findings is interspersed throughout these three chapters. This chapter begins by explaining how I have organised the findings and introduces the three themes of evolving maternal identity, growing a person, and creating a safe space.

Throughout the thematic analysis, I have tried to maintain the sense that this was a longitudinal study by capturing the participants' experience as it has evolved. This

analysis reflects the ongoing everyday care of their child and captured where relevant the temporal nature of their situation. The analysis gives voice to mothers to express how the maternal-infant relationship develops over time, the relationship developing in response to their mutual needs as the mother works to create and sustain identities for herself and the infant that will fit within their socio-cultural context and individual situations.

A reminder of this study's research questions and objectives are in Figure 10.

The research questions were to explore:

1. What are the influences and experiences that help to construct maternal perspectives of infant mental health?
2. How do maternal experiences of infant mental health influence the behaviours and strategies mothers may use with their infants?

The objectives of the research were to:

1. Consider how mothers perceive their infant's development and the significance they place on infant mental health and well-being.
2. Explore maternal perceptions of infant mental health; to what extent are these influenced by their personal narratives and societal influences.
3. Explore the extent that maternal behaviours with their infants are shaped by perceptions and knowledge of infant mental health.
4. Reflect on infant behaviour with their mothers and explore how they believe this behaviour is shaped.

Figure 10 Resesarch questions and objectives

Evolving maternal identity emerged as the dominant theme; however, the themes were all interdependent. Growing a person, both maternal and infant, and creating a safe space required the development of a maternal identity that could manage this in a way that met perceived socio-cultural requirements for parenting.

9.2 Evolving maternal identity

9.2.1 Introduction theme evolving maternal identity.

Motherhood is a place ‘where nature confronts culture,’ women are ‘masters’ of a biological process that belongs to them (Kristeva, 1980, p. 304). However, the biological process results in a woman becoming a mother with all the socio-cultural expectations that the role entails, forming a maternal identity. There is a tendency to view the concept of a ‘mother’ in line with the word's patriarchal construct, which emphasises a biological basis and essentialism (O’Reilly, 2010, p.7). There are challenges to this perspective, which proposes that identities are multiple and that the act of mothering can be undertaken by those who engage with the practice of mothering (Ruddick, 1989; O’Reilly, 2010; Takševa, 2018). Accepting that identities are multiple, we reflect on whom we want to be depending on the audience. As we share our stories internally, we reflect upon our experiences, using this knowledge to recreate

and present ourselves in further interactions. It is suggested that we create ourselves in this space, the self we offer, not a true reflection of that inner space, but the self we want to be recognised by others, forming a narrative identity (Benjamin, 1988; McAdams and McLean, 2013).

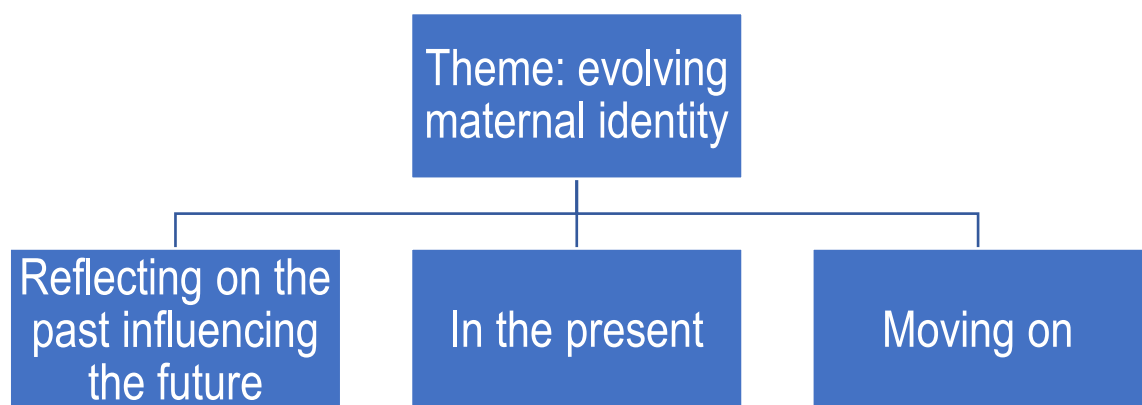
In terms of motherhood, it is proposed that the public face of how we want the self to be recognised takes the form of maternal identity. The idea of what it means to be a mother is experienced powerfully within our society, shaped by psycho-social and cultural expectations, that is driven by what it means to be either a good or bad mother, aligned with perceptions relating to social class and moral purpose (O'Reilly, 2010). The presentation of an accepted maternal identity might suggest to others the legitimacy of that person and, by association, their child. Regarding their identity, the maternal self was present in participants' narratives, an identity in progress, unfinished and changing in response to their lives and their child's needs.

Three sub-themes emerged as part of this theme, reflecting the temporal nature of being a mother, Figure 11 illustrates the organisation of the sub themes in relationship to the theme of evolving maternal identity. Experiences of the past direct the present future, while historical context guides mothering practices. The first sub-theme considers influences from the past, while the second sub-theme focuses on the present day; the final sub-theme concludes with a consideration of how participants adapt to their mothering role as life continues and their child grows in the theme ‘moving on.’ The psycho-social theories I draw upon in this chapter are Kleinian, relating to the management of anxiety (1935; 1946; 1959), object-relations (Winnicott, 1951), intersubjectivity (Stern, 1985), ecological systems theory (Bronfenbrenner, 1979; 1992), Goffman, on impression management (1959) and intensive mothering (Hays, 1996).

Figure 11 The relationship of the theme evolving maternal identity to the three sub-themes

9.2.2 Reflecting on the past influencing the future

This sub-theme explores how the past influences participant experiences of mothering today; participants adopted a critical lens to their experiences of being mothered and the



contribution from their partner’s mothers. Experiences of being mothered helped them

imagine and create the sort of mother they wished to be, considering both the positive and negative aspects of their previous experiences. In addition, these themes illustrated the significance of the relationships in their lives in helping them decide how to care for their child and how they might influence the emphasis they gave to aspects of their infant's wellbeing, such as their mental health.

9.2.2.1 Embracing the good, leaving the bad

Memories of 'being mothered' themselves influenced how participants wanted to mother their children; they made judgements regarding their childhood experiences. Therefore, the nature of what it means to be a mother is reflected through an intergenerational lens yet considering socio-cultural and economic factors (Thomson et al., 2008). Memories of 'being mothered' was a subject that participants drew upon early in the interviews, during the first or second interview. Becoming a mother, a possible way of connecting to her mother (Kristeva, 1980; Rich, 1986) but unaware at times of the influence of this experience. As Hanna explained:

'My mum is very um, energetic person but also quite short-tempered, so she would, for example, shout a lot, not in an aggressive way, that was just the way that she expresses herself, and that is something I remember as a child being quite, I didn't quite like it, so I am very aware of not raising my voice at all, not just with the baby, but in general with my friends with anybody so I think I'm quite aware of my mum's mistakes, and I am hoping consciously not to do the same, whether that is going to work or not we will see.' Hanna, Interview 2.

Hanna appeared aware that she might have limited control of her unconscious in how she related to Freddie and that behaviours learnt early in childhood might be challenging to control. Hanna appeared to appreciate the possibility that she may have introjected some of her mother's characteristics (Klein, 1959). 'In every nursery, there are ghosts,' whereby unwanted behaviours and events from the past are repeated

(Fraiberg, 1980, p.164). The intersubjective nature of our relationships, creating learnt patterns of behaviour formed early in life (Stern, 1985). Some participants recognised maternal influence, defining their adjustment to becoming a mother. Hanna contrasted the above critique of maternal behaviour with a positive outlook:

'My mum was stay at home mum for when I was a kid, and it was affecting massively the fact that she really paid attention to, to give us as much you know as much maybe not knowledge but it, it was the random things she was doing with us, it was loads of reading, loads of singing, loads of sightseeing trips, activities so that for sure is something I want to.' Hanna, Interview 2.

Participants identified aspects of childhood relationships that they did not want to repeat within their own families. Thus, wishing to correct what they viewed as possible mistakes from their childhood (Parker, 2005). As Mary explained:

'If we have another boy, which I think we are going to have another boy, I don't want it to expect it to be the same as Joshua in any way, and I don't want Joshua to rule the roost completely like I think my sister did looking back. I am sure there was an incident when I was about 2 when she pushed me off the swing, and I am sure she wasn't always very happy about having a little sister.' Mary, Interview 1.

Ruth recalled her own experiences as a teenager, desiring a different relationship for herself and Isla:

'I can't even begin to think how you deal with teenagers. I was a horrible teenager, and I don't know how my Mum put up with me, and I don't know how I would. We had some quite acrimonious conversations when I was a teenager (me and my Mum), and I wouldn't like to think that I would be like that.' Ruth, Interview 1.

While Tess reflected upon her mother's attitude to discipline, wanting to set her path and establish her way of doing things, commenting in interview one, that *'we've had a lot of unsolicited advice, especially from my Mum, saying "why would you do that?"'*

These discussions particularly centred on discipline, as Tess explained:

'My Mum was quite strict, but I don't think it did us any harm. I think it is quite good to have set boundaries and I think that helps when they go into school and education and helps them in later life. I probably wouldn't be...my Mum was very strict in that we got the wooden spoon if we were naughty so I wouldn't go quite that far, but I do think it's really important to have quite set boundaries.' Tess, Interview 1.

For several participants, the memories of 'being mothered' were overwhelmingly positive and appeared to reflect the mother's societal and cultural views as giving all to her child, absorbing the master narrative regarding motherhood- a rather patriarchal perspective (Rich, 1986; O'Reilly, 2010). Fran described the introjection of qualities she considered essential for being a good mother, from her mother, and her subsequent projective identification of these onto her children (Klein, 1955):

'My mum was also quite good at my opinion at bringing us up socially, we were confident with other people so never struggled when we went to new places, so we never had any anxieties about trying new activities or getting involved in new clubs and new opportunities that we were given to participate in extracurricular activities. (How did she do that do you think?) I think it's about the time you know giving; I know that she gave up a lot of her life and literally ran around after her children. I suppose that's what I've tried to do; I need to work two days, but actually, I wouldn't work at all...' Fran, Interview 1.

9.2.2.2 Values

Participants considered value systems they experienced during childhood and promoted and reflected upon these during the first year in their mothering, with some modifications. Here Ruth described the influences of both her and her husband's parents on their approach to their children:

'We probably both picked up the values that I was talking about being important, being polite, gentle and sharing earlier from our childhoods. Neither of us grew up in a house where there were ever raised voices or arguing, noisy arguing or anything, so actually, we're both very bad at dealing with that kind of thing. It is something we would try very hard not to do with our own children.'

Ruth, Interview 1.

While Natalie acknowledged that although these past values were important, times had changed, and there was room for modernisation:

'I'm very conscious of how I was raised and raised with manners. And I guess when I was little, there was a lot more of 'children are seen and not heard.' So, we're not kind of going down that route, but definitely, you should be polite and respectful to adults.' Natalie, Interview 4.

Tess, in her story, in Chapter 10, captured these values in positive aspects of maternal care that she wished to return to, as did Ella:

'We always had animals around, so I guess that's a big influence. Being out in the garden. Yes, Claire, it's more Claire at the moment, she's growing lots of seeds and things, but he sits in the pushchair and watches whilst we're potting and doing things. So, I guess that was my childhood that then has an influence on...what my mother used to do with me.' Ella, Interview 5.

9.2.2.3 Intergenerational mothering

Both mothers and partner's mothers (mothers in law, participants language) were asked for help in varying degrees by participants, with three participants drawing upon them for regular support for their childcare on return to work. The geographical distance between family homes was no barrier in asking for other forms of support, such as advice or just a listening ear; mothers and their families used social media to stay connected. Impediments seemed to originate from the dynamics that existed within the relationship. As Ruth described in interview one, *'neither my Mum or my mother-in-law would try and advise us on how to do things unless we specifically asked for their opinion.'* Whereas Natalie reflected otherwise:

'If it's family, then it does have an influence; from my Mum and my mother-in-law, I value their opinions and their suggestions, and that has quite a big influence on how we do things.' Natalie, Interview 2.

For others, it was about having the support but possibly trying to establish their own maternal identity, maintaining a sense of control, as Tess explained:

'I trust my Mum to look after the baby, and although she was very strict with us, I do know that she would respect what I want; I do trust that if I said "I don't want you to do that" or "I don't want the baby to eat that" she would respect that. I would be quite happy to leave the baby with my Mum even though we might not necessarily agree how things are done; she would respect my views.'

Tess, Interview 1.

Some grandparents were keen to be actively involved, and mothers found themselves open to criticism, having to stand their ground as Hanna described her mother and father's concern for Freddie's health:

'And the obsession problem with has he got cold feet? And Mum, it is twenty-four degrees, and he doesn't need socks! And when he had a blocked nose, and on WhatsApp, my father is "why has he a blocked nose? Where did you take him?" Because they are putting blankets over him, and I said why? He needs to regulate his body temperature somehow.' Hanna, Interview 4.

Participants valued up to date information in infant care, commonly using apps, books, and websites. Mary described using the 'baby buddy app' (National Health Service, 2021).

'It just gives you advice, and then there is a pregnancy one, and it gives you relevant advice to whatever weeks pregnant you are, and when you put the information in, it comes up with Joshua's and Harry's names and tells me what I should be doing.' Mary, interview 2.

Up to date information regarding childcare or recent experiencing of mothering mattered to participants. As Hanna, who relied heavily on her mother for emotional support, commented when describing where she obtained her information relating to childcare:

'Mostly the internet because, you know, because what my mum is telling me – Jesus Christ, it's all the, all the ideas from thirty years ago, thirty-five actually. Or even longer. It's not – and she says, "Oh, when you were a baby, I was – you were thin, and I was giving you rabbit stew." And I was like, "Ooh, thanks, mum! That's not going to happen." So yes, so yes, it's just that – so yes, we turn mostly to that.'

Hanna, Interview 4.

Bronfenbrenner (1989) considers how the socio-cultural context, the macrosystem, influences the microsystem of child-care and development; please see the discussion regarding Bronfenbrenner's ecological systems theory in Chapter 2, section 2.5.2 (Bronfenbrenner, 1979; 1992). These systems are situated within a historical context, with their associated knowledge and beliefs regarding childcare, influencing the care that the child receives directly from caregivers within the microsystem (Bronfenbrenner, 1979; 1992). The environment in which the child is raised is thought to constantly change in response to the interplay between internal and external factors. This temporal consideration to child development is what Bronfenbrenner (1988, p. 83) describes as the 'chronosystem.' Ella explained whom she looked to for advice; however, the historical differences between childcare then and now influencing how she perceived their contribution:

'Mum and your mother-in-law, but things are very different when they had their children 40 years ago, and that's one thing that they both say to me when they had their children one was in hospital for six days, one was kept in for ten days, you definitely weren't in and out. Even registering the birth, the Registrar came to the hospital and registered, but that's how things have changed.'

Ella, Interview 2.

Using Bronfenbrenner's (1988) chronosystem, it is possible to see how maternity care changes have altered the nature of the first few days of care that the infant receives in one generation, as the expectation is now that most mothers will manage at home.

Regardless of the lack of contemporary thinking, Ella appeared to mourn for the idea of a mother who was unable to support her due to an ongoing mental health illness despite living close by. Ella was in the carer's role; her mother's identity as a mother seemed spoiled by the illness (Goffman, 1959). Contrasting sharply with her mother-in-law,

who was keen to help and showed an interest in the children but lived some distance away:

'I think some of the things that makes it harder is that Frank's mum, who is probably the most hands-on granny, that she's so far away,' Ella, interview 6.

Fran reported a supportive and valued relationship with her mother, part of which, she described:

It wasn't necessarily an expectation that my Mum should have Toby on two days so that I could work or so they could bond. But it wasn't a surprise when she offered that she would do that and that she wanted to do that and when Toby is three, he'll go to pre-school, he goes one morning a week now, but he'll go and have his 3 hours and Jessica will go to my Mum while I go back to work part-time, and that's kind of how it's always been in our family.' Fran, Interview 3.

Despite the positive relationship with her mother, Fran preferred to use up to date health information and advice when caring for her first child, as she explained:

'My Mum will say well temperature for example because again this is going back to with Toby I had a grow egg in the room and would follow the advice that is on all the parenting websites from the hospital or the health visitor about what temperature the room should be and what you should dress them in and my Mum always said that I made Toby too cold, she was like "he's cold" all the time, and sometimes I'd feel I would be quite short with her in the end "well that's what I want, I want him to wear that that's what the health visitor said" and my dad would always joke "oh you can't do anything unless the health visitor says it Fran" so that was you know we'd have disagreements about the physical things like that....' Fran, Interview 3.

However, Fran continued, admitting that *'actually this time I don't even know where the grow egg is, oh there it is on the floor and not plugged in by the telly.'* In the present day, Fran preferred to disregard both health professionals and her mother, going with her own *'feeling,'* adopting an instinctive and intuitive approach to her children's care. Participants referred to intuition in caring for their children; some, such as Tess, acknowledged maternal influences in developing this, as she explained when describing making decisions for how she chose to mother Georgie, *'the way that my mum treated*

us as kids. She was very present. Yes, I think that's probably the biggest thing. A lot of it is intuitive; it's not something that I think, "Oh, I'll do that because..."

It is hard to disentangle the concept of instinct from previously learnt patterns of behaviour and childhood experiences, alongside socio-cultural influences of which we are unaware. The idea of relying upon instinct within maternity and childcare is discouraged as motherhood has become professionalised, reflecting mothers increasing responsibility for child outcomes (Parker, 2005; Macvarish, 2014). The teaching and adoption of useful parenting skills are, considered by some, equivalent to the parent-infant relationship, with the use of instinct and child-care based upon folk knowledge heavily discouraged by experts within the field (Lee, 2014). Participants discussed using instinct and intuition in caring for their children, also relating this to childcare choices that they were not consciously aware of, as Ruth explained, see Ruth's story in Chapter 8. Nevertheless, the situation is complicated as, for many years, women were encouraged to think of themselves as having a natural ability to mother when the evidence for an instinctive ability to do so is lacking (Chodorow, 1999). However, for these mothers, the awareness of an instinctive response to their child appeared to affirm their expertise and the uniqueness of their relationship, giving them the confidence to challenge family and professional influences (Burman, 2017; Stern, 1985).

9.2.3 Summary of the sub-theme reflecting on the past influencing the future

The use of current health and developmental psychological advice encourages mothers to disregard the support and guidance that they might get from their families (Burman, 2017). Effectively promoting dependency upon systems and structures within society, rather than upon those they might be closest to, encouraging what Foucault (1982,

p.777) terms as 'dividing practices.' Illustrating the influence societal factors have on how infants are cared for, affecting their development and, it might be argued, the mother-infant relationship. Given the apparent societal pulls, it was understandable that participants looked upon support from their mothers and mothers in law with a critical eye, viewing them as in common with other research as out of touch with current practice (Thomson et al. 2008), reflecting the historical context of mothering care. Despite this, there was evidence that these relationships loomed largely in the formation of the maternal-infant relationship from both a critical and positive way in the mothers' choices regarding their infants' care. Participants created a narrative by claiming to use instinct and intuition, which emphasised their expertise as a mother. Potentially participants used the concept as resistance against professional discourses to establish their omnipotence within their infants' lives and affirm their identity as expert mothers, a role expected of the master narrative (Hammack, 2008). As participants believed their mothers and families were outdated with modern thinking, they tended to turn to their peers for support; however, the extent of this support had limitations, a subject I explore in the following sub-theme.

9.3 In the present

This sub-theme explores the present-day influences upon maternal identity. Firstly, I consider mothering as a 'front region' or front stage performance (Goffman. 1959, p.109), illustrating how mothers felt it was vital for them to network with the other mothers and social groups that reinforced their perceptions of self as a mother, the mother they would possibly like to be. This emphasis by mothers on seeking this support from other mothers highlights the effect of societal influences on the role and

the need to possibly identify with a group that reflects the values they wish to embrace, thus influencing infant care. I then explore paternal involvement in their infant's care and illustrate the effect of maternal gatekeeping and paternal expectations of the maternal role. Lastly, all mothers, whether unconsciously or not, seemingly adopted intensive mothering practices (see Chapter 2) (Hays, 1996) that influenced mothering customs and perceptions of the care of their infant.

9.3.1 Mothering - a front stage performance

It is suggested that identities are adopted and performed, with participants assuming practices identifiable with those of being a mother and, therefore, others within their social network of mothers (Goffman, 1959). Arguably central to mothering customs are socio-cultural and historical contexts. In response, participants adopted and rejected practices that their mothers before them used and acknowledged applying instinct in caring for their child, see section 9.2.2.3, and as Mary said in interview five, *'I'm just using my instincts all the time,'* and as Hanna described how she made decisions regarding Freddie's care:

'I just Google it and whatever comes up. The NHS one mostly, but also (name of another country) websites. And then I kind of compare and see what's on both, and I kind of go with that. And also, really kind of my instinct...' (Hanna, Interview 4).

In doing so, participants possibly indicated the presence of unconscious influences upon their mothering that may have emerged from socio-cultural influences from childhood, as discussed in section 9.2, which may become conflated with biological and instinctive approaches. Mothering is an activity situated in identifiable practices and behaviours, props that help with impression management (Goffman, 1959). These practices and

behaviours are recognised as correct by society and arguably form part of a master narrative that influences mothering and perceptions of infant care (see Chapter 2). By managing their maternal identity, potentially mothers hoped to create positive perceptions of themselves, and by association their child, acceptability by others a positive step to developing relationships. Mothers formed networks with other mothers to seemingly establish their own maternal identity, focusing on those who echoed their perception of a good mother, reinforcing and sustaining their mothering activity. For some, this transition powerfully appeared to relegate other aspects of life that were less rewarding. Finding dissatisfaction at work and becoming a mother gave Tess something positive to add to her identity. When we discussed her fast-approaching return to work, she replied:

'Horrible. Yes, horrible. I think it would be different maybe if I have a bit more job satisfaction and it was maybe a job that I loved or...not that I don't like my job. It's fine. Like I don't have a problem with it, it's just not particularly stimulating mentally. For me, it's not like I'm going to go to work, and I'm excited about going back to a career because it's not a career.' Tess, Interview 5.

Tess had established a network of mum friends; during interview six, she told me: *'I guess we've probably all got fairly similar kind of parenting styles, which I guess is probably why we've kind of stayed friendly.'* Tess enjoyed the new identity she had established for herself, and her new mum friends were important in maintaining this. Tess championed practices that might be considered harmonious with a positive maternal identity; she embraced natural childbirth, breastfed successfully for 12 months, and aimed to keep going for the foreseeable future. These aspects of mothering identity were important to all participants to varying degrees; mothers heard others' stories. They wanted to share their stories of positive maternal identity experiences in front stage forums, such as the groups and antenatal classes they attended. For some

participants, friendships with other mothers formed a potential means of managing their ego and anxieties from internal and external sources (Klein, 1959).

I think, you know, over the last four years, since having Noah and then Isla, I've probably got closer and closer with friends who have children the same age, the same kind of stages. And I think I've mentioned before having a very close NCT group, who are all very like-minded, and we still see a lot of some of them. And they are probably big influences, probably on each other as well. We've discussed previously that we all breastfed for much longer than we might have done because everyone else was still doing it. And so, there was kind of a peer support or even a bit of peer pressure, I don't know, towards doing certain things. And those are probably the people that I have most parenting type conversations with.'

Ruth, Interview 6.

Mothers made friendships with other mothers who parented as they did; here, they found support and reinforcement of their childcare beliefs and practices. However, where mothers shared 'backstage practices' (Goffman, 1959, p.115) that they disapproved of, then they sometimes failed to find common ground as Fran explained:

'There's actually only one lady, one friend back in (name of a place) who had a very similar outlook to me, funnily enough, she's a reception teacher too, and so I used to speak to her quite a lot for advice, she already had a three-year-old, and now she's got another eight week old, some of the other mums I might mention it in passing, but without sounding harsh, I didn't value their opinion as much because in my mind the way that they did wasn't the way how I would do it, so it was interesting to know how they might, for an example I have one friend who for the bedtime routine for her 18 months is put him in the bed and close the door and leave him to cry and cry, and that just hurts my heart.' Fran, Interview 1.

At the same time, Fran was keen to guard her reputation and her 'backstage behaviours' (Goffman, 1959, p.115) when socialising with other mothers with whom she was unfamiliar—having two identities to safeguard both of a mother and early years teacher. Middle-class parenting values are viewed as the ideal within health and social care policy (Edwards, Gillies, and Horsley, 2015) (see Chapter 2), with research illustrating that the behaviours or perceived behaviours of a small group of the most advantaged

middle-class parents establish parenting practices (Dermott and Pomati, 2016). Fran, as an early year's teacher, was only too aware of this, here she explained how social class affects perception of parenting and the subsequent impact upon maternal identity within her networks, and the difference between 'doing' and 'displaying' parenting practices (Dermott and Pomati, 2016, p. 138).

'I have a set of friends who, to put it plainly, are quite well to do. And then I have a set of friends who are less well to do, and so their parenting styles are very, very different. And one group of friends would think actually that the other group of friends' style is probably unacceptable. I know that with my, with the set of friends who are more well to do, then I would discuss certain parenting styles with them that I wouldn't discuss with the others. You know, I might secretly, you know, not to sound arrogant, I might simply turn my nose up at something that's been done. I don't dish out any advice or any opinions unless I'm asked for it. And I do actually get asked quite a lot because I'm a teacher of you know, reception, lots of people do want to know what I would do. And I always say, well, this is what I do, I think, but it's not always that in reality.' Fran, interview 6.

Where mothers had existing trusted networks, with mothers, the need to form relationships with mothers diminishes, as Natalie and Mary described:

'I guess I haven't been to the baby groups and the clinics as much as I did with Jacob – just, I guess because we don't have quite as much time, and also, I've got my friends and some of them have babies of a similar age, so we're spending more time with them rather than with a new set of people.' Natalie, Interview 3.

'I am still very good friends with my NCT group and a couple of them; there are five of us now that meet up now and have had babies who are about 8 or 9 months old. So, we just grill them for advice all the time, and others in the group are pregnant as well, so that is probably my main source of people to talk to.' Mary, Interview 1.

Participants were all too aware that mothers were judgmental of each other, particularly when outside of trusted friendship circles. During interview five, Ella explained about her children's swimming class, *'It's not nice seeing them with their eczema, is it? I always think, when we go swimming, I think other mums must look at us and think, "Ooh, she's a bad mother."'* This perspective by Ella might reflect that she possibly

viewed eczema as a symbol to others that her mothering abilities were questionable (Goffman, 1963). Ella had no one within this swimming group to contain her anxieties regarding the children's eczema and her abilities. Therefore, possibly she projected her anxieties onto the swimming group members, identifying with them and attributing to the mothers in the swimming group the same beliefs that she held regarding what makes a good or bad mother (Klein, 1959).

Unusually for this sample, Hanna preferred to stick with her existing friendship circles, *'there aren't that many kiddies in our friends' groups.* This approach caused some conflict as her friends appeared not always to appreciate her motivations for mothering behaviours, their comments reflecting the public nature of pregnancy and child-rearing. Hanna's behaviour had altered from the usual probable expectations of others within that group of people (Goffman, 1959). She went on to express her disbelief at a friend's interest in her breastfeeding.

'It is a particular few people who very soon I'm going to stop, stop, you know, staying in touch with. It just bugs me. It's just like – with one friend of mine, who will be asking me like, "So how is it going with weaning him off the breast?" I was like, "What do you mean, how is it going? I'm not weaning him off the breast." "Well, I thought you did." I said, "No, I didn't; I never said that." "Oh, I think he's already fourteen months." And I was like, almost like, gosh...it's like really people – just leave me alone, like, you know, and no one would be asking me any private questions like, you know – and once, I was so close to, you know, to ask her very intimate questions and commenting on it and showing my approval or disapproval – things like – what?' Hanna, Interview 6.

9.3.2 Involving dads

On completing data collection, all the participants lived with their child's father and were married to them. Mothers saw themselves as responsible for all aspects of their baby's care; they took control of the domestic realm, reinforcing the public sphere's cultural norms for men and the domestic one for women (Chodorow, 1999). Given the

domestic reality of participants, this was not a surprise during the early months of the infants' life, but this position continued as participants returned to work, appearing to conform to the theory of intensive mothering (Hays, 1996) (see Chapter 2 and section 9.3.3). Generally, participants viewed their partners as supportive and involved their infant's father in the child's care. Paternal involvement reportedly increased over the year as the child matured and became increasingly separate from the mother. However, involvement is an ambiguous term, meaning different things (Dermott, 2003). Both fathers and mothers tended to regulate the fathers' contribution to their child. Fathers in terms of how involved they wished to be and mothers acting with varying degrees as gatekeepers to the relationship between the father with their young infant, directing their support and involvement as Tessa described:

'I tend to feed him before he gets to the point of being agitated or making a noise, so Mike doesn't get disturbed. But I do get him (Mike) up a couple of times in the night so that I get that break.' Tess, Interview 2.

However, research suggests that fathers may expect mothers to manage the interaction that they, as fathers, have with their child (Doucet, 2004), and of course, in this study, perceptions of their involvement is interpreted by me through maternal reports.

Although partners figured in decision making, their return to work and the public sphere reduced their influence on day-to-day infant care. Fathers input into decision making on the domestic and child-care front varied from active engagement to expected unquestioning support for maternal decisions regarding their child's care. Fran explained how, in some cases, mothers viewed their partner as an extension of themselves, used to confirm choices:

'A lot of the times, it doesn't even get to me asking Mum because I just say to John. It's almost like rhetorical questions, and then I'll answer them myself, or I'll speak to John, and he'll say it's that isn't it? We had it with Toby.' Fran, Interview 2.

On occasion, participants viewed dads as a nuisance, getting in the way of maternal decisions, and unsettling the domestic situation:

'I would say the couple of weeks that Frank was off, she was probably at her (refers to older sibling here) worst because Mummy has quite strict rules and Frank is more lax with her. So yeah, um, she was pushing the boundaries a little bit then. I found actually when he went back to work it was almost easier because, you start saying no, you get back into a routine.' Ella, Interview 2.

Alternatively, getting support from fathers with decision making and providing the mother with time to herself could be tricky, as Mary explained:

'Sam doesn't like them to have any. He doesn't want them to have comfort blankets or teddy bears or anything like that. He doesn't want them to be; I don't know, go to school and be taking their teddy bears. I think it's a bit harsh when you've got a three-month-old baby, isn't it? He's not allowed to suck his thumb because he doesn't want to be doing it when he's six.' Mary, Interview 3.

This belief possibly denied their children other sources of comfort, the experience of 'transitional phenomena' where children learn to see as objects separate from their bodies, 'transitional objects' (Winnicott, 1951 p.230). The emphasis appeared to fall to Mary as the ongoing source of comfort, potentially denying the children the opportunity to view her as a subject in her own right and emphasising their dependency upon Mary (Benjamin, 1988). Mary had no family close by, and her friendships were with other mothers. Although her friendships with other mothers were significant to her, mothers tend not to like to ask each other for support with child-care viewing them as too busy (Peters and Skirton, 2013). Sam preferred to spend their time together as a family; it appeared hard for Mary to get a break from the children and for Harry to adapt to other carers:

'It's only just me. I mean his dad looks after him sometimes but mostly if he's free, we sort of do things as a family. So, he's just mostly been with me all the time, really. (Must be hard?) Yes, it is, really. We had the occasional; occasionally, Sam will look after him for a couple of hours or....' Mary, Interview 3.

However, this was not always the case, as Ruth described; some mothers had more opportunities for support:

'If someone else is around and I can, you know, if my husband's around, then he'll take her for a bit, and I can go and have a lie-down or something.' Ruth, interview 3.

The expectation in some households was that mothers would continually be available.

As Ella explained when she described her experience of being unwell and how Frank reacted:

'One afternoon, I'd been swimming with the children and came back, and Isaac had a bottle and went to sleep, and I said, "I'm going upstairs." So, me and him went upstairs. And I had like an hour and a half on the bed. And that's the first time I have had a lie-down in the day since Isaac's, and Frank reminds me of that. I thought my head was going to explode. Every time you bent down. But oh, I did feel, poor head. But it cleared up on its own. I think it was because I went swimming and went under the water, it just. But yes, he reminds me of that, doesn't he? (To Isaac.) Your daddy.' Ella, Interview 5.

Gradually though, as their child matured, dad's roles were increasingly recognised, as Hanna described:

'He has really started appreciating his father as well, because before it was like "oh well there is somebody, but I am not really bothered about you", but now whenever Charlie comes in and started talking to him, he is properly smiling.' Hanna, Interview 4.

Sometimes it was hard to adjust to the changes, and mothers might attempt to interrupt or control the relationship. From an early age, babies show an increasing interest in other people and things, working on transferring love and affection from the mother, whom they first loved, to others (Klein, 1937). In this way, the child probably reduces the dependency and subsequent fear of losing his or her mother (Klein, 1937). The child's change in relationship with the mother signals a need for maternal identity to

evolve; there is a likely conflict between maternal and infant needs (Parker, 2005). Fran needed to feel wanted by her daughter and explained how she would influence this when Jessica was in the care of her father:

'Like I've been doing the milk sign, which is like milking a cow's udder, for a very long time. And whenever Jess sees me do that to her, if John is holding her, and if I sign from across the room, she gets quite excited and will smile and look over, and kind of try to move towards me and know, in anticipation of having her feed.'
Fran, Interview 5.

Tess fostered Mike's involvement with Georgie, particularly for them to enjoy specific activities together. Although this had undertones of expert-led intensive approaches applied to motherhood (see the following section), and echoed state guidance given to fathers to engage in library centred activities with their children (National Fatherhood Initiative, 2013, cited by Faircloth, 2014). Managing his public life and the domestic sphere was important for Tess, as she explained:

'Mike takes him to Rhyme Time at the library on a Saturday morning, just the two of them. So, they kind of have that bonding times. I think he feels he misses out a lot being at work. He's gone by the time before we're out of bed. And by the time he gets home, he's normally being put to bed or even in bed already. So, during the week, he doesn't really see him at all. (How does he feel about all that?) He gets a bit upset about it. Yes, well, he doesn't like it; he does feel he's missing out on a lot. Sometimes he does completely miss him as he's already in bed. And most days, he kind of catches me getting him ready for bed, and Mike will read a story and have a cuddle at bedtime. But I think it's important to keep the routine. I do know people that keep the babies up until about nine, so the husbands get to see them. But now we've got a good routine; I don't really want to mess with it.'
Tess, Interview 4.

Natalie had to return to full-time work by the time Freya was 9 months of age.

However, realising that her husband, their father, would need to care for the children, she encouraged his involvement. At our first interview, she explained his role in caring for their first child, Jacob:

'My husband works on weekends, so he has Tuesdays off, so he spent Tuesday with Jacob since he was nine months old, which has been brilliant for their relationship. We would like to do that with our second child as well, but he is talking about changing jobs because he works so much at the weekend.' Natalie, Interview 1.

When I met Natalie for our final interview, she had returned from a work trip abroad for one week. Her husband cared for the children, with his father (who lives in her husband's country of birth in Eastern Europe) making the journey to offer his support to both his son and family. As she explained:

'My husband was there, and his dad came over to help as well because we have a dog, so you just get that extra pair of hands to kind of have somebody around while you walk the dog and help with dinner and things like that.' Natalie, Interview 6.

9.3.3 Intensive mothering

In the present day, every participant reflected elements of intensive mothering in the care of their child, and the culture toward this approach may have led to them dismissing support and advice from sources that they viewed as outdated; please see the earlier discussion in section 9.2.2. Intensive mothering, a concept developed by Hays (1996), describes a culture where the mother self-sacrificing her needs while caring for her child (see Chapter 2). Evidence suggests that intensive parenting and mothering is a dominant feature of child-rearing today within the United Kingdom (Dermott and Pomati, 2016). The concept of intensive mothering was present in the data collected over that first year; mothers discussed their experiences of maintaining an ideal mothering role alongside meeting the other demands in their lives. For example, Natalie explained how she managed work alongside trying to maintain her expected maternal role:

'We just make sure that when I'm home that we spend quality time together, and we try and do that.' *(What do you mean by quality time?)'*

'Playing games, reading books, going to the park, and just making sure she's involved in everything as well. So, she's not just sitting in her pushchair, and it's quite nice. So, when we go to the park, she can now get out and climb on things and play on the equipment rather than just observing.' Natalie, Interview 6.

Balancing the needs of the baby with another child, alongside the demands of running a home, led to some mothers feeling conflicted and guilty as Fran and Ella explained:

'It's been different in the way that I haven't had the time to always be talking to her, and sometimes that makes me feel a bit guilty, but other times I think well, her development will just be different. She will have the luxury of an older brother that she'll always be able to communicate with, and she'll learn from me talking to Toby probably because a lot of the time I am talking to him more, and then I'll try and remember to speak to her, but it's just the way that it is when you've got the toddler and the baby at the same time.' Fran, Interview 2.

'I sometimes go and watch (the swimming), but he's (Dad) doing things with her, which has been good in one way, but it also does cause a bit of a divide. I think she's aware that I'm spending time with him and Daddy's spending time with her. (How do you feel about that?) It's nice. It's peaceful (laughs). You think, "oh, just a bit of, you know. I can feed him and wash up, well, you know," but then you think "I want to be part of it as well". Sometimes we've all gone together, but you just think you're just sat at the pool watching when you could be getting on with other things, so it's hard whatever you do, it's that guilt, isn't it? Guilt if you do go, guilt if you don't go.' Ella, Interview 3.

As part of the maternal role, mothers felt responsible for their children's emotions, another element of intensive mothering (Hays, 1996). Certainly, there are ingrained socio-cultural expectations that mothers will take on the emotional requirements of caring for children (Doucet, 2004). Maternal ambivalence, although tending to be frowned upon, allows the mother to have a more realistic expectation of her abilities (Parker, 2005). Here Ruth and Hanna give an insight into the expectations they have of themselves as mothers when managing their infant's emotions:

If I plonked her somewhere and got on with something and she's got bored or upset because I've not been giving her attention. I probably feel a bit guilty about

that. Of “oh, I should be, I shouldn’t be trying to do other things; I should just be looking after her and playing with her.” Which is not possible most, you know, all of the time. But it’s probably an element of being, feeling a bit guilty when I feel that something I’ve done has led her to become bored or sad. Ruth, Interview 3.

Well yes, but no, we try and – so we’re saying, previously I wouldn’t mind a lazy day or a lazy, you know, a lazy weekend, just, yes to do nothing – order pizza or watching the flicks. Or, on Saturday, whether it’s rubbish. Whereas now, no, every day we have to do something cool. So, we go for a walk or to baby group and to classes or to do something, just to, you know, make sure that he’s got some proper, you know, proper, thoughtful activity during the day than just, you know, going shopping and do nothing else. Like I had the ‘flu last week, I think it was the first time since he was born that for two days in a row we didn’t, you know, go somewhere. Hanna, Interview 5.

Hanna assured me that she had moved around every room in the house so that Freddie might not experience boredom during her illness. There is a suggestion that the development of intensive mothering in this age reflects neoliberal values whereby the child is an asset, social capital, which requires ongoing investment (Ennis, 2014).

Indeed, mothers endeavoured to attend groups or talked about making every effort in the future to encourage the right sort of activities, as both Tess and Mary explained:

‘There was a messy play advertised for tomorrow morning, which we might go along and give that a go. But it’s not very; it’s not local, it’s over the other side of (name of the place) (Oh right.) At 09.30. So... (you’ve got to leave home – you must have to leave home quite early then?) At 08.30 to get there up the (name of the road) with the traffic.’ Tess, Interview 4.

‘Things like playing musical instruments, having swimming lessons and all that kind of things and going off to Brownies and things like that. We used to do all that, and I think I want my children to do that kind of thing as well. (Yes. And why do you think these experiences are good for children?) I think it’s just good to expose them to as much as possible when they’re young. So that they appreciate things.’ Mary, Interview 4.

Evidence suggests that mothers consider their investment in children as a means of preparing them for the competitive nature of the Western world (Brown, 2014). In addition, maternal perceptions are that the attention provided compensates for the loss

of personal freedom that growing up as a child in today's uncertain world entails (Brown, 2014). Part of this entails creating a place of safety, a happy home, that requires the sacrifice of parental feelings:

I suppose if I think back, I want him to grow up in like a, in a loving environment and things, so it must be like if we're cross with the children, not arguing in front of the children and things like that just because, you know, I could remember, you know, you remember your own parents arguing and things like that, and you probably don't realise how you know how much you pick up on things like that. And perhaps you see other people out and about, and you think, oh, I wouldn't do that in front of my children. So, I think it's; I just want him to have lots of family time and grow up in a happy home, really. Mary, interview 4.

This excerpt might reflect intensive mothering but may represent Mary's attempt to manage her anxieties regarding the world, her children's exposure to it and perhaps her relationship. Mary seemingly expressed the desire to keep the family home a place of good, introjecting positive feelings into the household, which might be interpreted as a means of managing maternal anxiety regarding the realities outside of this and how these might affect her children (Klein, 1935). Therefore, the suggestion is that maintaining the home environment as a safe place with harmonious relationships is essential for maternal care to promote and preserve infant wellbeing.

9.3.4 Summary of the sub-theme in the present

Present-day influences on maternal identity appeared to reflect participants need to conform to socio-cultural perspectives on what it means to be a mother. Mothers included in this role, choice of social groups and principal responsibility for children's care within the home. Maternal behaviours seemingly reflected the concept of intensive mothering (Hays, 1996); this sub-theme reflects how socio-cultural positioning on what it means to be a good mother influences the care children receive. Maternal behaviours revealed their perceptions of the most desirable conditions and activities for child

development and influenced their ongoing relationship with their child and significant others.

9.4 Moving on

As the interviews came to completion, participants were either in the process of returning to or had returned to work. Having got to know them and their babies over the last few months and observing and reflecting upon the intensive nature of relationships with their infants, I felt trepidation for the forthcoming changes. Both for them and, if I am honest, a little for myself as I progressed with the research. Although delighted on some levels to be finishing data collection, I would miss them and the opportunity to continue sharing their experiences. Preparing to make my goodbyes, I thought of the all-encompassing care they had given their infants, the intensity of the mother-child relationship perhaps amplified by the knowledge that they would need to separate from their child to return to the workplace. The mothers could not stop time, but they could keep the period alive with memories that they had made. However, now they had to allow others in as they progressed to the next stage of their lives, reflecting the changing nature of maternal identity. Ideally, the participants' maternal identity had to evolve (Parker, 2005) to move from sole carer to sharing that care with others, learning to separate from the child and possibly imagining what this might be. None of the participants expressed anything other than a reluctance to leave their child. However, given the influence of the master narrative relating to what it means to be a good mother, linked as it is to optimal infant development, I wondered if they would have felt able to voice anything other than this.

The use of alloparenting was an essential aspect of childcare for all participants, as they considered using either nursery or grandparents' care. Hanna described Freddie's adjustment to the nursery, his changing dependency upon her, and his beginning to move away:

'Whenever I come to pick him up, he's kind of – I'm like "Freddie", and he's like, "yes whatever." And after the second, "Hey Freddie, mummy's here." And he's like, "Oh, okay." And then he's shuffling on his bum to see. But the first thing – "yes, I know you're my mum; that's all right." Hanna, Interview 6.

Freddie's reaction to his mother suggested that he viewed her as a subject in her own right, and Hanna's subsequent acknowledgement of his response confirmed her ability to think of him in this way. Thus, Hanna appeared able to accept Freddie's ambivalent reaction to her.

Maintaining differing roles might be seen as the fulfilment of intensive mothering (Hays, 1996); for some participants, work provided an opportunity to return to careers they had strived to achieve. Appreciating their agency, sense of self and recognition from another (Benjamin, 1988), but this was not without conflict and a sense of loss, as Natalie expressed her feelings regarding her return to work:

'A bit torn, really. I want to go back because sometimes I feel in a way that I'm missing out on the work because I'm part of a big project, and that's kind of carrying on without me there, which is good it's doing that, but I'm quite involved in it, so I feel like I'm missing little bits of it. But I'm also torn, I don't want to leave her. And with Jacob, he was eight or nine months by the time – I think he was about eight and a half months when he started nursery. So ideally, I'd like for Freya to be the same age. I don't really want to send her any younger than that. So a bit mixed emotions. It will be good to get back and get into a good routine. But, in other ways, it feels like that's it then because I've had, I've got two children, and we're not really planning any more. So long stretches of time with my children – so this kind of will be an end.' Natalie, Interview 3.

'In some ways, it's hard leaving her because after nine months together it's, there's kind of a big wrench really. And I'm constantly when I'm driving to work; I'm checking in the back of the car that she's not still in the car seat. I'm so used to her being there. But then, in other ways, it's nice to have a bit of time for

myself. And to be able to concentrate on something else and a bit of 'me' time. And I think that makes me a better mum when I've had a bit of time away, and you know that's only a few hours a day.' Natalie, Interview 5.

Natalie's reflections on her experience of returning to work highlight the positive impact this might have upon maternal wellbeing and, therefore, her relationship with her children. Behaviours that she might view as positive in promoting Freya's mental health.

Other participants found the separation from their child and adjustment to this difficult; here, Ruth reflected upon her situation:

'I do miss her, especially when I go away to (overnight commute) every fortnight for two days. I really miss her.....I'm away two days a fortnight. So, I don't, I see her on, very briefly on Tuesday morning and then I'll see her at some point overnight on Wednesday whenever she decides to wake up. But, you know, it's nearly 48 hours that I don't see her. And I find that quite hard. I don't think she cares because she's got daddy and nursery and Noah. And she's fine. Life carries on for her. And she's always very pleased to see me when I'm back. But I don't think she notices I'm not there, necessarily. But I actually miss her quite a lot. So yes, I think we're just, it will all be normal quite soon, I think. But we're still in that quite new phase of it.' Ruth, Interview 6.

Ruth's narrative illustrates the juxtaposition of the experience as she perceives it for both herself and her daughter. Ruth emphasises the time that she spends away from Isla yet reflects on the continuation of Isla's life without her presence. Ruth may interpret this as Isla's ambivalence toward her presence, which might be an attempt to project how she feels regarding her position (Klein, 1946), a position she feels unable to acknowledge within the context of the self as a good mother. Ruth's behaviours here reflect that she believed that maintaining a secure and stable environment for Isla while working enabled Isla to manage the changes that occurred.

While for Mary, the idea of separation was painful to contemplate and made planning the eventuality of this with a need to return to work problematic:

'When not yet, but at some point, when I go back to work, I need for him to be all right to be left with other people. (Right). Which I'm not quite working on yet, but I will, you know. (How will you work on that?) In another three months' time.'
Mary, Interview 5.

'Yes. Just in denial, trying not to think about things. But feel okay about it, I think. I think I've, you know, it will be, it will be a big change for the both of us. Obviously, being, yes, obviously being back at work and him, he'll spend the Wednesday mornings with his dad. Yes, I'm just hoping that it all works, really. I guess I feel a little bit anxious about it in case he's upset in nursery.'
Mary, Interview 6.

Reading this and reflecting on my interviews with Mary, I felt that she had limited space to project her fears and manage her anxieties regarding her return to work. These anxieties she projected (Klein, 1946) onto her belief that Harry would not cope with the separation and that this would impact his wellbeing and, therefore, his mental health. Her lack of near family and supportive but competitive other mother friendships appeared to make it difficult for her to seek the 'reverie' she required for herself (Bion, 1959; 1962a).

Other participants chose to leave careers that they had developed. Still, they needed work for economic reasons, finding work that fitted with their family lives and available support from family members. For example, Fran placed her career on hold as a reception teacher to work in a care home; she relied on support from her mother to help and explained her reasons for choosing this path:

'I don't know how long it will be for, but it's just whatever fits, isn't it? For until I maybe go back to teaching full time. I don't know what another year or so will bring. But I like being at home in the day as much as I can with them.'
Fran, Interview 6.

Fran had clear views regarding the impact of parental employment on children and reflected the position that the child came first, sacrifice expected as part of the maternal role, possibly viewing this as a moral endeavour (Miller, 2005):

'I see children coming in that haven't had opportunities with their own family they've just been going off to childminders full time, don't see their dads because of work and y' know granted some people cannot manage it, but I've had to take a few steps back with career, y' know I put my child first rather than myself first (yes), and that's what my mum did, I know that there are friends who have, who will very much fit around their families, but I know that my family kinda fit around the children.' Fran, Interview 1.

Tess felt that it was important for Georgie to develop his own space and ability to socialise from a young age. Despite having other willing family support, she felt that nursery was the best place for him to realise this. Tess appeared to reflect intensive mothering in her approach, where early educational opportunities are the best way to develop within this competitive world (Brown, 2014). Her actions with Georgie shaped potentially shaped by societal influences and a perception that his ongoing development required this input. Tess's story explores this further in Chapter 7. However, the reality of this experience was hard for Tess:

'It's fine. I would just rather be at home with Georgie, really. I know a lot of people like to go to work for kind of like a bit of me time and a break, but I don't really feel like that. I'd much rather be at home. It seems to come round very quickly.'

Tess, Interview 6.

Whereas Ella, who organised her shifts around her husband's work, used nursery childcare to provide respite so that she could catch up on what needed doing around the home. There was no family to help on an everyday basis, and she felt this, her behaviours reflecting the need to care for herself so that she could care for her children. Ella described her rationale for sending John to nursery one day a week:

'Yes, it gives me, because we haven't got a nanny or a granny or I haven't gotta sister that pops up for a few hours every now and again so you can... (You don't really feel you're getting any respite, is that what you're saying?) No, no. And sometimes there are things you need to do which – generally the things I need to do, I generally do it the day Claire is at pre-school. So, I've only got the one to try to juggle. But there are some times when you need to do some paperwork or, you know, things like that. And you end up doing it at night when they're in bed. So, on Monday, it will be good.' Ella, Interview 6.

Both Tess and Ella reflected aspects of intensive mothering (Hays, 1996) in their rationale for sending their children to nursery. However, they seemingly perceived that both mother and infant were subjects with lives to lead. Like the other participants, they recognised the need for various reasons to allow their maternal identity to evolve and move on to the next stages in their lives.

9.4.1 Summary of the sub-theme moving on

This sub-theme illustrated the need for mothers to adapt to the changes expected of them by their re-immersion in the workplace. Even for those who welcomed the return to employment, the transition was hard and illustrated the problems of moving from having more or less sole care of their child to a member of the workforce. Moreover, the adjustment tinged with sadness likely due to the loss of a dependent infant and the resultant change in their mothering role. Perhaps made more profound by the observation that this was an experience that some felt they would not have the opportunity to reprise.

9.5 Conclusion of the theme evolving maternal identity

In the theme of evolving maternal identity, I have illustrated the influences that may construct maternal perspectives of infant mental health; what emerges is the importance

of the past, present, and developing relationships both inside and outside the home environment on maternal identity and the care of the infant. On considering research objective two, this theme illustrated the possible influence of personal and societal narratives on maternal perceptions of infant development and how maternal identity evolves to meet the infant's needs. Maternal experiences illustrated that the past has a constant pull on present and future perceptions of maternal identity and the care that participants gave their children. The unconscious nature of past experiences was acknowledged, alongside the mother's need to form her own maternal identity, both shaped by her own experiences of being mothered and the wish to conform to socio-cultural expectations of the role. The significance of infant well-being appeared synonymous with a maternal identity that conformed to the role's socio-cultural expectations, alongside a mother who was able to act instinctively toward her child. Mothers engaged in conscious behaviours to safeguard their child's well-being, such as a safe, happy home, continuity of care, and consideration of how the return to work would affect their child; see research objective three, and to some extent in this way, perceptions, and knowledge of infant mental health shaped maternal behaviours with their child. However, it is difficult to be sure how much of the behaviour discussed throughout this theme is due to knowledge of infant mental health or trust in their assimilation of current infant care practices (see Miller, 2005), reinforced and confirmed by their desire to seek out like-minded others and the 'displaying' of good mothering practices (Dermott and Pomati, 2016, p.138). In doing so, they signalled to others that they conformed to contemporary infant care, maintaining a social front to indicate their belonging to the group (Goffman, 1959).

Chapter 10: Growing a person

10.1 Introduction

Concepts of developing identity are central to this theme. This theme is one of becoming a person, both from the perspective of child and mother. As mothers helped their child to become a person, someone to be accepted within their socio-cultural environment, they developed as mothers. Participants seemed to realise that their actions as mothers affected not only their child but also others' perceptions of them. Growing a child that was liked by others and healthy were professed as fundamental elements of maternal care as these factors had the potential to affect a child's future wellbeing, happiness and subsequently their mental health and perceptions of maternal abilities. As part of this theme, the idea of the imagined child was created not only in the mind's eye during pregnancy but also in the expression of maternal hopes and ambitions for their infant's future.

I have divided this theme into two sub-themes; a liked child and a healthy child, figure 12 illustrates the relationship between the theme growing a person and these two subthemes. In this section I have drawn upon the following psycho-social theories, Goffman's (1959, 1963) on impression management and stigma concerning identity. Klein (1935; 1946) and Bion (1959) on managing anxiety. Vygotsky (1978), Bruner (1990), Rogoff (2003), on the cognitive development of children within a socio-cultural context, and eco-cultural theory (Weisner, 2002). Bowlby (1969) and Winnicott (1971)

on object-relations theory and, where appropriate, the concept of biological determinism.

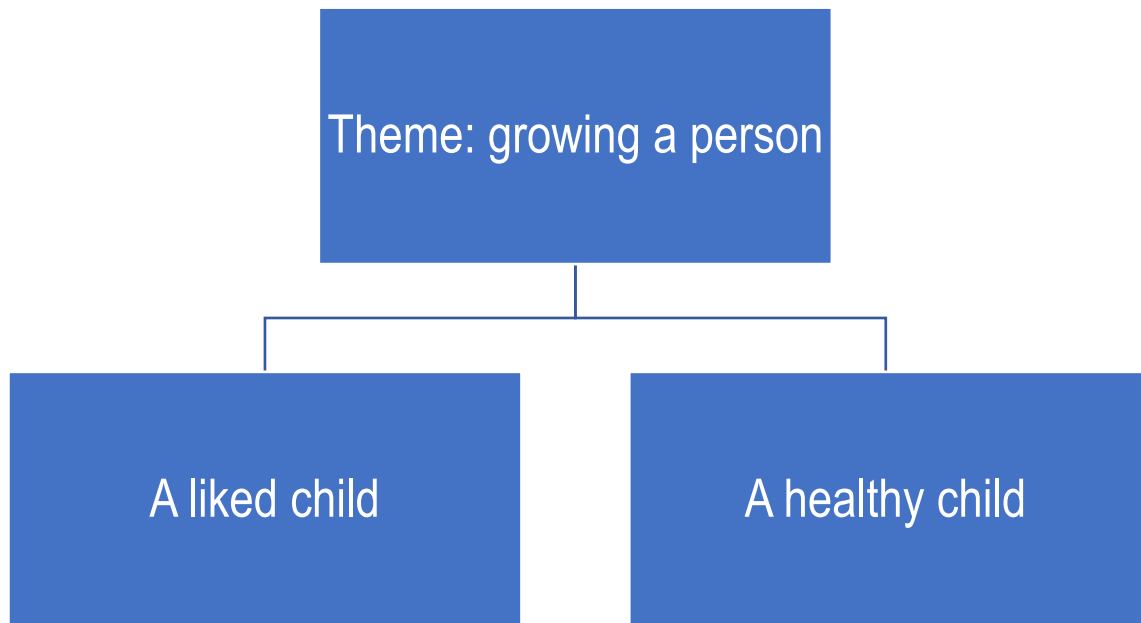


Figure 12 The relationship of the theme growing a person to the two sub-themes

10.2 A liked child

10.2.1 A moral tone

Before birth, participants created narratives of characteristics they wanted their child to develop. For example, in interview one, Natalie described the behaviours she expected

from her children, *'to be respectful of people, be polite.'* Tess and Ruth explained their perspectives:

'I'd quite like them to have quite a strong moral, know right from wrong. For me, I'm quite a black and white person; I can't stand being lied to, and I would hate that my child might lie, so instilling those values of morals and being honest.'
Tess, interview 1.

'Me and my husband have values that we would want that child to pick up, like being nice to other people and sharing, being polite and that kind of thing.'
Ruth, interview 1.

Important in getting along within their socio-cultural environment, they believed social acceptance depended on these characteristics and maintained this view during our interviews throughout that year. As Fran said,

'That's something important for me as they're growing up is to be socially accepted. Because sadly, I feel in the world that we live in, it can be cruel if you're not socially accepted.' Fran, interview 6.

These perspectives reflect a moral tone that pervades society regarding mothering and child development (Burman, 2017); understanding mothers' motivations in promoting these characteristics is a complex undertaking. Mothering is an endeavour, which others may judge, a responsibility that is heavily influenced by moral public discourses (Miller, 2005). Having a child who behaves well in others' company is an essential front stage behaviour, helping maintain their social identity as a mother and confirm a good job done (Goffman, 1959). A desire to maintain this is understandable given the current sociocultural discourses focused on the influence that parenting has upon child development, linking back to master narratives of mothering and infant care explored in Chapter 2—for example, linking secure attachments to parenting behaviours' success and insecure attachments to deviant behaviours (Moullin et al., 2014). 'Feral parenting' is concurrent with antisocial conduct, with an ongoing public offensive of holding

parents responsible for societal ills (De Benedictis, 2012, p.2). This approach has implications for both women and those from lower socio-economic backgrounds. Although the term ‘parenting’ reflects the neoliberal discourses surrounding this issue, there is an unspoken assumption that women are mainly responsible for childcare within our society, with poverty and a working-class mentality to parenting adding to poor outcomes (De Benedictis, 2012). Mothers are culpable of reinforcing societal views on parenting behaviours and resisting them, as will become evident (Geinger, Vandebroek and Roets, 2014). Where the development of a child is concerned, western society views middle-class parenting values as the most effective (Edwards, Gillie and Horsley, 2015); participants tended to replicate this, for example, by attending specific groups for infants, as Hanna described:

‘Yes, oh he loves it, he loves it – he likes the babies and the ladies, especially when they’re singing. And they lie – because they’ve got like a sensory room, and he absolutely loves the sensory room. And everything that makes the noise with. So no, he really likes it because there is so much to do that he hardly, you know, looks at all - and he’s just trying to try all those different toys and stuff like that and touch other babies. And yes, so he really likes it. And charm all the ladies.’
Hanna, Interview 5.

10.2.2 The social baby

Infant happiness was synonymous with their ability to be sociable. The ability to get along with others was highly valued, and as the first year progressed, mothers articulated this consistently as Mary explained:

‘I want him to be social and friendly. He’s lovely when he is. I just want him to be happy, really. I don’t think I try, would try, and push him in any sort of direction. I just want him to be happy. Happy and contented. And happy to be around other people and things.’ Mary, Interview 3.

Infants were interpreted as being happy if they were out and about mingling with others in group settings or with their mothers' friends; getting out of the house positively

impacted mothers who enjoyed the escape. Infants were characterised as being frustrated or bored if they were unable to socialise. Hanna described a time when she and Freddie were at home with a cold:

'He looked bored every now and then. I mean, we had some – because we invited some friends over with their babies, so at least he would play with the babies. So, it was kind of, you know, entertaining.' Hanna, Interview 5.

Mary explained the importance of maintaining maternal happiness to help keep their child happy:

'For mums to get out the house and things and see other people than it is really for the babies. I think the babies are just kind of happy so long as they've got things to play with and so long as they're kind of fed and entertained and things. I think the most important thing for Harry, as well as keeping Harry happy all the time, is that I'm happy as well.' Mary, Interview 4.

The passages of dialogue can be linked to the Kleinian concept of projective identification. The infant introjects both good and bad objects, projecting them onto the mother (Klein, 1935; 1946). The bad feelings described here are 'boredom' and 'frustration.' The question is, whose boredom and frustration, is the situation one of maternal projection of feeling onto the infant that the infant then introjects and projects back? Mothers described relief by both parties at getting out and socialising; see the theme creating a safe space Chapter 11. Spillius et al. (2011) emphasise that projective identification is understood by Klein as linked with the feeling of both bad and good. While Bion (1959) argues that there is a normative level of projective identification, which is associated with typical development for the infant, suggesting that mother and infant are caught in an ongoing cycle of engagement with each other, communicating on an intersubjective level and identifying with each other's feelings. Participants found attending groups a rewarding experience, highlighting the positive aspects of networking and informal support as Fran explained:

'for starters, it's just lovely to speak to other mums, and I've got a nice group of friends that I've actually been out with even through playgroups.'
Fran, Interview 4.

Generally, mothers report mixed experiences of groups. Some mothers experience other mothers as containers accessing them through groups (Parker, 2005), while others experience groups as quite stressful, feeling they must work to maintain a positive identity of themselves as a mother (Peters and Skirton, 2013). Experienced positively, groups and networking with other mothers provide an opportunity for positive reinforcement regarding parenting practices, providing reassurance that they are doing an excellent job with their babies (Parker, 2005). However, given the participants focus on 'attachment parenting,' see Chapter 11 and intensive mothering practices (Hays, 1996), I wondered if the group attendance allowed respite from the all-encompassing mother-infant dyadic relationship, with relief fully felt if they were embracing motherhood 'in the right way.'

Participants used groups to begin educating their babies regarding socially acceptable behaviours; this suggests a cultural level of expectation around the nature of behaviours experienced within these settings. Mothers emphasised their babies' social nature, echoing developmental psychology narratives determining that infants are born to be social (Burman, 2017). This emphasis suggests a biological basis for sociability, an explanation that tends to limit the environmental factors that impact infants' socialisation (Burman, 2017). As Ruth described:

'They really like watching people who are closer to their own age. I don't know. Maybe it's a, something tribal in their brains that they notice. It is evolution takes them to the people who are the same generation as them.' Ruth, Interview 3.

Participants observed a natural fascination by their infants for other children, which like Ruth, they felt to be an innate quality, suggesting the intersubjective abilities of the infant (Stern, 1985; Trevarthen and Aitken, 2001) as Ella explained:

'I go to the toddler group there are obviously lots of other children there, and although they've got a few chairs like that...he might sit on my lap, but he is looking at the other children. Try to say 'hello' 'hello' (makes a gesture at her baby). It's just introducing him to people.' Ella, Interview 3.

10.2.3 Learning to learn

Participants were keen for their infants to mix well with other children, preparing them for life within the structured child-care and school settings of their futures, engaging with them in directed child pursuits, as is familiar to European American mothers (Rogoff and Angelillo, 2002). Participants expressed their hopes for their children in this area quite early in the interviews; from 12 weeks of age, mothers wanted and imagined their child to have successful relationships with others. Fundamental to this was learning how, as Natalie explained in interview four, *'to share her toys. To be gentle.'* Being able to share was something that all participants wanted to achieve for their children, as Hanna described:

'I think trying to, you know, teach him to be kind and to share and things. I'm not sure how really that's going to be – if he can understand the concept of sharing now. But it's going well actually. So, if we eat, let's say we have blueberries, I would give one to him, one to me, one to Charlie or whoever else is around, and say, "Look we need to share and to do this." And he's actually doing it. So, it's quite nice to see.' Hanna, Interview 6.

Learning for their child was not only confined to when the mother-infant pair attended groups or in their contacts with other mothers, friends and other infants. Human parents are thought to provide instructional tutoring for their children (Bruner, 1972), and participants began teaching their children at home, using older siblings when

available to reinforce this activity. Rogoff (2003, p.323) likens this learning to an 'apprenticeship,' whereby children learn by observing others' actions as they participate in home life. In doing so, children learn the 'values, skills, and mannerisms.... through involvement with a socialising agent' (Rogoff, 2003 p.323). The influences of psychology and child development theory were evident in these actions. The ability to follow verbal direction and gesture was fundamental to this, as mothers tried to relate verbal sounds to actions, as Natalie and Fran explained:

If she's given me something, I say, "thank you." If she wants something – I say "please." And then just - if she's got something of Jacob's (a toy), then we take it and say we're sharing with Jacob. And show her how to be gentle with her hands.' Natalie, Interview 4.

'Toby and Jessica and I often sit in a circle and just pass an object around, and Toby enjoys going "thank you" and passing it on and then she passes it on to me, and I say, "thank you", and then I pass it to Toby and he says, "thank you." So, we're just teaching her very basic things, and she likes doing that.' Fran, Interview 6.

It is likely that participants used play to 'create a cultural experience,' play is the first way in which the infant can make sense of their cultural environment, the development of which occurs in a potential third space between the individual and the environment (Winnicott, 1971, p. 100). An intersubjective space where experiences are absorbed and internalised, leading to interpsychic development (Vygotsky, 1978; Benjamin, 1990). Participants used this interaction with their children to teach them socio-cultural forms of behaviour that others would recognise (Bruner, 1990), again perceiving them as 'apprentices' (Rogoff,2003, p.323). The teaching of children occurs in ways that are workable in the environment in which they live, with eco-cultural theory suggesting that this makes it easier for them to fit in by using practices favoured by the community, thereby increasing children's wellbeing (Weisner, 2002). Developing good social skills and being able to adapt to social situations was thought essential to developing

confidence and self-esteem, as Mary explained how and why they encouraged Harry to be *'kind and caring and affectionate.'*

'All those things. I suppose we encourage them partly by encouraging Joshua to be like that towards Harry and us all. But I suppose that in the way that we all interact with Harry. Want to encourage him to be, yes, kind and caring towards other people. But I also want him to be confident. A confident child.'

Mary, Interview 5.

Object-presenting is a way in which the carer can bring the outside environment into the infant's life. It requires the carer to attune to the infant when introducing the objects; if these are presented when the infant is receptive, it is thought that the infant will develop a sense of confidence in the outside world and will feel both connected to others and a sense of self (Winnicott, 1971, Gomez, 1997). In a reciprocal process, if the situation is agreeable for the parent, then all being well, then the introduction to the object will be easier to accomplish. Fran's description of her experience with Jessica appears to concur with Winnicott's (1971) perspective. Here Fran explained how she encouraged Jessica to engage with the object of the social environment in a way that is sensitive to her needs and one, which helped her to develop her ability to connect with others:

'One of my main priorities for Jessica is to be confident in herself and secure enough that she doesn't find new experiences too daunting and that with big changes like for example starting at a pre-school or going with a new caregiver without me I hope that we can do it gently and slowly so that she always remains happy, remains content with whoever she's with. It's a long process, even now being passed around at playgroups and things from day one. I think she was about a week old when we first went back to playgroup, and everyone wanted a cuddle, so from day dot she's basically been happy being passed around, and hopefully, that will now help out if it continues in the future to not be afraid of strangers so much, yeah and in her self-esteem and self-confidence.' Fran, Interview 3.

10.2.4 Acceptable behaviour

As infants matured from 6 months of age onwards, participants were keen to discourage infant behaviours that negatively impacted others. For example, as Ella explained how Isaac pulled Claire's hair:

'You then don't want him going to nursery, and he's doing it to other children. I guess you just, yes, you don't want them being spiteful. You want them to be children that other children want to play with them, not being afraid of them.'
Ella, Interview 4.

Trying to stop their children from projecting out these negative feelings appeared essential to promoting friendships. Participants believed encouraging friendships with other children to be fundamental to their child's wellbeing. The emphasis in this sub-theme was upon preparing the infant to have the ability to form these relationships and to manage away from the home environment; autonomous socialization is an approach that is consistent with Western parenting goals (Keller, 2003; Carlson and Harwood, 2014). Participants imagined a confident, happy, and popular child, the three traits existing in harmony. As Ruth described, her wishes for Isla in hoping:

'That she makes some of her own friends rather than just being friends with the younger siblings of Noah's friends.' Ruth, Interview 6.

Participants wanted their child to manage in a nursery or school setting. Natalie explained what friendships could offer a child, illustrated through Freya's settling in at nursery:

'She's got a lot of friendships with children her similar age, and that's been really good for her, and it's nice to see. It's hard some weeks watching her grow. It seems to be going very quickly. A lot quicker than I remember it doing. I think it's good for her. It's good for her social skills and building her confidence.' Natalie, Interview 6.

Despite their focus on 'attachment parenting,' see Chapter 11 creating a safe space, mothers appeared pleased if their children failed to exhibit signs of what they

considered to be clingy attachment behaviours, which they expected to see on separation as Fran explained:

'She doesn't have like I said, have that attachment thing. She doesn't seem to. She's not gone through the stage that I expected because, you know, maybe around 8, 9 months or a bit later. You know, lots of people say, or you'll read on baby websites, they might get a bit of an attachment and want only you. And she hasn't had that at all. (And so, you feel, you feel happy about that, then?) Yes, I feel it's more because not because she doesn't love me or anything. I feel it's more that she does feel so secure that she, that she's more confident in herself, maybe. I don't know.' Fran, Interview 6.

Where clingy behaviour was described, it was seen as more of a problem than anything, as Tess described:

'It's nice that he can get around more, and he's gone back to, so he was going through quite a clingy stage. And he's gone back to kind of being a little bit more independent and happy to play by himself rather than needing me there... all of the time, which is quite nice.' Tess, Interview 6.

Hanna described Freddie's transition to nursery a couple of months before this particular interview, which went smoothly, without any sign of upset from him; I asked how this made her feel:

'I'm like, 'come on, really? Don't break my heart,' sort of thing, you know. But no, it's nice to see him happy there, definitely. And I know I'm grateful his social development and everything else – that he likes other kids.' Hanna, Interview 6.

Participants referenced attachment theory described by Bowlby (1969), which entails developing attachment behaviours during the first year of life; see Chapter 3.

Attachment theory is the dominant psychoanalytical discourse amongst health advice and books directed at parents (DH, 2009; Hardyment, 2007). Missing from this is the enculturation of individuals, which begins in infancy, with caregivers developing the mother-child relationship in a way that meets their environment and needs (LeVine and Norman, 2008). Despite mothers' apparent preoccupations with attachment parenting,

their perception that their child required an active social life to experience well-being and adapt within their environment suggested they valued input from others to do this.

10.2.5 Summary of sub-theme a liked child.

This sub- theme illustrates the need for the child to conform to expected behaviours within their socio-cultural milieu, front stage performances (Goffman, 1959). Maternal care appeared directed toward preparing the infant to undertake this successfully when away from the maternal gaze. Participants felt that it was important for their child to be liked and able to accommodate others; the emphasis upon achieving this was enhanced by the majority of mothers return to employment and the need for formal childcare settings. Mothers imagined their child being confident and able to cope with social settings, leading to a successful school and academic life; the child's behaviour seems to reflect the participant's ability to mother as she imparted expected behaviours to her apprentice (Rogoff, 2003). This sub-theme illustrates the influence of societal narratives on how mothers choose to care for their infants and how these are potentially used to shape infant behaviours. However, maternal care cannot be undertaken in isolation, and peer supports were important to reinforce maternal behaviours of 'good' mothering. Mothers wished to encourage the development of an individual who can 'fit in' with anticipated social situations—the ability to 'fit in' synonymous with a child's future wellbeing.

10.3 A healthy child

10.3.1 Biological determinism

Participants worried about their child's future health during pregnancy, and this was a narrative that continued throughout the first year. The increasing use of biomedical know-how emphasises fetal health, alongside a discourse of minimising risk and promoting safety (Lupton, 2012). Physical anxieties and worry over the health of a child caused participants some alarm toward the end of their pregnancies, as Hanna explained:

'I had to just check if I'm not diabetic, because the tummy was bigger than it should be at that stage, (oh right, OK) so I was expecting a massive baby, ah eventually it was all rubbish, cos he was 2.8 kilos, so he was actually super tiny.'
Hanna, Interview 2.

Participants felt responsible for their child's growth and survival; this was a taken for granted assumption; no further explanation was necessary. They accepted and appeared to embrace the centrality of their maternal role in their infant's life. Arguably biological determinism was a key influence on the performance of this role; see Chapters 1 and 2. Biological determinism entails the responsibility of the developing brain to parenting (Edwards, Gillies and Horsley, 2015). Given that most childcare falls to mothers, this becomes an expected reflection of gender-designed roles (Macvarish, 2014; Gillies, Edwards and Horsely, 2016). The subject of infant feeding emerged during our interviews, particularly in the early months of life, when I asked about their child's health or if I simply asked them to tell me about their baby. The emphasis was unsurprising, given that infant feeding is a dominant theme in research and policy (DH, 2009), notably, in connection with child health, with breastfeeding associated with the discourse of being a good mother (Lee, 2007a). All participants chose to breastfeed their infants, breastfeeding until at least 6 months of age. The prominence of infant feeding in their narratives mainly focused on whether the child would feed successfully,

with the associated implications for infant wellbeing and threats to maternal identity.

Breastfeeding was important for several reasons, as Ruth described:

'It's a lot less hassle, and you've got guaranteed comfort. Sometimes it's just easier. Also, for the baby's health and for your health, I know that it's the best thing to do. I think it's important for bonding and everything like that as well. It's cheap!' Ruth, Interview 1.

All participants were keen to breastfeed and felt that this advantaged their child, however establishing breastfeeding had its problems, and support for feeding difficulties was variable. In some areas, breastfeeding support was not a priority if all else was well, as Tess explained:

'I couldn't get him to latch on at all. And then I asked someone; I asked someone to help. But yes, we had problems feeding the first couple of days, that wasn't very nice. The birth was lovely. But that aftercare – I suppose because there's nothing really wrong with either of us, I didn't have to have any stitches or anything. He was perfectly healthy. I think we were probably low risk, and they're so busy, and they had people that need help.' Tess, Interview 2.

Whereas Natalie felt well supported, when she experienced difficulties due to Freya's tongue-tie:

'The feeding didn't start so well I was a bit worried that we wouldn't be able to carry on breastfeeding, we went through quite a tough time in the first couple of weeks with it, so I'm really happy that we're still able to do that and that we've got through those first few weeks, with a lot of support we did really well. It's really satisfying, and I'm glad we're doing that.' Natalie, Interview 2.

Some mothers viewed difficulty establishing breastfeeding as failing one's child and a potential threat to perceptions of maternal identity (Lee, 2007a). Reflecting beliefs that breastfed babies are advantaged, and those that are formula-fed are not (Lee, 2007b).

Declining to breastfeed was not an option for these participants. Failure to breastfeed, viewed as a stigma by some mothers, resulted in choosing not to discuss feeding

methods with their peers. Mary described her experience of interacting with other mothers:

'When the baby is little, it's a big thing breastfeeding or bottle-feeding and things like that, whereas all my friends breastfed for a long time, and I probably wouldn't talk about it with someone who was bottle-feeding; because I wouldn't want to offend them.' Mary, Interview 1.

Breastfeeding represents an interembodiment between mother and infant, the experience of an individual's separate body entangled with that of another (Lupton, 2013).

Interembodiment begins in pregnancy, developing through breastfeeding and the caregiving practices provided to infants by their mothers, with mother and infant sharing their reactions of the experience (Lupton, 2013). If a child fed well, this led to positive maternal perceptions of the child, describing the infant as emotionally happy as Ella; in interview two described Isaac's experiences of breastfeeding, *'he's been a good little boy actually. He's tolerant, pretty chilled as long as he's got food, he's happy.'*

Responding to physical needs, feeding and changing and keeping the infant clean is a way of regulating the infant's body into accepted routines (Lupton, 2013). The interaction between the infant and carer through ongoing routines of feeding and care potentially allows the infant to form memories, which are situated in embodied and socialised experience, going on to shape neurophysiological development that is socio-culturally located (Lorenzer, 1986 cited by Bereswell, Morgenroth and Redman, 2010).

10.3.2 Visible maternal love

Once participants had their child breastfeeding well, they started to look for the physical evidence of the child's well-being. The child's weight gain was one of the most important aspects of maternal care, illustrating how well you were doing as a mother.

As Ella interview three explained: *'I guess that he's gaining weight which we know he*

is he's feeding well. He looks healthy. You look at some babies, don't you? And you think they're not really chubby, which he is.' Participants wanted their babies to be chubby; they felt it gave their infant a little something extra should they need it; as Ruth described during interview four, *'she's nice and fat, which is always nice in babies. She's very chubby thighs.'* Or, as Fran said in interview six, *'looking like a healthy baby with Michelin man legs!'* Infants perceived as being at risk are viewed by society as vulnerable and weak, with mothers accountable for any harm (Lupton; 2013; Faircloth, 2014). The infant embodied maternal care, and participants who were reportedly doing all the right things in terms of maternal care knew that they were open to surveillance and critique from health professionals. As Hanna explained:

'The health visitor told me that, you know, she put him on the scales – he was on the twenty-fifth. So yes, the health visitor checked that he should be on the twenty-fifth, but he was a bit under. So, she said probably he doesn't get enough food, which was a bit worrying, because, you know, because obviously, I was trying to give him enough. But I thought – one thing I read that, that the solids are just, you know, just for fun. And really, the milk is what gives him all what they need to grow.' Hanna, Interview 4.

The confidence in a maternal body to nourish a child was susceptible to becoming undermined by episodes of ill health on the infant's part. Harry was admitted to the hospital over Christmas with bronchiolitis, resulting in Mary feeling that her on-demand feeding, currently prescribed to mothers by health services (National Health Service, 2020), may not have been enough for Harry:

'I mean Harry's never been to the doctor, and then suddenly he's taken to hospital. And then because he's not, because Joshua was a big baby and Harry's just a, quite a small baby and Harry's. And the health visitor's always been a little bit worried about Joshua's weight, and then I end up thinking, 'oh, maybe it's because he's, I don't know, the quality of my milk's not so good. Then he's not quite as robust as Harry's was or something. Where it could just be that they're different babies, I think he's going to be a bit more tall and thin. But I think there's just a, you know, wanting to make sure that there's nothing we are doing that's making him ill or anything, you know. Because he wasn't, that's why I started just feeding him all the time afterwards because he doesn't really. We

were feeding him on demand, and he wasn't a very demanding baby.'
Mary, Interview 4.

10.3.3 Engaging with surveillance

Although potentially undermining and stressful, most participants viewed the surveillance provided by health professionals as helpful:

'I had him weighed. Yes, and she followed him on the centile. He's dropped a little bit, but she said actually because he's mobile now, that's, you know, normal, what they expect to see for his age. So, it's just reassuring, isn't it, that he's...' Ella, Interview 5.

As helpful as this surveillance was, some participants did not want in-depth interaction with health professionals. Mothers felt that they did not require this, perhaps echoing the emphasis of early intervention that targets families and mothers perceived to be at a disadvantage (Gillies, 2014). Tess, as her story demonstrates in Chapter 7, had a powerful sense of her maternal identity, and maybe she perceived professional support as a threat to this, as Tess said:

'I can't imagine what I would phone the health visitor for. I suppose if I'd carried on having problems with feeding him, then I might have wanted to phone her because it's kind of evened itself out. Yes, I don't know what I would phone her for.' Tess, Interview 5.

Participants relied on contact with other mothers and their children to gauge the health of their children, as Fran explained how she judged Jessica's health:

'Just like good colour, physical appearance, you know, healthy nails and eyes and hair and just looks like a healthy baby, because, you know, sometimes you can see some very scrawny – or children that just don't look that well-kept health-wise in terms of the colour of them or their eyes, you know, they're looking a bit sallow or a bit pale or gaunt or something.' Fran, Interview 4.

Not only did mothers compare their perception of their infants' health in this way, but they used these interactions to estimate their infants' development, a time-honoured method of doing so (Urwin, 1985). Participants looked to do this as their infant

matured, from when the child was around 6 months of age. Ruth described how she assessed Isla's development:

'Comparisons with friends' babies. So, I have a friend whose baby is about eight weeks older. So, he is a bit more advanced, but from he's always been much more mobile. He rolled quite early and then did lots and lots and lots of rolling and wiggled around the room and everything like that. Whereas she's never rolled over, and she's just, and I think first time round that stressed me out quite a lot.' Ruth, Interview 4.

Mothers with an older child used a comparison between the two to monitor their infant's development, as well the comparison with other babies as Mary described when reflecting on the most significant change to date in Harry's development at 9 months of age:

'Just that he's on the move, I think. (Why is that important do you think?) I'm not sure that it's important in the sense that it wouldn't matter if he wasn't, he's got babies at the same stage that aren't crawling. And he's not as active as Joshua was at that age when I look back. Joshua was more active at his age. It's a bigger, it's a bigger change for us because it means he can do different things. Like he can pick, he can also stand.' Mary, Interview 5.

Mothers made use of professionally sanctioned sources of information such as Bounty (2021), which they viewed as social media:

'I'm signed up to a few bits and pieces here and there. So, I get emails about your baby and what they should be doing at this time and how to encourage them to do this and things. I just take some of it with a pinch of salt.' Natalie, Interview 5.

Or books, which could be the source of some resentment, as Ruth reflected upon her reaction following the birth of her first child, Noah, who was born prematurely:

'I understand the need for developmental milestones and a ballpark of – and, you know, a lot of the time it is about, at this time, about six months they'll sit up. But I think I've got this book; it's a day-by-day baby book. And I've had to stop reading it with Noah because it was so depressing. It used to make me really angry that it would say about, you know, "your baby should be doing this at this point."' Ruth, Interview 5.

Judgements regarding child development were made using traditionally accepted norms that most likely originated from medically agreed standards; for example, participants expected their child to be interested in walking from approximately 12 months of age.

Deviations from the norm were a cause for concern, as Natalie explained:

'It is at the back of my mind that she's 15 months and she's not walking independently yet. So, it is always at the back of mind that you kind of can't help worrying that is there some underlying cause for that.' Natalie, Interview 6.

Promoting their infant's physical development was important to mothers, echoing concerns regarding their strength and vulnerability (Lupton, 2012). Strength meant the infant could partake in social activities, which might help maintain a sense of mental well-being and provided testimony to a mother's ability to mother successfully.

Participants found this reassuring, as Fran described:

'Physically, you know, she is strong. And I know, you know, she – her grip and her kick and her – even trying to pull herself up, you know, and she's almost sitting as well – that's really pleasing for me because I think if she's quite physically able, then she must be in quite good health to be able to have the energy and the strength to do all of those things physically.' Fran, Interview 4.

Whereas where mothers had concerns regarding physical development and growth, these became a matter for medical practitioners. A question mark over an infant's size and strength was a source of anxiety as expressed by Hanna, despite Freddie following an accepted growth trajectory:

'But now, when he starts walking a little bit, I realise that oh, I'm not sure if his posture is all right, and I'm not sure if the way he puts his leg is fine, and this and that. So actually, we're going to see a GP to double-check that everything is okay on this side. I also said I'm a little bit worried because [inaudible 21.44] small baby, so I was getting a little bit worried, oh is it all right that he's so small. Of course, there are smaller and bigger people, so it's all fine.' Hanna, Interview 6.

Participants experiences and concerns regarding their infant's body emphasised the influence that the medical 'gaze' has had upon how we may view human development

(Foucault, 1973, p.64). Concerns regarding milestones and development norms removed individuality from judgements made, with comparisons with other children appearing to produce a competitive edge to this consideration. Generally, participants were conflicted, as they feared that maternal negligence might lead to them missing a problem. Medical surveillance through self-initiated means, for example, using books or engagement with medical professions, reinforced this position with expectations regarding development manifesting from professional discourses.

10.3.4 Summary of sub-theme a healthy child

The sub-theme of a healthy child illustrates how vital physical development was to participants' perceptions of a happy child adjusting well to life. A child that demonstrated adequate growth and expected development embodied the concept of being healthy and reflected a mother who was doing a good job, a good mother. Participants were concerned about their infant's health and wellbeing. However, this concern seemed multifaceted, mixed with anxieties about how others perceived them as mothers; a sickly child was not the child they imagined; any suggestion detracted from the physically robust child who could participate in the life they wanted and imagined for them.

10.4 Conclusion to growing a person.

This theme emphasised the importance of growing a child who knows how to manage themselves in social situations, consider their social identity, control personal information in social life, and avoid stigma (Goffman,1963). Part of the impression management involved helping a child to develop in a way that others might like;

arguably, the child also needed to embody the participants' ability to mother, what Goffman (1963, p. 60) terms a 'prestige symbol.' In developing a healthy body and appearing happy, the child potentially conveys to others that they are being mothered well and can participate in society. A child that could conform to social situations and separate successfully from primary caregivers to be with others, learning to be confident in those situations appeared to emerge as desirable. In this way, the child obeyed Western expectations of socialisation as mothers seemingly encouraged independence, consistent with individualist socialisation goals. However, the situation was complex as there was also an emphasis on values traditionally aligned with collectivist cultures, such as tolerance and being unselfish (Park, Coello, Lau, 2014).

Participants saw physical and social development as essential indicators of child wellbeing and that the infant would fit in, develop relationships with others, and flourish within the environment. Without these aspects of child development, participants felt their child would not thrive, and therefore be unable to enjoy emotional wellbeing. In considering research objectives one, and three, the significance of infant mental health to the child's wellbeing, appeared viewed in terms of physical and social development, and maternal knowledge centred on achieving these goals for her child. While in terms of research objective two, the impact of societal influences on maternal behaviour appears throughout this theme, although how much this is related to maternal perceptions and knowledge of infant mental health is questionable. Mothers worked to conform to a master narrative of good mothering and expectations regarding infant care, establishing a child that provided a symbol of their abilities (Goffman, 1963). There was some reflection of infant behaviour by participants; see research objective four, as

mothers described actions that moulded the child as her ‘apprentice’ (Rogoff, 2003, p.323).

Chapter 11: Creating a safe space

11.1 Introduction

The theme of creating a safe space reflects the space required for infants and their mothers to develop during that first year of their lives. Space reflected a sense of distancing from a situation in terms of time, location, or psychic response, theoretically allowing the mother to pause and let her infant develop in the potential space between herself and the infant (Winnicott, 1971). Winnicott (1971) suggests that this potential space occurs because of the trusting relationship that the infant develops with the mother, which allows them to gradually separate from one another, and for the infant to start to fill that space with other learning- resulting in the development of the individual.

This theme is divided into two sub-themes: emotional space and a place of safety, please see figure 13 for a diagrammatic relationship of these to the theme creating a safe space. The psycho-social theories I used to inform my interpretation of the data in this chapter are object relations theory (Winnicott, 1956; 1963, 1971; Bowlby, 1969; 1979),

intersubjectivity (Stern, 1985), the management of anxiety (Klein, 1936; Bion, 1962a; 1962b), and socio-cultural perspectives on the construction of emotions (Rogoff, 2003; Gaskins, 2006).

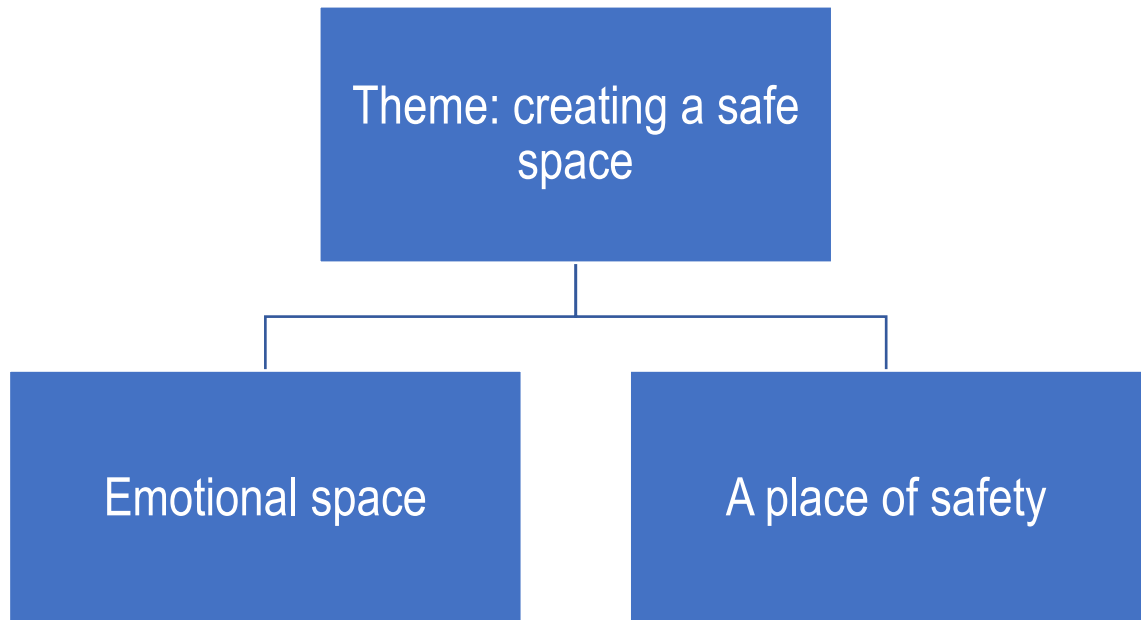


Figure 13 The relationship of the theme creating a safe space to the two sub-themes

11.2 Emotional space

Creating a safe space, the space in maternal lives for another person – is not only a physical undertaking that manifests through pregnancy and the making of physical space within the home but also demands an emotional response. The participants talked of creating emotional space, space for feelings, as they dealt with the ongoing changes that a new baby brings. In an academic sense, the word emotion applies to unconscious behavioural and cognitive reactions that respond to stimuli detected by the brain. The word feeling is given to our conscious interpretation of bodily reactions to

the emotion (LeDoux and Damasio, 2013). For interviewing and recording participant responses, these words were used interchangeably. During the year, the child's ability to express emotions changed and participants' responses adapted. Mothers moved from managing the infant's emotions in the early days connected to their physiological needs, and as the child developed to helped them to express their emotions in a way that worked for their socio-cultural milieu.

11.2.1 Meeting physiological need

As communication occurs within a socio-cultural medium, infants articulate affective expressions, such as sadness and happiness, as encouraged by their caregiver (Rogoff, 2003). Participants identified physical need as the prime cause of their infants' emotional expression during the first few weeks and months of life. Recognising maternal care as the primary source of engaging both expressions of happiness and discontent. As Fran explained:

'It's really just the basic needs of the nappy changes if she's full. She loves having a bath; she really chills out if she's in the water. The basic need of a feed she'll cry if she needs a feed, and she'll quite often be quite content looking around the room at this picture in particular which has obviously got bright shapes on. She just likes to have a little look around. She will cry possibly with boredom, I don't know, after a few minutes, but then you can quickly settle her by moving to a new place.'
Fran, Interview 2.

Ella described what made Isaac unhappy or happy, with happiness identified as him being *'content.'*

'He doesn't like being wet or dirty, yeah he does make... You can just tell that he's not comfortable. Obviously, when he's hungry or if he's got wind, and I think if he hasn't got any of those three things, then he's content (pauses) generally.'
Ella, Interview 2.

By keeping the infant alive, responding to physiological needs and the signals of distress and happiness that come about because of these needs, mothers potentially help their infants make sense of the world. Winnicott (1960a, p. 43) describes this as 'holding' whereby mothers are in a state of 'primary maternal preoccupation,' they are at one with the infant, helping them feel safe both physically and mentally (Winnicott, 1956, p.302; Frosh, 2012). Winnicott (1963) suggests that mothers draw upon their experiences of being mothered to provide this care; of course, these responses might result from the socio-cultural environment in which the mother and her mother resided. Therefore, subsequently illustrating a reaction to the master narrative of what is expected of mothers absorbed not only consciously but unconsciously.

11.2.2 Getting out of the house

The participants adopted a traditional mother-infant dyadic relationship. Mothers were the primary carers and decision-makers regarding their babies. The mothers' position took away some freedoms and yet provided potential power and status within their relationship and society. Managing these expectations and how they experienced the mother-child relationship required emotional resources, the extent of which varied between participants. However, for all participants, getting out of the house to create space and escape from the dyadic relationship's insular nature was an essential element of managing their feelings. The need to get out of the house remained important for mothers throughout the first year of their infant's life. Not an insubstantial achievement, getting out of the house might involve walks, attending groups, meeting with friends, or seeing family. Second-time mums found the idea of dealing with two children at home by themselves a concern as Mary described:

'I was very worried about how I would suddenly manage with two of them at home, but we managed to get out and about and things.' Mary, Interview 2.

Those with an older child had a perceived advantage, having existing connections to provide support as Natalie explained:

'I think because Jacob has got his friends, so we're invited out more ... I think it's because I'm seeing more people and doing more things everyone's a bit happier.' Natalie, Interview 2.

While first-time mothers focused on creating new connections and drawing upon family for support, here as illustrated by Tess:

'The first point of call just wouldn't have been what I would have expected, would be the people that I've met at antenatal group. They've all got – I'm quite friendly with three other ladies, it's quite nice, all their children are from two weeks older than him up to a month older than him. So, it's quite nice to be able to say, "Oh what do you think, what have you done?"' Tess, Interview 2.

Seeking peer support from mothers with infants of a similar age was important, but just getting out might be enough for both mother and infant wellbeing. Sometimes reasons were manufactured to get out of the house – as Ruth described when trying to manage Isla's more challenging emotions:

'I sometimes reach the point where I just say, right, we're going out, that's it. And I'll put her in the sling, and we'll go for a walk, or we'll go to the shop. You know I did, the other week I had a very quiet week, I didn't see many people just before Christmas, and she was getting really fractious, and I was just inventing ridiculous reasons to, you know, I'll walk over to Lidl, and I'll buy some bananas because you always need them. You know, it was really inventing little outings, reasons to go out, because she's always happy when we were going out.' Ruth, Interview 3.

As I succumbed to a cold just before Christmas, I decided that no one wants to be ill, particularly those with young children at that time of the year; therefore, I cancelled an interview with Ruth the week before Christmas. I expected relief on calling Ruth.

Instead, I got disappointment, and a *'well, never mind.'* Reflecting on the telephone call and the transcript, I now wonder if she was looking forward to the relief and space the

visit may have created through the act of chatting about life with Freya, providing some emotional support.

11.2.3 Managing everyone's emotions

Participants expressed both their responsibility and susceptibility towards their baby's emotions, emphasising the importance they placed upon the dyadic mother-child relationship. Mothers wanted their child to experience happiness and subsequently tried to make and keep them happy. Participants tried to help their infants manage emotions. However, on occasion, it appeared the weight of managing this would become too much, and escape was needed as identified by Ruth above, and if available, others to help create emotional space as Hanna described:

'Well, I think I am quite vulnerable to his emotions, so when he is unhappy like he was yesterday, I felt tired very quickly. Not doing anything physically tiring apart from holding him and walking him around, but I was feeling what am I doing wrong, why suddenly he is feeling upset what have I ... have I eaten something? Have we slept in an uncomfortable position? What is wrong? So, it was time for me to get, I was talking to my mum over the phone, and she said it's OK it's just a bad day you wake up sometimes with a feeling, so don't worry if he is not in pain, and he is not if he has been fed, his nappy has been changed, and he has been sleeping all right it's a bad day. Fine but it affects me very quickly, and I don't know how to make him happy and smiley then it doesn't work well for me, but then I have my mum on the phone straight away or my sister and it's don't worry its normal, don't panic he will be happy tomorrow and actually he is today he was perfectly fine.' Hanna, Interview 2.

Maternal reverie is a term used to describe the mothers' ability to manage their own emotions while receiving difficult emotions from the baby and turning them back into a more acceptable format (Bion, 1962a; Bion, 1962b). It is hypothesised that to deal with her baby's emotions, the mother must have the capacity for reverie; to achieve this, she must actively consider her situation and provide reverie for herself (Parker, 1997; Baraitser, 2009). Through contact with her family, Hanna afforded herself some reverie to help make sense of her baby's emotions, thinking through how to manage them.

Accessing others' support supplied participants with a potential source of reverie to fulfil the infant's needs in a socio-culturally appropriate manner; in taking care of themselves, they created the space to help them manage the mother-infant relationship. Babies manage their emotions through the medium of interaction with caregivers between 2- 7 months of age (Stern, 1985). Maternal perception of their role in helping babies to manage their emotions confirmed this, reflecting a culture that emphasised maternal responsibility, reproducing the narrative of developmental psychology and attachment theory that the good mother is devoted and available to her baby (Burman, 2017). Mary expressed how she felt about managing Harry's emotions while recognising her need to return to work and her subsequent unavailability to him. Thereby producing conflict between the economic requirement for her salary and the sociocultural perspective of her mothering role:

'I guess I feel it's, feel guilty and torn if he's sad about something or if he's crying about something you think he's been, you know what can I do to make him happy all the time? Or how can I make him cope? Because obviously, you can't just be there all the time for him. How can I somehow make him cope with those bits where you can't be there? Yes, and I get, I suppose I get a bit stressed when I try and get him to sleep and things like that, and he's just crying because he's so tired, but you can't get him to have a sleep, and that's just a bit frustrating. Which doesn't create a nice sleeping environment.' Mary, Interview 4.

11.2.4 Recognising emotions

With time, babies could express a broader range of emotional responses due to various stimuli; initially, mothers recognised this through the infants' reactions to food and movement, emphasising the physiological basis for emotion. In addition, babies had the means to communicate their likes and dislikes, finding their voices, giving mothers the cues to interpret their emotions in a more meaningful way; this became particularly apparent when infants were around 6 months of age. Ella explained how she recognised Isaac's need for a change of position:

'I think that makes him sad. But you can pick up on those cues much easier now. And then do something about it to change it. You get a grizzle. And yes, sad little face. Not a smiley face. You just know he's, yes, he's had enough. He's had enough.'
Ella, Interview 4.

Resolving the situation for a sad baby was important for participants, reflecting their knowledge and beliefs about creating a secure and confident child, explored in more detail below in section 11.3. However, second-time mothers recognised that quick a response was not always possible, perhaps reflecting maternal ambivalence. The conflict originated in trying to meet the needs of an older sibling while caring for her infant. A manageable form of maternal ambivalence toward the infant may provide mothers with insight into their situation, giving them space to consider how to cope, varying between individuals in its manifestation reflecting individual journeys in maternal development (Parker, 1997). As Fran described:

'I don't get as upset when she's sad, which maybe sounds a bit horrible. But – and this is again in comparison to the first child, because whereas previously I was very anxious about the reasons for Toby crying, with Jessica I know that she's well-fed, she's well-cared for, she has regular bum changes, she's not in ill-health – so when she is crying, I know it's more of a moaning....' Fran, Interview 4.

Words chosen by mothers to acknowledge the presence of similar emotions varied, reflecting the acceptability of what they believed their child was capable of feeling, using different words to express emotions of a similar type, words that might be considered less extreme. For example, Ella used *'frustration'* rather than *'anger,'* while Ruth said that Isla was *'annoyed'* rather than *'frustrated,'* or *'angry.'* Fran acknowledged that Jessica might feel *'fear'* in response to loud noises. At the same time, during interview four, Tess maintained that Georgie had not felt an emotion *'like fear – because he's never really been in a situation to, to feel afraid, have you?'*

Expression of emotion and the characteristics attached to them have a cultural and biological origin (Fischer et al., 1998), and choice of maternal language might reflect

cultural considerations of what a child should feel, this reflecting on the care provided by the mother.

11.2.5 Helping infants to express their emotions

As infants developed, mothers were able to identify their emotional responses from around 6 months of age; as this happened, mothers then taught them how to express and manage their emotions appropriately. Participants gave the infant space to articulate their emotions and encouraged the infant to communicate with them in a way that reflected their parenting style, trying to shape infant behaviour into an acceptable form through interaction (Gaskins, 2006). An interpersonal process, as exemplified here by Natalie when managing Freya's anger and request for attention, responding to Freya with role modelling behaviour and working to Freya's perspective of the situation, her zone of proximal development (Vygotsky, 1978). Providing the means for Freya to potentially learn to manage her anger and frustration for herself in a suitable manner for her socio-cultural setting:

'I talk to her, try and encourage her not to shout quite so loudly. I try and talk more quietly to her and interact with her and give her some toys to play with while we're doing – because sometimes we just, we have to cook dinner, or we have to be doing something. We can't always be there a one hundred per cent of the time playing with her.' Natalie, Interview 4.

Ruth viewed Isla's behaviour differently, emphasising the uniqueness of accepted behaviour within each family's milieu:

'As long as I'm not completely exhausted or had enough of both of them, it's just quite amusing because it is like she's this tiny little tyrant who, you know, she thinks, you know, it's just very amusing. It's kind of a big emotion in a tiny person. And the way that she, you know, pushes something away and looks at you with this very annoyed look on her face, it's just quite funny. Yes, I get, I get annoyed if she does things like, you know, throwing her entire plate of tea on the floor because it means I've got to clear it up. And that's what's annoying. I don't even know why she does it.' Ruth, Interview 6.

When infants were happy, mothers gave them the space to express these emotions, replicating situations that kept their infant amused. In contrast to their trying to manage or escape from emotions, they perceived to be negative, as described above. Mothers reported the ability to share emotions with their infants during social interactions, perhaps demonstrating interaffectivity, whereby infants can identify with how they feel within and how another feels. When the infant is between 9-12 months of age, the ability to share 'affective states' is the main form of communication between mother and infant (Stern, 1985, p.132). Hanna explained how she made space for sharing emotions with Freddie, aged around 9 months at the time:

'We've noticed, like yesterday we went to the shop, and he was laughing when I was squatting to see something on the shelf. So, and he found it hilarious, so I ended up just squatting up and down and up and down, up and down for a good minute. And he was still finding it funny. Then he stopped, and I stopped, like an idiot in the middle of Morrisons. But why not?' Hanna, Interview 5.

All mothers judged their infants to be happy if they could play without direct interaction with them for a while. A fundamental aspect of the child's development, giving both mother and infant respite from each other. Participants viewed their child as needing emotional space so they could learn to be independent, as explained by Hanna and Natalie when their children were around 9 months:

'I basically, you know, let him, let him play by himself, not constantly trying to entertain – giving him the space for himself when he seems happy with it, and it's perfectly fine.' Hanna, Interview 5.

'Generally, she's so placid, she's happy with her toys. If you sit her somewhere with a few toys and you're around, she's just happy to play. And if you go on a trek with her and you can step away a little bit, and she's happy on her own as well. And yes, just, she's just very relaxed and takes everything in her stride.' Natalie, Interview 5.

Playing in this way possibly represented a means of transition for the baby from needing the mother present to interpret objects for her or him, with the ability to control the activity while the mother was still present in the background, available when needed (Winnicott, 1971). In addition, playing allows the baby space to be creative and develop as an individual to discover the self through expressing ideas and emotions (Winnicott, 1971). By recognising their baby's need for self-expression through play, mothers were helping the baby develop as an individual. However, I am not sure if this was always consciously recognised by participants as it was mainly borne out of necessity, for example, preparing food, doing domestic chores, or having time for themselves, as Ruth said, '*playing on my phone.*' Nonetheless, they acknowledged the need for their baby to have space and that this was a mutual requirement for both mother and child.

11.2.6 Summary of sub-theme emotional space

This sub-theme illustrated how mothers recognised their infant's emotional development from total dependency towards an individual capable of some separation and independence from them. However, the development of that individual baby takes place within the context of their environment, and in these early months, with mothers as their principal caregivers, they were the primary influence (Winnicott, 1971). Mothers demonstrated their ability to work alongside their infant in tune with their emotional and physical development to promote the infant's well-being and their relationship with them; participants grasped how these factors worked to shape their infant's behaviour. Mothers worked to provide a sense of reverie for their child, but in turn, they required assistance and space to help their child, a sense of reverie for themselves (Bion, 1962a; 1962b).

11.3 A place of safety

As the relationship between participants and their infants developed over the year, a considerable shift in infants' care occurred. Initially, maternal care reflected the child's initial state of complete vulnerability and dependence, changing as the child progressed towards independence, moved, interacted with others, and coincided with the maternal need to return to work. Regardless of these changes, participants wanted to ensure their infant felt a sense of security and safety throughout; this was synonymous with love for the infant. However, mothers rarely used the word 'love' to describe the relationship with their infant; perhaps this was an almost taken for granted assumption; instead, they appeared to express the 'love' they had for their child, through the expression of affective states and in the care they provided.

11.3.1 Making them feel safe and secure

In interview one, Ella described what was important in looking after her newborn, *'making them feel safe and secure in a nice clean home where she/he or she is looked after and loved really.'* Making a child *'feel safe and secure,'* defining the maternal role in this way is reminiscent of the language used to describe attachment theory (Bowlby, 1969). Attachment theory emphasises the maternal role in the infant's care, and participants felt their role was central to the infant's wellbeing and development. In the first few months of life, mothers stressed the importance of the monotropic relationship (Bowlby, 1969) and the need for constant attention. There is no denying that young infants require a high level of nurturing for their physical and emotional needs. However, a narrative of possible harm accompanied this, reflecting the felt experience of surveillance and infant determinism with the supposition that any harm

befalling the infant either now or sometime in the future, resulting from early experiences, falls with the mother (Faircloth, 2014). During late pregnancy and the first few weeks of motherhood, participants contemplated how to keep the infant physically safe, for example, the possible consequences of sleep arrangements, monitoring breathing, and consideration of holding and handling the infant. Tess explained her and Mike's concerns about positioning Georgie for sleep:

'He gets all red and uncomfortable, which is why I don't think he likes being on his back, really. When we try and put him down in the cot, so he's so scared (Mike) of all the guidelines about, you know, putting him down any other way than on their back – but in the day, when I put him down on his front, he's fine. But then I'd be nervous of doing it – I would never, I wouldn't forgive myself if something happened to him when I put him down to sleep on his front, and then I fall asleep.' Tess, Interview 2.

In the first few months after birth, babies were kept close to their mums during the night, enabling participants to be responsive and monitor their physical wellbeing, as Mary described here:

'He could be kind of awake and lying there and us not knowing he's awake until he gets kind of upset enough to cry. So, I think we just like to be able to respond to him a bit quicker by having him nearby and me being able to keep an eye on him.' Mary, Interview 3.

11.3.2 Attachment parenting

'Attachment parenting' (Hardyment, 2007, p.291) was a concept that most participants seemed to endorse as a means of keeping their baby both physically and emotionally safe. The concept originates from Bowlby's theory of attachment (Bowlby, 1969). Attachment parenting entails care such as skin to skin contact, letting the infant establish their routine, and keeping them close always, for example, using a baby sling to carry the infant and co-sleeping at night. The suggestion is that attachment parenting creates a healthy emotional bond between parent and child, preventing problems

associated with a poor attachment relationship, such as mental health issues and criminal behaviour (Attachment Parenting International, 2021). Attachment parenting is associated with enhanced brain development in children (Sunderland, 2006, cited by Hardymont, 2007). Sanes and Jessell (2013) support the concept of an experience-dependent brain but do not relate this to either attachment parenting or attachment (see chapter 2). The need for close physical contact between mother and child was taken seriously by mothers in the early weeks and months, demonstrating to the infant that they were safe and secure, promoting the infant's mental health and wellbeing. If the infant felt safe and secure, then, in turn, she or he would be content as Natalie explained in how she cared for Freya:

'I try to keep her close and cuddle her and comfort her and try and soothe her with my voice as well. She likes being rocked when she's tired. It's just trying to make her happy and soothe her...' Natalie, Interview 2.

And Fran's perspective:

'My Mum will say, 'you should put her down to sleep more' my Nan will, people at playgroups will even John has said Fran you don't want to do the same as you did with Toby where he wouldn't go down at all. I do realise that I have to be practical about it, and so I will put her down at times, but I just think it goes so fast, and "I would rather be cuddling my Mummy than just lying in a" cot so when I can do it, I do.' Fran, Interview 2.

At the second interview, infants breastfed frequently and were kept physically close to their mothers, with infants demanding this contact. In Kleinian terms, the infant occupies the paranoid-schizoid position for the first three to four months of life, having a fragile ego coping with immense anxiety from internal and external forces (Klein, 1952). At this age, Klein (1952) theorizes that the infant cannot integrate good and bad experiences, experiencing extreme sensations of either anxiety or fulfilment. The infant experiences are through external and internal stimuli, with the sensation of fulfilment

experienced at this age through feeding (Klein, 1936). Infants sought close contact, signalling distress by crying and were only able to tolerate at best a couple of hours by themselves, perhaps activating attachment behaviour from the infant to keep their mother close (Bowlby, 1969). Alternatively, the behaviour is interpretable as the response to Western socialisation (Röttger-Rössler, 2014; Lancy, 2015). Klein (1937) views these behaviours as expressions of hate from the infant at a mother unable to satisfy his or her needs, making the child fearful for survival. The mother allays these fears by feeding the infant, and the infant receives gratification; this gratification leads to a sense of security, which is then associated with feelings of love (Klein, 1937).

There is the possibility that the relationship between mother and child might become one of love as they mutually regulated their affective states (Trevarthen and Aitken, 2001). Although the participants were tired, they did their best to provide the support they perceived their infant required, using their bodies in the early days to regulate both the infants and their own affective states, illustrating the intersubjectivity of the relationship and the possible implications for promoting both maternal and infant mental health. I observed Hanna and Freddie cosied together in a big chair at my first visit, as she appeared to enjoy intimate contact with her son:

‘He definitely likes to be close, so I keep him close. I wish I could put my bra back, but he seems to like being cuddled more with a naked boob; I don't mind just in case he needs a little top up it's there. It's not like he's going to be like it forever, so as long as he likes it, apparently, you can't spoil them when they are so small, you just can't, that's what my mum was like when she came here (she puts on a voice) “yeah you just need to cuddle him all the time and talk to him all the time, and he'll be fine.”’ Hanna, Interview 2.

By maintaining a close presence with their child, seemingly in tune with attachment theory (Bowlby, 1969), participants were hoping to establish the child's security and

independence. However, Bowlby (1979, p.139) is not keen on the term 'independence', preferring 'self-reliance'; this implies that there is always an attachment to the loved person, whereas 'independence' infers that person is surplus to requirements. Participants did not interpret the word in this way, appearing to perceive 'independence' as the child's ability to separate from them for a while and manage that separation, a separation that they anticipated becoming more pronounced as their child grew. As they considered this, mothers thought about their child's future self and their relationship with them; they expressed the hope that they would be able to nurture this relationship into one that was based upon mutual love and understanding. As part of this developing relationship, participants acknowledged that the infant's immaturity meant they could not manage distressing emotions, and their actions in helping their child with this reflected those of a container for their child (Klein, 1952). As Fran illustrated:

'It's just the balance between putting her down and giving her that security because I really am a really strong believer in when a child cries, certainly at this age, I just don't believe they have the capacity to understand why they would be being left to cry. So, I try and get to her as soon as possible. If she does start crying and I'm in the middle of a bum change with Toby, then obviously, I have to leave her a few minutes, but that's something I try not to do. I think because if you do have a really secure child, then they do become more independent, and they will be more confident as they grow up.' Fran, Interview 2.

While Hanna considered this to be a lifelong role, as she explained:

'I hope in the future I want him to just be himself and you know, in whichever way he wants to go to, to back him up with that, I think that you know if building up this kind of bond and this safety idea, this will hopefully payback in the future, and knowing I'm here no matter what he wants to do, I'm fine as long as he doesn't want to be a war criminal or something like that, yeah, or whether he wants to be a ballet dancer or ah or a footballer, that's fine, I'd prefer a ballet dancer though I hate football. (Speaks to baby, uses voice) "if you want to do it, though, it's fine." (What do you mean by safety?) I think for us it's the fact that no matter what I'm here and that he's fine and yeah, and nothing bad can happen because you know we're here, that's my thinking because that's what I have at home as well, cos you know although I am thousands of miles away I know that if something happens I can get back home and it will be fine, as you know I have my

sisters, my mum, my father, that you know that they will take care of me, so I think it will be nice for him to have the same feeling that you know, even if he decides to live god knows where you know I'm back here for him, I can take care of him, and you know not judging by letting him make his own mistakes but being there when he needs me.' Hanna, Interview 2.

11.3.3 Developing independence

As the infant develops, they are thought to integrate good and bad feelings towards an object; for example, their mother, becoming more secure in relationships (Frosh, 2012).

This development happens from around 3 months of age; at this age, mothers reported that their infant felt secure enough to be left for short periods to play by themselves.

However, the ability of the infant to manage this can be erratic, as Hanna explained:

'Normally when he wakes up after the morning feed, he is very happy to be by himself for about an hour, and hour and a half so I can just leave him in his bouncy chair or even sometimes on the floor, he just likes to be on the mat, and I can sort out the dishes and things like that, but when he is in grumpy mode, there is like no way.' Hannah, Interview 3.

Although the infant required the presence of a carer to respond to their needs, the need for physical contact was declining, a sign to mothers that their baby was content:

'I know when she's, well, I feel I know when she's getting unhappy or bored or annoyed or tired because she wants to be picked up and she wants to be carried around, and she's not happy if you put her down. You know, she'll cry, or she'll shout at you a bit or something or just fuss if she's put down. So, yes, I think when she's not doing that, when she's happy to play for a bit by herself or if she's, you know, being carried around or sitting on a lap and smiling and playing and cooing a bit, then I think it's, I find it quite obvious that when she is happy and when she's not.' Ruth, Interview 3.

A considerable change in the mother-infant relationship was described by mothers when the infant was 9 months of age. Mothers recognised the need for their children to go off and explore, wanting them to be curious about the world. Participants encouraged behaviours consistent with their socio-cultural environment, promoting independence and autonomous behaviour, a feature of Anglo-American values (Gaskins, 2006).

Mothers might feel societal pressure to promote care that encompasses the right values in their children, resultant in them feeling bad for not doing so (Carlson and Harwood, 2014). In promoting these values, mothers also helped their children fit into their environment. Ruth explained what this would mean for Isla:

'I think when she starts moving, that will be quite important because it will be her ability to get places under her own steam. It will be quite interesting for her; I think she'll be able to get where she wants to go. And explore thing a bit more widely. You know, her world will expand a bit, but she's not, not really anywhere near to that at the moment. I can just see the beginnings of intent around that.'
Ruth, Interview 5.

Participants believed that if their child were confident and in control of his/her body, they would hopefully feel able to go out and explore the world and feel secure in the care of others. Furthermore, getting their infant used to being with or being looked after by others appeared fundamental to the act of mothering and had implications for their child's future wellbeing. Mary explained how being bodily confident would help Harry to develop the independence to achieve his objectives without parental help, and he would, therefore, cope with being cared for by others:

'If we feel like he really wants to stand up, which he seems to like standing a lot, we'll give him the opportunity to try that, try that out and to practice it. And if he wants to move around, we'll, yes, make sure he has some time on the floor so that he can move around. I suppose confident in that way, really. But also confident in that he doesn't, I don't know, need to kind of be held or need us all the time. I'd like him to be confident around other people. When, not yet, but at some point, when I go back to work, I need for him to be all right to be left with other people.'
Mary, Interview 5.

Attachment theory focuses on the dyadic mother-infant relationship (Bowlby, 1969).

There is now increasing recognition that infants need to exist within a society, learn whom to trust, and form culturally harmonious relationships (Weisner, 2014). Infants come with the ability to form social connections and form intersubjective relationships, which are arguably essential to their survival (Stern, 1985). The rapid ability of human

mothers to produce infants means that we rely upon others- alloparents to help support our children's development (Blaffer -Hrды, 2009), to say nothing of the family's economic needs or the mother's wishes. By the time infants are 9 months of age, they are considered able to share intentional and affective states with a carer (Stern, 1985). The scope for the transference between mother and infant appeared to come to the fore with the transition to nursery. Some mothers recognised the possibility of transference of their feelings regarding nursery and how this might affect the infant to make the necessary adjustments (Klein, 1957), as described by Natalie:

'Now she's really settled in (nursery). But I don't know if it's because I was familiar with the nursery and the staff and so my, kind of, when I was talking to them, I was very friendly with them. And I don't know if she picked up on that I was very relaxed with the environment. Whereas with Jacob, because it was all new as well, he didn't settle quite as quickly.' Natalie, Interview 6.

For some mothers, the experience of settling their infants into a nursery was traumatic, resulting in some tears for Mary at our final interview. About to return to work, Mary had to help Harry manage the transition, despite feeling sad and unhappy at having to do this. There was possibly a transference of feeling between mother and infant (Klein, 1957). It is not easy to ascertain what prompted these feelings in Mary; she might have wished to stay at home with Harry. However, attachment narratives that underpin the nature of the infant-mother relationship may have resulted in feelings of maternal guilt (Blaffer-Hardy, 2009). Mary described a settling in session:

'Well, the first one I just, I was there with him. So, he was fine because he knew I was there and the second one I stayed for half of it and again he was fine and then the times when I've left him, which have been probably well for about half an hour and then 45 minutes and then today for an hour he has been quite upset when I've not been there. But they said since they've been able to settle him. So, I'm a bit worried about quite how he'll cope for a whole day without me because I think he's not used to me not being there. And it's a long time for him to have, just be around other people.' Mary, Interview 6.

11.3.4 Summary of sub-theme a place of safety

This sub-theme charted how the mothers' recognised their infant's complete dependence from birth and how they viewed the need for a safe and secure environment for him or her. Responding to the infant in a receptive way that embraced their affective needs was the central means of achieving this for participants, as they adopted practices attributed to attachment parenting (Attachment Parenting International, 2021). The participants moved to nurture their relationship with their child, the intersubjective process of this apparent. Despite the emphasis upon attachment parenting, mothers were keen to move beyond their monotropic relationship with their child. The child's ability to form social networks was important, as participants acknowledged their child's needs for relationships with others as they faced transitions in life that brought separation from them.

11.4 Conclusion

The theme of creating a safe space illustrates the complexity of caring for an infant in the first year of life as portrayed by the participants. Safety was not only about the child's immediate physical wellbeing; although this was an essential element of the care they gave their child, but it also reflected the desire to allow both mother and child to grow emotionally and learn to separate from one another. Fundamentally mothers felt that it was important to ensure that their child was content and that they had the means to develop as an individual, for example, through exploration with others or time to play without impediment from others. Participants viewed these qualities as essential to developing independence, helping the child self-regulate within environments away from home, which the child required reflecting the socio-cultural reality for participants

and their families. The emphasis upon attachment (Bowlby, 1969) and maternal relationships with the infant echoed societal constructs of mothering and mothering; as Miller (2005) reflects, societal demands on mothers have changed, but concepts of what constitutes good mothering have not.

This theme demonstrates that maternal behaviours that focus on keeping the child safe from both a physical and mental perspective centred on helping their child cope with possible future expectations that life might bring. The need for the mother-infant relationship to move beyond the dyad to encompass others was vital in helping both adapt to the changes that life brought and would bring. Regarding research objective three, it is possible to see how maternal behaviours were shaped in response to their infant's physical and affective needs, arguably crucial to developing positive mental health. While reflecting on research objective four, this theme illustrates how mothers believed that infant behaviour was partly responsive to the care given to that child and reflected the child's developing agency.

In the following final chapter of this thesis, I present my discussion and conclusion for this research. I begin the next chapter by identifying what this research has achieved.

Chapter 12: Discussion and conclusion

12.1 Introduction

This chapter discusses the overall findings from my research relating to relevant research, theory, and policy. Initially, I consider what this study has achieved, discussing the critical points from the findings. I then move on to make some recommended actions for practice, policy, and education, reflecting how this research extends existing thinking for the development of health care services for mothers and their infants.

12.2 What this research achieved

This research set out to answer two questions: firstly, to explore the influences and experiences that help to construct maternal perspectives of infant mental health, and secondly, to explore how maternal experiences of infant mental health influence the behaviours and strategies mothers may use with their infants. In using qualitative research, I adopted an inductive approach (Ellis, 2004; Guba and Lincoln, 2008). Qualitative Longitudinal Research (QLR) was used to collect data during a period of 15-18 months through interviews in a setting chosen by the participant, usually their home. A hermeneutic approach was adopted for the study; in doing so, I accepted that the hermeneutic circle never closes, and therefore interpretation is always in progress (Squire, 2011; Frank, 2012). By using a hermeneutic approach, I embraced the concept that individual perspectives are considered in relation to the experiences of all of those who participated (Squire, 2008; Josselson, 2011), with themes emerging that illustrated

what was of importance to participants. In consequence, the subsequent findings from this study illustrated the emphasis that mothers placed upon the developing relationship with their child. This relationship was considered fundamental to both maternal and infant wellbeing and evolved over time between mother and infant to meet their mutual needs. Participants worked to create and sustain identities for themselves, and their infants suited to their socio-cultural context and individual situations. Temporal influences were apparent within the construction of the mother-infant relationship, as illustrated within the findings as mothers drew upon their past experiences of being mothered and their childhood. These considerations sat alongside participants social networks, socio-cultural milieu, and family relationships to shape their childcare practices and how they perceived the developing relationship with their child. Participants drew upon these influences as they looked to the future to consider what they imagined for their child and the mother they wanted to be. Arguably, given the participants' emphasis, these relational factors were fundamental to promoting their infant's mental health and wellbeing, the following section considers the findings from the study within the context of infant mental health.

12.2.1 Within the context of infant mental health

The definition of infant mental health that operationalised the study as outlined in section 1.2 and repeated here, characterises infant mental health:

'as the ability of infants to develop physically, cognitively, and socially in a manner which allows them to master primary emotional tasks of early childhood without serious disruption caused by harmful life events. Because infants grow in a context of nurturing environments, infant mental health involves the psychological balance of the infant-family system.'
(Fitzgerald and Barton, 2000, p. 28).

This definition represents an interplay between the environment and their caregivers' psychology. Fitzgerald, Weatherston, and Mann et al. (2011) emphasise the importance of viewing infant mental health within the context of a system, a system which is represented by ecological theory, see Bronfenbrenner (1979; 1992) and Super and Harkness (1986), see Chapter 2, section 2.4.2.2. for a discussion relating to this. Fitzgerald and Barton's (2000) definition of infant mental reflects the 'developmental niche' (Super and Harkness, 1986, p.546), emphasising the link between anthropology and psychology, as explored in section 2.4.2.2. It underlines the child's microenvironment, including childcare practices and beliefs and how they interact with the broader environment.

This research has captured the significance of maternal childcare practice, beliefs, and interactions with the wider socio-cultural environment. These elements were largely missing from the literature obtained from the systematic review study described in this thesis (Peters et al., 2019) (see Appendix A and Chapter 3). The research presented as part of the systematic review (Peters et al., 2019) tended to focus upon the perspective of professional groups, such as psychology, with mothers primarily considered as research subjects. However, a body of work as outlined in Chapter 3, for example, Oakley (1986); Ribbens (1994); Nielsen and Rudberg (2000); Thomson et al. (2011) and Thomson et al. (2012), illustrates that in order to explore mothering, and child care practices from the perspective of mothers a different approach was required. An approach that allows the researcher to 'walk alongside' participants in real time as they experience transitional moments in their lives, in essence QLR as adopted in this study (McLeod and Thomson, 2009. P.61). The findings from this research adds to the work of Oakley (1986); Ribbens (1994); Nielsen and Rudberg (2000); Thomson et al. (2011)

and Thomson et al. (2012) with this study demonstrating how the mother-infant relationship within this group of participants developed over the first year of life. The development of this relationship is partly driven by the demands of the microenvironment in which mother and infant reside, with maternal responses influenced by acceptability to the socio-cultural milieu of the macroenvironment. These findings reflect Weisner's (2002, p.277) concept of 'cultural pathways', which are activities children, and their carers engage in to make sense of and harmonise within their local communities. The following section explores the developing maternal-infant relationship within the context of this study in more detail.

12.2.2 The developing maternal-infant relationship

Central to the findings within this thesis is the nature of the developing relationship between the mother and her child. The research illustrated how the relationship is responsive to their mutual needs, with infants capable of subjective behaviours from as early as 2-3 months, illustrating their ability to engage in this process (Trevarthen and Aitken, 2001). The mother-infant relationship was tailored to individual circumstances yet influenced by their socio-cultural milieu, reflecting the interaction of these factors as also illustrated by Thomson et al. (2011) and Thomson et al. (2012). The findings demonstrated that mothers centred their care for the infant by being responsive to their physical and emotional needs or, as Winnicott describes it as 'holding' the infant, being at one with him or her to make them feel safe and secure, helping their infant to adjust to the world (1960a, p.43). Participants believed that these actions not only contributed to their child's ongoing well-being but also would help establish a positive mother-infant relationship. However, this relationship depended on attunement and reciprocity between mother and child and support from others. Mothers seemingly needed this

support to help them as they acted as the container (Bion, 1959) for their child and their emotions. They sought reverie (Bion, 1962a; 1962b) through their interaction with social networks, illustrating the importance of the eco-cultural setting (Weisner, 2002). This form of care was usually found from other mothers or, in some instances, family, as demonstrated by Ribbens (1994), whose research illustrated the importance mothers placed upon their local social networks as a source of support.

As the infant developed, the mother and infant engaged in what Stern (1985, p. 141) terms 'affect attunement.' Meaning that the mother was able to share the infant's affective state to reflect what the infant was feeling and understood by the infant. This behaviour was particularly noticeable as mothers encouraged infants to express their emotions, particularly when happy or engaged in play with them, and by allowing her child some time and space for themselves. Both behaviours formed a mutual need, mothers needed to see their child happy; this reinforced that their baby was well and that they were doing a good job. However, as the infant developed and began to be capable of spending time away from the mother's immediate focus, mutually they were able to give each other space. These findings illustrate how important it is to think about research with the mother and infant relationally, to try and understand the unique relationship they have and how this influences maternal care (Thomson and Baraitser, 2018).

12.2.3 Co-constructing maternal and infant identities

The research illustrated that maternal and infant identities are constructed in relation to each other and others in their social world (Trevarthen and Aitken (2001). Maternal

identities appeared constructed in response to the interplay of the socio-cultural environment, maternal imagination and experience of the past, present and participant hopes for the future. In terms of developing identity, a person has to learn how 'to be in the world' (Heidegger, 1927, p.39); arguably master narratives help to do this by providing an understanding of how to position oneself in relationship to their socio-cultural environment and to others within that environment (Bamberg, 2004; Hammack, 2008). The internalisation of master narratives is considered vital in enabling a person to adopt a particular culture; however, this is a two-way process, as when the person interacts with their environment, they also create culture (Vygotsky, 1978). This process reflects the collective nature of our existence that we can reproduce culture yet work within cultural rules, learning to adapt within them, reflecting our need for individualism and intracultural differences. For the participants in this study, engaging with other mothers of young children was influential in developing their maternal identity, as illustrated in other research, such as Miller (2005).

Caring for a young child was viewed by mothers as a risky activity, a position reinforced through the impact of biological determinism on narratives that surround motherhood (Gillies, Edwards and Horsley, 2016; Macvarish, 2016). To manage the risk associated with this and the uncertainty in their abilities to handle this, mothers found the company of other mothers with similar parenting strategies helpful, giving them emotional space and providing a means to measure their mothering abilities and child's development. The possible displacement of mothers from networks of familial and local support resulted in motherhood being a potentially lonely prospect; this is also something which has been described by Rich (1986), Hill Collins (2000) and Miller (2005). However, the thematic analysis and individual narratives illustrated that

although mothers looked to professional sources for information, particularly online resources, there was some resistance against health surveillance from health visitors and midwives. Instead, they preferred to develop relationships with other mothers, use community groups to share their experiences, and maximise child development opportunities, reflecting Ribbens' (1994) findings. This narrative appeared to relate to their positioning as experts in their own children's care, as suggested by other research (Miller, 2003; 2005), and referencing health professionals was a possible threat to maternal expertise and the narrative of a good mother.

The participants in this research gave prominence to informal networks, such as grandparents and peers, and formal support groups to help them through the first few months with a new baby; the pandemic has severely limited the availability of these supports. When writing this thesis, the United Kingdom is in its third national¹⁷ lockdown due to COVID-19, a coronavirus pandemic (WHO, 2021; GOV.UK, 2021). Considering the findings of this study and the emerging results of research with parents who have children aged 0-13 in lockdown, which has reported that parents are experiencing parental exhaustion (n=17%), with mothers more likely to be affected (Fontanesi et al., 2020), there must be some concern over the impact of the current situation on families with young children.

As discussed in Chapter 2, creating an identity is a temporal process (Vygotsky, 1978).

The temporal nature of the developing maternal identity was evident as participants

¹⁷ National lockdown refers to the precautions taken by the UK Government to combat the spread of COVID-19. This involves staying at home, unless the individual needs to leave for work, food shopping, health concerns, domestic abuse or exercise (GOV.UK, 2021).

reflected past experiences, those of their childhood, perceptions of being mothered themselves, and the socio-historical context that their mothers and the mothers of their partners had mothered, as reflected in research by Nielsen and Rudberg, (2000); Thomson et al. (2011) and Simmons et al. (2021). They considered these experiences and perceptions in relation to contemporary mothering practices, for which they used other mothers, social media, and professionals to gather knowledge. There was a synergy between the concept of a good mothering identity and child wellbeing; maternal identity developed from a master narrative (Hammack, 2008) that provided participants with cues for behaving in this role. Participants looked to the past, as illustrated in the studies by Nielsen and Rudberg (2000); Thomson et al. (2011) and Simmons et al. (2021), drawing upon what they felt was right and identified the need to do things differently; however, they also acknowledged the unconscious influence that experiences of being mothered had upon their practices as mothers (Chodorow, 1999). Therefore, the intergenerational nature of mothering was acknowledged by all participants, for example, either through the rejection or adoption of similar parenting values; also see Nielsen and Rudberg (2000). In addition, there was the realisation that 'ghosts' from their childhood sometimes unwittingly appeared in their attitudes and behaviours toward their children (Fraiberg, 1980, p.164). The findings from the study are therefore that of complexity, as reflected by Nielsen and Rudberg (2000); Thomson et al. (2011) and Simmons et al. (2021), who also suggested that mothering identities and child-rearing practices are shaped by intergenerational factors and reflect an interweaving of socio-cultural and historical considerations.

Maternal identity was in a constant state of development in response to the changing needs of their lives, co-constructing this identity in response to their children as they

responded to their children's needs, echoing the research findings of Simmons et al. (2021). Participants, identity reflected their expectations as new mothers, learning to adapt to new demands, for example, their child moving from dependence to relative independence and returning to work. Mothers always had an eye on their child's future well-being. It seemed important for all participants to help their infant become independent, suggesting individualist socialisation goals (Park, Coello and Lau, 2014) and cultural perceptions of children from the West (Harwood et al., 1996; Miller and Harwood, 2002; Park, Coello and Lau, 2014) while also having a child that would 'fit in,' echoing the collectivist aspect of mothering a child.

Helping a child to develop in such a way that they could adapt to a situation, whether that be a nursery or school, was an essential aspect of mothering, the success of which they felt reflected on them and their child. Returning to Bruner's (1990) folk psychology, it might be argued that their child needed to interpret cultural scripts and absorb the underpinning values of society (Erikson, 1959). Therefore, mothers engaged in helping their child create an identity to accommodate this by using informal peer support, as illustrated previously in Peters and Skirton (2013) and Tighe, Peters and Skirton (2013). Thus, demonstrating the need to consider child care practices within the context of the mother-child relationship (Thomson and Baraitser, 2018) and in relation to other social networks as illustrated in research by Ribbens (1994) and Thomson et al. (2011), and reflected in Weisner's (2002) eco-cultural and Lewis' (2005) social network theory, helping their children to assimilate into their communities. Participants took their infants to groups and encouraged collectivist socialisation goals alongside those connected to individualist ones (Parker, 2014). These actions were an essential aspect of their role, helping their child internalise culture, demonstrating that mothers may

choose socialisation goals for their children depending on their particular cultural setting and needs (Super and Harkness, 1986; Weisner, 2002; Thomson et al., 2012) rather than reflecting traditionally accepted perspectives. Maternal perceptions and needs shaped infant behaviours; individual infant behaviours were encouraged through independent play, see Winnicott (1971); directed in part through the maternal need to be with another child or engage in other activities. More broadly speaking, it was possible to see the interplay between the wider social environment, maternal psychology and how this works to manage the child's microenvironment as described by the ecological model of the 'developmental niche' by Super and Harkness (1986, p.546).

12.2.4 Imagined maternal self and child

The findings illustrated the importance of imagination to maternal identity; this potentially encompassed imagining the mother the participants wanted to be, their child's character, and the person that child might become. However, this construct must move from imagining into our 'everydayness of being' (Heidegger, 1927, p. 39), in essence, what it means for someone to exist as a mother. The participants in this research appeared to internalise the master narrative (Hammack, 2008) of motherhood as represented in their socio-cultural milieu. They were perhaps using the reproductive imagination based on an existing image (see section 4.2.2) to feed the productive imagination, to produce something new – a fresh reality with the self's changing dynamic as a mother to a new baby (Ricoeur, 1975, cited by Taylor, 2006). As we move through life and establish our identity, we both introject and project aspects of psychic life; these introjections and projections are both positive and negative entities (Klein, 1946; Bion, 1959, 1962a). We introject external events and narratives as they happen around us, which we internalize and become part of the self (Bruner, 1986a;

McAdams, 1996). As mothers shared their stories with me, imagination became somewhat of a reality, as their narratives regarding the mothering self-reflected the mother they wished to be and the mother they already were (Ryan and Irie, 2014).

The participants illustrated a powerful perception of what it means to be a mother within their socio-cultural context, potentially making the imagined mother within this setting a reality (Ryan and Irie, 2014). By following socio-cultural scripts (Miller, 1996), mothers imagined a child that was to become, participants started to create an identity for their child from before birth, giving themselves an image with which to work, to feed their productive imagination (Ricoeur, 1975, cited by Taylor, 2006). Socialisation goals were an essential aspect of mothering their infants, as previously found in the research by Ribbens (1994). A child able to conform to socio-cultural expectations was seemingly imagined by participants as able to get along well with others and, therefore, likely to be happy. Therefore, participants appeared to apply perspectives they might use to form their own identity onto their child, see Ryan and Irie (2014). Thus, childcare practices were focused on engagement with opportunities for their child to mix with other children and develop relationships with others, as illustrated by Ribbens (1994). Weisner (2002) and Rogoff (2003) discuss the importance of the environment and how it shapes parents' priorities. Interestingly, the participants prioritised socialisation goals based upon a mixture of individualist values relating to autonomy such as independence and collectivist goals such as respect for others, which illustrates the problems in making assumptions regarding parenting behaviours based upon culture (Park, Coello and Lau, 2014).

Mothers created images that might help to nourish the child's reproductive imagination through play and stories, images that the child might then use as a basis to develop the productive element of their imagination (Ricoeur, 1975, cited by Taylor, 2006). The mothers in this study worked on designing a narrative for their infants, reinforced by telling stories of infant behaviour, creating opportunities to experience the world, and collecting memories through keepsakes such as photos, which they then used to underpin their stories. The 'everydayness of being' (Heidegger, 1927, p.39) is reflected in these mementoes, and through the stories, mothers will most likely later tell their children to recreate the past, ascribing characteristics to their actions and helping them form a sense of who they are and how they might expect to react to situations. Thus, their actions potentially create a sense of continuity for the child, of a past and a life they cannot actively remember but present in their subconscious, a guide to how they fit into their environment, a place for the developing ego to access (Freud, 1923).

12.2.5 Socio-cultural context

The socio-cultural context was central to the developing maternal-infant relationship, helping to co-construct maternal and infant identities, influencing how mothers perceived the relationship with their child and reinforcing knowledge regarding child development and childcare practices. In addition, the temporal nature of mothering practices was apparent, existing within the context of historical time (Nielsen and Rudberg, 2000; Thomson et al., 2011). Influenced by theoretical knowledge, for example, attachment theory (Bowlby, 1969) and societal expectations, driven not only by the media but a culture of intensive mothering (Hays, 1996) (see Chapter 2), again reflecting findings by Thomson et al. (2011).

The findings from this research indicated that mothers took a moral approach to the practice of mothering, embracing narratives of the good mother by reflecting childcare customs that reproduced this, for example, their approaches to infant feeding and expectations of infant behaviours and beliefs regarding the need for the mother to make sacrifices in favour of the child. Mothering was viewed as risky due to the special status of both the mothering role and that awarded to children within their social-cultural milieu, the amplification of risk associated with infant feeding and growth as documented with breastfeeding by Knaak (2010); and Lee (2007b) (see Chapter 10). Taking this approach may help mothers resolve negative feelings that can accompany the adoption of the maternal role, as this can make other aspects of a woman's identity invisible, yet playing to the social construct of the good mother can augment a feeling of self-worth (Weaver and Ussher, 1997). All the participants were interested in maintaining and perpetuating the 'front stage' behaviours expected of the mother (Goffman, 1959, p.129), constructing the 'good mother' rather than behaviours they viewed as reflective of 'bad' mothering practices, for example, a failure to breastfeed or to help a child become an individual that others could like. Good mothering was replicated through their use of intensive mothering (Hays, 1996) strategies and mothers' ability to engage in active learning environments with their infants and most likely representative of socio-cultural beliefs that this was the best learning experience for their baby.

Mothers predominately assumed their infants' care, reflecting essentialist expectations of their gender and role, as reported in similar research (Miller, 2005). Fathers, while involved, mainly left the caring and daily decision making regarding the infant to the mother. Their behaviour echoed gender expectations regarding the roles, a not unusual

scenario within the UK (Dermott and Miller, 2015). Despite advancements in paternal involvement with children, it is difficult to assess what motivates this, whether it reflects a practical need due to maternal employment or internalisation and change to paternal identity (Dermott and Miller, 2015).

In this section I outlined the findings with reference to other literature in the field, in the next part of the Chapter, I consider the strengths and limitations of the study.

12.3 The strengths and limitations of this study

The World Association of Infant Mental Health (2016) has declared that the child is of special interest between the ages of 0-3 years due to the experience-dependent nature of their neurological development at this time. This research formed a doctoral study; the nature of the methodology and the time frame meant that I could only recruit a relatively small number of participants and limited data collection to 15-18 months. Therefore, using a longitudinal research methodology that would follow the development of the maternal-infant relationship in those first three years of the child's life would provide insight into how mothering culture affects attitudes towards mothering and maternal care that infants receive in this critical period.

However, this study considered the unique relationship between the mother and their infant within their own socio-cultural milieu over a period of time, which is essential to try to understand mothering and child care practices for what they are, rather than concepts to be measured against unfairly created social constructs (Thomson and Baraitser, 2018). The relatively homogenous nature of the sample is both a strength and a limitation. The sample lacked diversity, for example, from differing ethnicities, lone mothers, young mothers and gipsy and travelling groups; capturing the experience from the perspective of mothers with differing characteristics is an area that requires further consideration by researchers. I have interpreted the phenomenon through the perspectives of a similar group of women in terms of their white ethnicity and middle-class working backgrounds. Nevertheless, the findings illustrate that maternal identity and mothering practice are an experience constructed through interaction with the individual's socio-cultural milieu and relationships with her child and those close to her, reflecting research findings by Ribbens (1994); Thomson et al. (2011) and Thomson et al. (2012). Despite the participants being part of a well-represented group in terms of research (Henrich, Heine and Norenzayan, 2010) this study differed as it looked to explore their perceptions and knowledge. Whereas previous research in the field of infant mental health as explored by the systematic review outlined in this study (Peters et al., 2019) and in Chapter 3, which has tended to view mothers as research subjects.

This study is situated within a hermeneutic framework (Heidegger, 1927; Ricoeur, 1981, 1991a) as such findings are grounded within my interpretations of the research and are then completed by you, the reader (Ricoeur, 1991a). I used a psycho-social lens to inform my analysis of the data; as part of this process, my supervisory group were consulted throughout, and their involvement prompted thinking about

countertransference, whereby I acknowledged the emotions that I had internalised due to contact with participants (Jervis, 2009; Hollway and Jefferson, 2013). Using this approach is problematic as the researcher's emotional responses can cloud the data analysis, which is where the supervisory role and researcher reflexivity are especially useful. However, the interpretations presented here, although founded in participant narratives, researcher field notes and open to scrutiny through reflexivity and the supervisory process, may not represent participants as they perceived the situation. It is important to remember that reflexivity is a subjective process, which although open to scrutiny through supervision, there is some inevitability that researcher interests are included within the process of data analysis (Koch and Harrington, 1998). In adopting a psycho-social approach to thinking about the data, I provided a theoretical basis which is contestable by the reader (Squire, 2008) but is open to critique by some for its expert led, and top-down approach to interpretation (Frosh and Baraitser, 2008).

The findings of the systematic review (Peters et al., 2019) (see Appendix A) and my personal and professional background situation resulted in a research project that focused on maternal perspectives. On the one hand, it would be easy to claim that equivalent research needs to be undertaken to address fathers' perspectives of the issues addressed in this thesis; however, it is a complex subject. Dermott and Miller (2015) make the case that research on fatherhood needs to address some of the issues that impact fathering practice, such as divorce or separation, rather than focusing on issues that appear to be important to researchers.

In the following sections (12.3-12.6) I consider recommended actions for practice, policy, and education.

12.4 Recommended action for practice

This research has demonstrated that mothering a child is a huge responsibility reinforced by societal expectations. To sustain them in this role, mothers need support from others. The mothers in this research illustrated that social networks, friendships and family were fundamental to maintaining their wellbeing and, therefore, the infant. The findings from this study suggest that practice should focus on providing ‘nurturing care’ to the child, parents, and family within their community setting (Britto et al., 2017, p. 98). By adopting an approach that focuses on educational and social needs and the family's ecological setting rather than modification of parenting behaviours. A narrative review by Cowley et al. (2015, p.465) found that health visiting is symbolised through a ‘particular orientation to practice.’ This orientation to practice is identified as a set of skills, values, and attitudes to provide universal health visiting services, typified as ‘salutogenesis,’ ‘person-centredness,’ and ‘person in situation,’ (Cowley et al., 2015, p.465). Thus, the practitioner moves toward helping the individual and their family view health positively, focusing upon strengths and resources (Antonovsky, 1996), using an approach that values them within their ecological situation (Cowley et al., 2015). This orientation to practice, which emphasises the development of the practitioner-parent relationship within the client’s setting, is supported by the findings from this study that suggest the primacy of the participant’s socio-cultural setting, local social networks and those close to them in developing a relationship with their infant. Therefore, indicating how important these aspects of participants’ lives were as

strengths and resources in maintaining the health and wellbeing of both themselves and their infants (Antonovsky, 1996), and as such practice needs to support mothers in developing and maintaining these networks.

Practitioners should be aware of the strengths and weaknesses of the evidence base in the field of childcare practices and the emphasis upon parenting values, identified as higher middle class, reflecting one group in society, with this group tending to set the bar for what is considered good parenting (Dermot, and Pomati, 2016). Intensive mothering (Hays, 1996) was apparent throughout the findings of this research, an approach to practice that focuses more so on the maternal-infant relationship within their ecological setting may help both practitioners and mothers to consider what is significant for childcare practices, rather than these negative constructs (see Thomson and Baraitser, 2018). Practitioner reflexivity and insight is needed to consider how their expectations of mothers are informed by their perception and interpretation of socio-cultural values rather than by what is 'good enough' parenting (Winnicott, 1971, p.10). Practitioners should encourage parenting practices situated in evidence, not within their value systems, and need to be aware of how their values may influence practice. Practitioners must appreciate that mothers may experience guilt if they cannot meet what they perceive is expected from them as mothers by society, resulting in higher maternal stress and anxiety (Henderson et al. 2016).

12.5 Recommended action for policy

There are three key areas for policy development that have emerged from this study. First, current policy (DH, 2009; Axford, 2015) does not recognise that mothers need

others or the community's pivotal role in supporting them, and this needs further consideration. Secondly, the professionalisation of services has led to some resistance among mothers. A public health approach is required that identifies parenting as a universal need to remove the stigma that targeted interventions bring (Cowley et al., 2015; Clarke and Younas, 2017).

Lastly, this research provides evidence that we should reimagine policy in this field. Acknowledgement is needed of how societal values underpin the research in this area and the limitations this imposes on our understanding. The research focus is at times poorly interpreted (see Chapter 1) and has led to a focus on the individual parent as seen within the Healthy Child Programme (DH, 2009; Allen Review, 2011; Axford, 2015). As this research illustrates, the developing infant is subject to a complex interplay of various factors, one of which is biology; however, the influence and interpretation of research that leads to physiological development tend to result in policy and practice that emphasises a 'one size fits all,' approach. The focus upon individual parenting behaviours sits within a biologically deterministic framework and does not reflect the reality of maternal lives. The eco-cultural setting is essential in what a mother perceives as important for her child (Weisner, 2002) and reflected in Cowley et al. (2015) orientation to health visiting practice. Services need to be developed that are place-based to respond to the needs of a specific community, with consideration given to policies that address how structural components affect parenting behaviours (Tomlinson, 2015; Marmot, 2020). The systematic review (Peters et al., 2019) (see Appendix A) and the problems with recruitment for the research illustrate how difficult it is to get representation from mothers from a range of backgrounds, and action is

needed to ensure that this is taken into consideration when engaging mothers as end-users of policy directives.

12.6 Recommended action for education

Mothers worked to develop the relationship with their infant and maintain maternal-infant wellbeing within their microenvironment, influenced by their wider socio-cultural milieu (Super and Harkness, 1986, Weisner, 2002). The draft standards of proficiency for specialist community public health nursing (Nursing and Midwifery Council, 2021) emphasise an ecological perspective is required for health visitor education, describing how practitioners need an in-depth knowledge of the communities in which they work, the population group and how these local contexts affect the resources and support available to families, and the choices they might make. The finding from this research supports this approach.

Educational programmes need to recognise the complexity of the maternal-infant relationship and the factors that influence the development of both mother and child. This thesis has demonstrated the complexity of this relationship, and it is a mistake to focus on one aspect of this relationship, as represented by a theory for example, attachment theory (Bowlby, 1958; 1969). Those responsible for educational programmes need to consider carefully how concepts such as infant mental health are operationalised as required within the draft standards of proficiency for specialist community public health nursing (NMC, 2021). Ultimately though, the nature of the

relationship between the mother and her infant is an individual one (Burman, 2017), located within a particular historical and socio-cultural context. Educational programmes should acknowledge the unique nature of this relationship and be aware that it is all too easy for mothers to become side-lined by research and for motherhood to be devalued (see Thomson and Baraitser, 2018).

Practitioners require skills to work within community settings to promote a universal service to mothers and their families, as outlined by Cowley et al. (2015). The future practitioner needs to see the links between the community setting and the individual at its heart. To achieve this, future practitioners require the ability to work at a macro and micro level, forming partnerships with those in the community and taking a person-centred approach to the mother and her infant. In achieving this, educational programmes need to produce practitioners confident in-home visiting and adept at building therapeutic relationships with mothers and their families (Cowley et al., 2015).

In the next section I consider the implications for future research.

12.7 Implications for future research

Recruitment was a particular issue for this study, particularly recruiting participants from more diverse backgrounds. To try and resolve this difficulty, researchers might engage with specific communities and groups to consider how they might recruit a more diverse group of mothers. For example, using a more traditional ethnographic approach, as I undertook in my MSc research (Peters and Skirton, 2013; Tighe, Peters, and Skirton, 2013) might be one approach, whereby the researcher engages within a group

setting of mothers, which may provide the opportunity to enhance the relationship between researcher and participants (Heys, 1997; Tighe, Peters and Skirton, 2013).

A community-based participatory methodology (Wallerstein and Duran, 2006) may epitomize mothers' voices more fully. This methodology supports partnership working, tackling health inequalities, health improvement and community transformation (Oetzel et al., 2018) and is used to give underrepresented groups a voice, as demonstrated by Vedam et al. (2019), where service users designed indicators of maltreatment in childbirth. In using this approach, the intention is to support and encourage the community to be actively involved in the research design, for example, identifying the sort of research questions that they might wish to ask about the issue of concern to their community (Wallerstein and Duran, 2006). Of course, this might result in a view that the community does not perceive the developing maternal-infant relationship or questions of maternal-infant wellbeing or childcare practices as issues of concern. However, using this approach might also recruit a more diverse sample and a study with a stronger claim to ecological validity (Bronfenbrenner, 1977 and Cicourel, 1982). However, there is the potential for individuals to remain marginalised even with a community orientated approach.

In the following section, I conclude my thesis.

12.8 Conclusion

In this thesis, I have demonstrated my claims for originality by using qualitative longitudinal research set within a hermeneutic framework to explore the factors that influence maternal perceptions and use of knowledge relating to their infant's mental health. In doing so, I have provided mothers with space over 15-18 months to explore and give voice to their experiences. Maternal perspectives illustrate how the maternal-infant relationship evolves to meet their mutual needs reciprocally as mother and child develop. Participants worked to create and sustain identities for themselves, and their infants suited to their socio-cultural context and individual situations. These relational factors were considered crucial to maintaining both infant and maternal wellbeing.

Although identities are fragmented and multiple (Takševa, 2018), the research demonstrated how the need to form a robust maternal identity responsive to an understanding of their socio-cultural master narrative dominated the understanding of the mother-infant relationship and childcare. The development of maternal identity and care of the infant occurred concurrently within the context and changing milieu of the microenvironment, where the family's needs were identified and subsequently influenced maternal behaviours with their infant. Throughout the research, the temporal nature of maternal perceptions regarding maternal identity and maternal care were apparent, as mothers reflected on the past, constructing narratives to establish how they might want to nurture their child and the possibilities for their future. Mothers were primarily concerned with establishing a child with a formative identity that others might recognise positively, identifying an interconnection between this and what it meant to be a successful person within their society.

As highlighted from the outset of this thesis, there has been little representation of mothers and consideration of the settings in which they live in the development of policy and research connected to early childhood development and subsequent practice. This study has demonstrated the importance of the mother-infant relationship towards positive infant growth and development, and the fundamentality of the ecological system in supporting this. Thus, highlighting the importance of considering these factors and embracing maternal consultation in the development of policy, practice, and research.

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Appendix A: A systematic review of the literature

This is a version of the systematic review paper as accepted for publication, by Peters, J., Skirton, H., Morgan, J. and Clark, M. (2019) How do parents perceive and utilize knowledge of their infant's mental health? A systematic review. *Journal of Child Health Care* 23, (2) pp 242-255.

Introduction

Promoting the development of good mental health in utero and infancy is one of the key components for wellbeing throughout life (Public Health England, 2016) (PHE).

Infancy is a critical period of neurological development (Sanes and Jessell, 2013), as early experiences during childhood have been shown to have an impact upon brain development (Sheridan and Nelson, 2009). The environment in which children live affects their biological development, through a process called 'biological embedding,' which leads to neural development and neural sculpting (Irwin, Siddiqi and Hertzman, 2007, p.21). Although the brain continues to develop throughout the life course, the neurological development that takes place within the prenatal period and first three years of life provides a foundation that influences our emotional, perceptual and cognitive abilities, and subsequently our learning as we progress through life (Fox, Levitt and Nelson, 2010).

Infant mental health (IMH) is defined as:

'the ability of infants to develop physically, cognitively, and socially in a manner which allows them to master primary emotional tasks of early childhood without serious disruption caused by harmful life events. Because infant growth is maximized in a nurturing environment, infant mental health involves the psychological balance of the infant-family system,' (Fitzgerald and Barton, 2000 p. 28).

The environmental factors that influence a child's development and subsequently their mental health are multiple and complex, extending from the individual child to the global context (Irwin, Siddiqi and Hertzman, 2007). The focus on how early experiences influence the developing brain has led to the promotion of infant emotional and social development through early interventions aimed at children aged between 0-3 years (Allen, 2011). Early interventions focus on parenting as the source of infant brain development, the emphasis usually upon the action of parents, particularly the mother (Lowe, Lee and Macvarish, 2015). Parenting practices and understanding of child development are shaped by the culture of communities, for example the activities, practices, beliefs, and ecology of the settings, in which children and their carers live (Weisner, 1996). However, central to infant mental health, is the infant's subjective experience of the world, and this initially takes the form of relationships with care givers (Zeanah and Zeanah, 2009). Quality of the infant –parent relationship may impact the development of adult psychiatric disorders; particularly when the relationships are neglectful and intrusive (Fryers and Brugha, 2013).

Encouraging parents to create an environment to maximize infant mental health, is a key task for health and social care professionals (Department of Health and NHS England, 2015; PHE, 2016). Yet little is established regarding parents' knowledge of their infant's mental health. Therefore, the aim of this systematic review was to explore how parents perceive and utilize knowledge of their infant's mental health, with a view to informing professionals of the best way to support them. The objectives were to, 1. Identify what infant mental health means to parents, 2. Consider how parents gather knowledge of infant mental health, 3. Explore how parents use their knowledge of infant mental health, 4. Consider how health and social care professionals can utilize the

current evidence to promote infant mental health with parents.

Methods

A systematic review can be used to identify and evaluate the current evidence on a topic and is used frequently in a healthcare context as a foundation for recommendations and policies (Centre for Reviews and Dissemination, 2009) (CRD). Using guidance provided by the CRD (2009), a search of the literature was undertaken using both electronic and manual methods to find empirical studies in peer reviewed English language journals published between end of January 1992 and December 2017. The search strategy (see Appendix A) identifies the descriptors used to identify population groups, and terms to establish parental perception and knowledge. As an extensive amount of brain development takes place in the prenatal period up until the age of 2, the search focused on infants aged 0-2 years (Knickmeyer et al., 2008; Fox, Levitt and Nelson, 2010).

All authors were involved in the selection process, with any differences of opinion resolved through group discussion.¹⁸ A total of 103 papers were read, 56 papers were excluded: the child's age did not meet the inclusion criteria in 18 papers; in 37 papers the research question was not addressed, and one paper was not retrievable. A further 47 papers were appraised for quality, using the 'QualSyst' tool (Kmet, Lee and Cook,

¹⁸ An up to date Prisma Diagram is provided at the end of this chapter illustrating the study selection process up to the end of November 2020.

2004), which allows the appraisal of both qualitative and quantitative research using a list of criteria (such as sample size, use of blinding, appropriateness of analytical method) to address the quality of each (Kmet, Lee and Cook, 2004). Two researchers assessed papers independently and any disagreements were discussed until a consensus was reached. We included papers of a high methodological quality only (scoring 80% or more); subsequently 16 papers were included in the review. Risk of bias was addressed through robust definition of eligibility criteria, independent selection of studies for inclusion, involvement of several authors, using a recognised tool for quality appraisal of the research, and appropriate methods for synthesis of findings (Whiting, Savovic', and Higgins, 2016).

Data abstraction

Characteristics of individual studies were abstracted according to the four research objectives, with groupings and clusters of study characteristics, such as methodology and focus of study (see Appendix B). Due to heterogeneity of the methods, samples and outcome measures, neither meta-analysis nor meta-synthesis was possible. Data from the studies were synthesised using thematic analysis, which involves identifying key and repeated findings from the studies and arranging them under thematic headings, (Dixon-Woods et al., 2004). The results are presented in narrative form.

Results

The study selection and quality appraisal process outlined above yielded 16 papers.

Of the sixteen studies, nine were conducted in the United States (US), two in Italy, one in the United Kingdom (UK), one in Australia, one in Germany, one in Switzerland, and one in Korea. Four studies were undertaken using qualitative methods (Dallas, Wilson and Salgado, 2000; Moscardino, Nwobu and Axia, 2006; Degotardi, Torr and Cross, 2008; Kurth et al., 2014). The remaining twelve studies were undertaken using quantitative methods. Of these, eight studies were based on a cross sectional approach (Harwood, 1992; Stoiber and Houghton, 1993; Harwood et al., 1996; Bornstein, Cote and Venuti, 2001; Keller et al., 2003; Hane et al., 2006; Seo, 2006; Turner, Wittkowski and Hare, 2008) and four were longitudinal studies (Miller and Harwood, 2002; Huang et al., 2005; Donovan, Taylor and Leavitt, 2007; Jessee, McElwain and Booth La Force, 2016). Inferential statistics were used to analyse data in all the quantitative studies. Cohort sizes ranged from 7 to 1114 participants.

It is noteworthy that it was not possible to answer in full the research objectives due to limited research in this area. We found that the research almost exclusively focused on mothers alone, apart from one set of authors who reported findings related to both parents (Dallas, Willson and Salgado, 2000). All studies included data on participants' perceptions of infant mental health, and how they might gather knowledge of this. In nine studies, authors reported how participants used knowledge relating to their infant's mental health (Dallas, Willson and Salgado, 2000; Bornstein, Cote and Venuti, 2001; Miller and Harwood, 2002; Keller et al., 2003; Huang et al., 2005; Moscardino, Nwobu and Axia, 2006; Seo, 2006; Donovan, Taylor and Leavitt, 2007; Kurth et al., 2014). The themes identified from the literature are (1) knowledge and understanding of child development; (2) influences of society and culture; and (3) interpretation of infant emotions and expressions.

Knowledge and understanding of child development

The research within this theme focussed primarily upon measuring maternal knowledge of child development and the relationship of this to child development outcomes and parenting behaviour. Specific groups, related to ethnicity, socio economic status and age are the focus for the research, including teen parents (Dallas, Wilson and Salgado, 2000; Stoiber and Houghton, 1993).

Korean working mothers living in poverty (Seo, 2006), and differing ethnic and demographic groups from within the U.S who were part of an intervention called Healthy Steps, (Huang et al., 2005). The research methods for the studies drew upon an imposed etic approach (Berry, 1969) all relying upon testing parental knowledge and behaviours using measuring tools that are not culturally specific or sensitive. There are some universals in child development between cultures, usually defined in Western terms as age specific developmental milestones (e.g., social smiling), but there are differences structured by cultural environments and the expectations and experience of infant carers' in relationship to their development (Super and Harkness, 1986; Super and Harkness, 2010).

Stoiber and Houghton (1993) and Seo (2006) demonstrated that higher levels of maternal knowledge relating to child development resulted in children with better developmental outcomes and more positive parenting behaviours. However, the impact of maternal knowledge of child development on parenting behaviours may be situation specific. Huang et al. (2005) reported that knowledge of child development only

influenced parenting behaviours when engaged in a teaching task, with lower levels of knowledge associated with a less sensitive interaction during the task. This may not be the same for all ethnicities and social groups: for example, White American mothers' greater knowledge of child development was associated with better interaction during a teaching task; this was not the case for Hispanic and African American mothers (Huang et al., 2005). Whereas lower levels of child development knowledge in Hispanic mothers was positively associated with a quality home environment and better interaction with their child during play (Huang et al., 2005).

Maternal perceptions that were mature, positive, and realistic about child behaviour resulted in children with better coping strategies (Stoiber and Houghton, 1993), whilst providing a more stimulating home environment was linked to increased knowledge of child development (Seo, 2006). The participants in the study by Dallas, Wilson and Salgado, (2000) reported gathering their knowledge of child development from family and neighbour's recollections of themselves as children, emphasising how child development is influenced by social networks (Lewis, 2005). However, for the purposes of the research, an expert text by Green et al., (1994, cited by Dallas, Wilson and Salgado, 2000) decided normal variations in child development. In using this approach, *ibid* (2000) found that teen mothers and fathers had unrealistic expectations of child developmental milestones.

Influences of society and culture

The literature depicts what infant mental health means to parents through the study of social and cultural factors, measuring how parents, mostly mothers, view child

behaviours, the parenting practices they use to promote specific child behaviours, and how they perceive their parenting. Examining child development from a cultural perspective involves considering children and their parents as part of a community and the practices of every-day life (Rogoff, 2003; Weisner, 2002). The focus is upon comparing the beliefs and practice from mothers of differing ethnicities, socio economic groups, immigration status and regional areas. Bornstein, Cote and Venuti (2001), Miller and Harwood (2002), and Moscardino, Nwobu and Axia (2006) focus upon maternal beliefs and parenting practice in terms of the infant behaviour encouraged; showing how parents gather knowledge and use their knowledge of infant mental health, whilst Harwood (1992) and Harwood et al., (1996) consider maternal beliefs relating to desirable and undesirable child behaviours.

Studying child development within a cultural context usually involves one of three methodological approaches (Super and Harkness, 2010). Ethnographic, used by Moscardino, Nwobu and Axia (2006); social address, comparing groups from two or more cultures, as used by Harwood (1992) and Harwood et al. (1996) and unidimensional, comparing two contrasting societies, used by Bornstein, Cote and Venuti (2001), and Miller and Harwood (2002).

Cultural background influenced maternal perceptions of desirable child behaviour. For example, Anglo-American mothers valued behaviours that demonstrated toddler independence, and scope for personal development, whilst Puerto-Rican mothers viewed interdependence and ability to maintain respectful behaviours in public as important (Harwood, 1992; Harwood et al., 1996; Miller and Harwood, 2002).

Maternal parenting practices demonstrate some differences that appear to encourage these behaviours. For example, Anglo-American mothers encouraged self-feeding at the ages of 8 and 12 months and engaged in social play that encouraged infant choice and movement. Puerto-Rican mothers were more likely to spoon feed their infants at 12 months and encourage quieter more interactive social play (Miller and Harwood, 2002). The research does not describe contextual factors such as the environment, which influence choice of parenting behaviours, a criticism of both the social address and unidimensional approaches (Super and Harkness, 2010).

Moscardino, Nwobu and Axia (2006) found that child behaviours reflecting autonomy, respect and a calm personality were viewed as significant by first generation Nigerian immigrant mothers living in Italy. These mothers promoted autonomy by helping their infants to develop their motor skills through games and use of massage. They also believed that close physical contact with their infant was required for infant health, reporting parenting behaviours to promote this, including co-sleeping, infant massage and breast-feeding (Ibid.). However, the mothers used Italian medical services for their child and expressed the desire for their babies to understand the systems of their new country (Ibid.). This suggests an ecocultural approach to child development, as these mothers recognised the need to adapt their parenting behaviours to encourage their children to adopt activities that would help them thrive in their environment (Weisner, 2002). Some authors attempted cross- cultural studies. The consideration of parenting behaviour by applying frameworks for comparison is problematic, as each society will place a different meaning on their behaviour (Berry, 1969). Some researchers attempted to overcome this, for example Harwood (1992) demonstrated that maternal perspective

of what is desirable and undesirable attachment behaviour as framed by the Strange Situation experiment differs dependent on Puerto Rican or Anglo origin. This is achieved by using a derived etic approach, meaning that frameworks for studying beliefs are created using an insider emic approach (Berry, 1969). The derived etic approach allows the identification of cultural patterns, the identification of which may then become an imposed etic approach (Rogoff, 2003).

Interpretation of infant emotions and expressions

Central to human development is emotional growth, depending upon the reciprocal interpretation of cues between primary caregiver and infant (Bornstein, Cote and Venuti, 2012). In determining how parents gather and use knowledge of their infants mental health we found that researchers focused on how the dyadic relationship between primary caregiver (usually the mother) and infant shapes the regulation of one's own emotions and subsequent social relationships with others (Lewis, 2005). The papers included in this theme largely focussed upon the ability of mothers to interpret infant emotions and expressions, measured by knowledge of child development and maternal beliefs, reflecting the importance given to the dyadic relationship in research. The research largely disregards how exposure to fathers, other care -givers, community and social networks will influence the care infants receive, and the significance placed on infant emotions and expressions (Weisner, 2002; Lewis, 2005).

Turner, Wittkowski and Hare (2008) assessed the link between the mentalisation and executive functioning abilities of mothers, their capacity to recognise signals of infant emotion and self-reported perception of the bonding relationship with their baby.

Testing of maternal abilities and perspectives occurred using a series of assessment tasks, which apart from the appraisal of the bonding relationship did not include reference to their own baby. For example, maternal ability to assess signals of infant emotion was undertaken using a collection of photographs of infant facial expressions, called the 'infant facial expressions of emotions from looking at pictures' (Emde, et al., 1987, cited by Turner, Wittkowski and Hare, 2008: 502). Use of this type of assessment tool to assess emotional expressions is questionable, when evidence suggests that infants engage with their caregivers in mutually coordinated interactions to create shared meanings (Tronick and Beeghly, 2011). In fact, another paper in this section highlights that maternal perceptions of infant emotions may be context dependent. With mothers agreeing with observer ratings of infants that display high amounts of negativity during home-based activities and agreeing with observer ratings of infant positivity when they experienced low positivity in affect when playing with their infant (Hane et al. 2006). This study was conducted in home as well as laboratory settings, which may add to the validity of the findings, as laboratory are not usual environments for mothers and their babies. The research by Turner, Wittkowski, and Hare (2008) did not support a link between executive functioning and bonding relationship with maternal ability to recognise emotional cues from infant facial expressions. A strong positive association did emerge between maternal ability to identify mental states and interpret infant facial expressions, indicating a link between maternal ability to recognise infant emotions and mentalisation.

Donovan, Taylor and Leavitt (2007) use laboratory research to explore if maternal self-efficacy mediated by knowledge of child development anticipated behavioural sensitivity of a mother when feeding her child. The suggestion was that maternal

sensory sensitivity, operationalised by maternal ability to determine digital impressions of unrelated infant expressions, would mediate the relationship. Similar to the research by Turner, Wittkowski and Hare (2008) the focus is not upon the mother and child or family relationship but upon one individual in the relationship (namely the mother), therefore ignoring the interactive nature of the relationship and predetermining the type of behaviour expected from the individual (Burman, 2017). Mothers undertook a mixture of questionnaires, and child-care tasks and a relationship was revealed between the ability to interpret positive and negative infant facial expressions to maternal self-efficacy, with high self-efficacy resulting in greater behavioural sensitivity and more positive emotional responses than low/moderate self-efficacy. The operationalisation of self-efficacy was organised using a measure of illusory control, with high illusory control determined as low self-efficacy, moderate illusory control as high self-efficacy and low illusory control as moderate self-efficacy. Knowledge of child development was a mediating factor with those mothers having moderate self-efficacy and low knowledge of child development demonstrating less sensitive behaviour than mothers with high self-efficacy. Maternal high self-efficacy and high knowledge of child development were associated with greatest sensory sensitivity to infant facial expressions, whilst mothers with the low self-efficacy and moderate to high knowledge levels were the least sensitive (Donovan, Taylor and Leavitt, 2007). Measurement of maternal behavioural sensitivity was undertaken using a scale devised by Ainsworth et al. (1974, cited by Donovan, Taylor and Leavitt, 2007). Keller et al. (2003) also used this scale to observe the interaction between three parenting behaviours of warmth, contingency and sensitivity in response to infant communications and maternal attitudes towards their infants. Whilst Donovan, Taylor and Leavitt (2007) and Keller et al. (2003) made adjustments to the scale to conform with their research, the identification

of parenting behaviours are problematic as constructs such as sensitivity are culturally situated and determined by individual interpretations of behaviour between mother and infant (Burman, 2017). The expectation by Keller et al. (2003) was that a cultural commonality exists between the three parenting behaviours of warmth, contingency and sensitivity demonstrated by maternal attitudes in their views of these behaviours and their infants. The sample was homogenous in terms of nationality, ethnicity, socio-economic status and contained mothers with first-born children only. However, the choice of research instruments reflected an imposed understanding of the variables under study, and these were not sufficiently adapted to meet the understanding that research participants may have of the experience (Rogoff, 2003). The subsequent results of the study were unexpected in that observations of maternal sensitivity were significantly associated with maternal attitudes towards contingency, rather than, for example, observations of maternal warmth being associated with maternal sensitivity.

Jessee, McElwain and Booth La Force (2016, p.70) assessed the supportive parenting behaviours of 1114 mothers, when their child was aged 24 months, using measures of 'sensitivity to non-distress,' 'stimulation to cognitive development,' and 'positive regard for the child.' Development of the scale to measure supportive behaviour took place in an earlier study involving the same sample, there is limited explanation regarding how the content of the measures was decided (National Institute of Child Health and Human Development, 1999). Arguably, these measures reflect an idealised version of maternal behaviour, and are assumptions of what constitutes supportive parenting behaviours. The behaviours were assessed alongside maternal ability to engage in cognitive mental state talk and emotional/desire state talk, measured using coding practices identified by the authors from related literature. The research

demonstrates that maternal actions of supportive behaviour, cognitive mental state talk and emotional/desire state talk are separate features of maternal parenting behaviour. The longitudinal nature of the research allowed for comparison of maternal parenting behaviours alongside maternal depressive symptoms assessed at 1 and 6 months postnatal, infant temperament assessed at 6 months postnatal, and beliefs regarding parenting assessed when the infant was 1 month of age. Depressive symptoms at 1 and 6 months postnatal were associated with less supportive parenting behaviour at 24 months, whilst progressive rather than traditional parenting beliefs were associated with higher levels of supportive behaviour, cognitive mental state talk and emotional/desire state talk. Mothers from higher socio-economic groups and whose children were European-American demonstrated more supportive behaviour and cognitive talk, suggesting that the constructs used to form the measures, reflect the consequence of psychology undertaking research using mainly 'Western, Educated, Industrialized, Rich and Democratic (WEIRD) societies' Henrich, Heine and Norenzayan, 2010, p.61).

Kurth et al. (2014) use interpretive phenomenology to analyse maternal experiences of infant crying, and Degotardi, Torr and Cross (2008) use grounded theory to develop a conceptual framework of mothers' beliefs about their infant's minds. The methods move from an emic to a derived etic approach, using maternal experiences to understand the phenomenon and progressing to researcher interpretation based on participant experiences (Rogoff, 2003). Authors of neither papers report the use of respondent validation and therefore it is difficult to ascertain if the subsequent researcher analysis would be recognizable to participants (Bryman, 2012). Experience helps mothers to manage infant crying, in terms of recognising the severity of the cry, having the confidence to manage infant crying and manage their own reactions to crying (Kurth et

al., 2014). Mother's attribute psychological states to their infants, which the child may realise, giving some indication as to how children come to be able to interpret their own behaviour and that of others (Degotardi, Torr and Cross, 2008). Two categories of infant behaviour were identified from interviews with mothers of infants aged 12-24 months, non-psychological, and psychological. Whilst mothers viewed the infant as the passive recipient of psychological experience, they also interpreted their infant behaviour as constructing psychological meaning to external events, using this knowledge to communicate. Mothers acknowledged the ability of infants to be individual in their expressions, having the ability to express what they want to achieve (Ibid.).

Discussion

Despite some interesting themes emerging from the literature regarding parental, particularly maternal perceptions and knowledge of infant mental health, it is difficult to fully answer the first three objectives of the systematic review for three reasons. Firstly, the use of definitions to operationalise the concept of infant mental health, secondly, the dominance of developmental psychology in this field and lastly, the positioning of mothers as research subjects.

Adopted by the World Association of Infant Mental Health (2018), the definition used to generate search terms for this review is perhaps more recognisable to educational and research professionals than parents. The majority of the research presented originates from developmental psychology, where decisions on units of measurement and how to measure them during the research process, represent wider beliefs about the place that mothers and children hold in society (Burman, 2017). The focus on the dyadic

relationship and the behaviour of just one participant, usually the mother, lacks consideration of the structural factors that influence how the infant is cared for (Burman, 2017). Therefore the instruments used to measure maternal behaviours in most of the research presented here, is detached from the reality and complexity of participants every-day lives. The emphasis on the dyad and the theory of monotropy suggests that the attachment relationship dominates the focus of research included in this review. Subsequently ignoring environmental considerations, failing to capture the intricacy of the infant's social world, and the influence these factors have upon decisions related to child rearing (Weisner, 2005; Keller, 2017). Whereas child development theories and concepts emphasise the importance of the cultural environment (Super & Harkness, 1986; Weisner, 2002). Reflected in the systematic review, is the detail that mothers rather than their children have become the focus of research by developmental psychology (Burman, 2017). Discounting the active role that infants have in relationships with multiple caregivers, and the individualised nature of their interactions (Tronick and Beeghly, 2011). Whilst emphasising the gendered socialisation of parenting as something that only women can do (Hays, 1996). The criteria used to measure behaviours and abilities reflecting desired parenting characteristics, and a paternalistic approach to research. Mothers are very much the subjects of research, rather than active participants.

Conclusions and recommendations

The evidence presented in this paper will help health and social professionals to develop a research informed awareness of infant mental health. In working closely with parents, they may recognise and address the roles that cultural values play in parenting research. The subject of infant mental health is value- laden and practitioners and researchers

reflect and inform these values. Drawing upon critical theory or constructivism would help to explore this, better incorporating researcher reflexivity into primary studies of parental influence and knowledge about infant mental health (Guba & Lincoln, 2008). Pivotal to infant care and development is the cultural context in which the infant lives (Rogoff, 2003). The realities of caring for infants in differing contexts requires further recognition, and development of etic approaches, such as research using an ethnographic design that is ecologically positioned (Weisner, 2014). This approach will help practitioners and parents to vocalise what is intuitive and therefore obtain evidence of how they respond to and affect their infant's mental health. Quantitative methods informed by derived etic approaches, for example in aiding the design of research measurement tools that are recognisable to participants can be useful in identifying patterns among groups of people (Rogoff, 2003). Further development of quantitative methodology that draws upon derived etic approaches would help to address some of the limitations of the research in this review.

This systematic review highlights the lack of contemporary research knowledge available regarding parental perspectives of infant mental health, and the difficulties with research in this area. This is surprising, given the growth of child and adolescent mental health services and a recognition of the impact of adverse childhood experience (ACE) on mental health across the life-course. Practitioners should be familiar with the dominant research approaches used, and the ways in which these influence how mothers and their infants are involved (or not) in the research process. The review highlights the complexity of parenting behaviours and the influence of socio-cultural values and beliefs in this regard. Concepts of health and expectations of infant behaviour vary among family groups and individuals. To promote infant mental health, practitioner

knowledge of the importance of the home and wider environmental resources available to families is a good starting point. In helping parents with their infant's mental health, practitioners need to observe the family as an ecological system, with an appreciation of the role the infant plays as part of this. Expansion of research that focuses upon the infant and family within the ecological and cultural context in which they reside will help practitioners to do this.

Strengths and limitations of this review

Multidisciplinary evidence was gathered in a systematic way for this review and as such, the multidisciplinary nature of infant mental health was acknowledged (Fitzgerald and Barton, 2000). The decision was taken to only include high quality evidence to strengthen the review and ensure that the results were robust. The result is that several papers were excluded, including grey literature that might have contributed towards an understanding of the question in telling us about the scope and scale of research approaches. The heterogeneity of the literature included in the review has meant that only a thematic analysis of the evidence was possible.

The intention was to explore parental perceptions and utilization of knowledge about their infants' mental health: the dominance of the quantitative approach adopted by higher quality evidence included in this review shows that understanding of the topic is shaped by and limited to measurable aspects of parenting behaviours. As such, it is difficult to draw conclusions regarding how parents perceive and utilise knowledge of their infant's mental health. This systematic review provides the practitioner with a critical insight into the dominant higher quality research that

underpins this area and recommends a greater use of qualitative research designs and methods to extend the nature of the debate.

An update to the literature search

I have repeated the literature search until the end of November 2020. There were no new additional studies at this time to include within the review. Below is Prisma diagram (Figure 1) (Mohler et al., 2009) that details the study selection process.

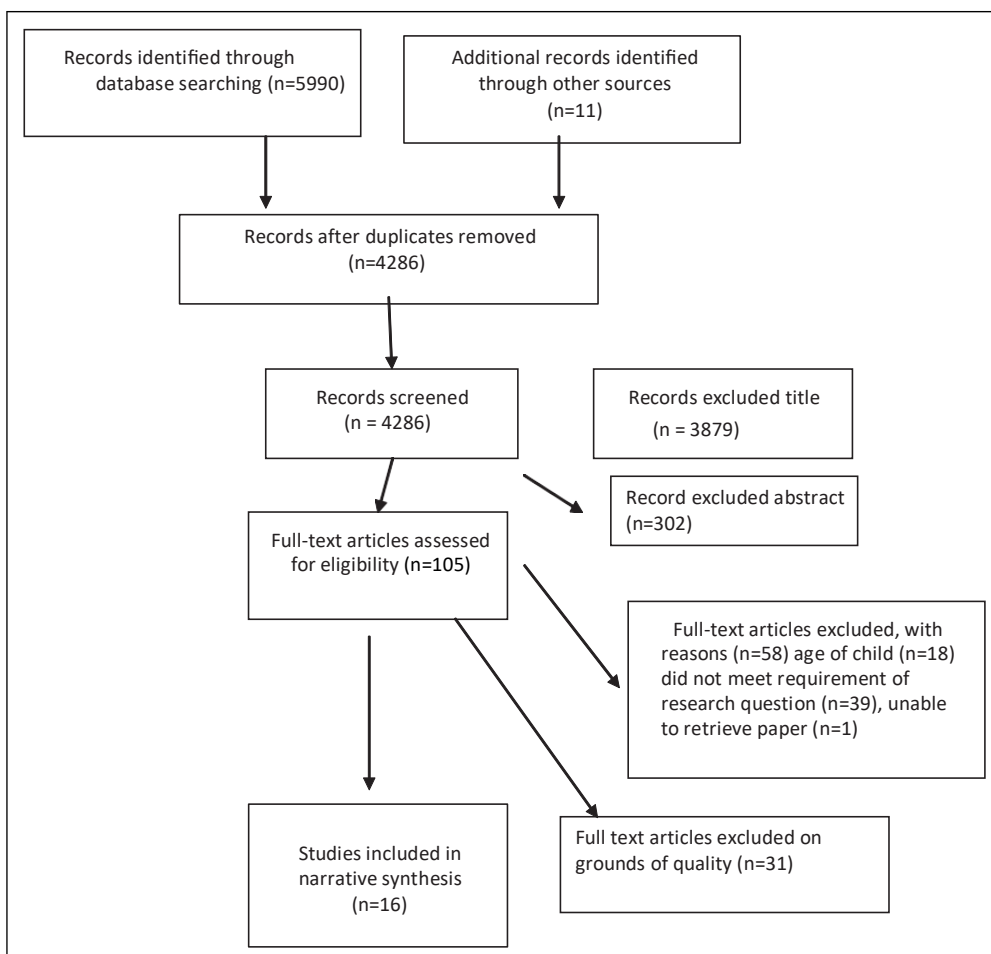


Figure 1 Prisma diagram – study selection process

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Appendix B Systematic literature review search terms

Population	Pregnan* OR infan* OR neonat* preschooler OR pre- schooler OR toddler OR child					
	AND					
Interventions	Parental awareness OR parental attitudes OR parental	OR maternal beliefs OR maternal understandin g OR	OR paternal knowledge OR paternal awareness OR paternal	OR mothers' knowledge OR mothers' awareness OR mothers'	OR fathers' knowledge OR fathers' awareness OR fathers'	

	understanding OR parental beliefs	maternal knowledge OR maternal perceptions OR maternal awareness OR maternal attitudes	beliefs OR paternal attitudes OR paternal understanding OR paternal perceptions	beliefs OR mothers' attitudes OR mothers' understanding OR mothers' perceptions	beliefs OR fathers' attitudes OR fathers' understanding OR fathers' perceptions	
	AND					
Comparators	1. Social development OR cognitive development OR emotional development OR language development OR neurological development OR motor development OR visual development OR auditory development OR physical development	2. Parent-infant interaction OR parent-child interaction OR mother-infant interaction OR mother-child interaction OR father-infant interaction OR father-child interaction	3. Parent-infant relations* OR parent-child relations* OR mother-infant relations* OR mother-child relations* OR father-infant relations* OR father-child relations*	4. Behaviour OR self-regulation OR regulation	5. Object attachment OR attachment OR bonding OR social	6. Mental OR mind mindedness OR mentillation OR attunement, OR emotion OR feeling OR mental health OR reciprocity

Appendix C Table of studies for systematic literature review

Please see the tables on the next few pages.

Author, year of publication, title, and country	Aims	Methodology and data collection method	Sample and size	Method of analysis	Findings most relevant to this review	Quality including Kmet score and any limitations
<p>BORNSTEIN et al. (2001) 'Parenting Beliefs and Behaviors in Northern and Southern Groups of Italian Mothers of Young Infants.'</p> <p>Italy</p>	<p>'To evaluate intranational variation in the ways of northern and southern Italians believe and behave in their basic infant rearing':663</p>	<p>Cross-sectional survey. Questionnaires. Video observation.</p>	<p>Mothers of 5-month-old first born infants. Northern Italy n=42, Southern Italy n=40. N=82.</p>	<p>Inferential statistics</p>	<p>Mothers living in both regions reported that they engaged in more social than didactic behaviours. Northern mothers engaged in social behaviours with infants about 50% more than Southern mothers. Mothers from both regions spent twice as much time in didactic than social behaviours with their infants.</p>	<p>83% Study design not explicitly stated. Further information required as to how sample recruited – appears to be volunteer. Sample size appears small, no mention of power. Some data missing.</p>

<p>DALLAS et al. (2000) 'Gender differences in teen parents' perceptions of parental responsibilities.'</p> <p>USA</p>	<p>'To assess the knowledge and expectations of unmarried, low-income, Mexican American and African American adolescent mothers and their male partners regarding normal child development, paternal role behaviours, and their responses to efforts to formalize specific paternal responsibilities: 423</p>	<p>Qualitative study. Data collected using interviews from focus groups.</p>	<p>Five Mexican American parenting couples and two African American parenting couples. N=7 couples.</p> <p>African American females in last trimester of pregnancy.</p> <p>Mexican American couples reported having at least one infant under 2 years.</p>	<p>Tape based analysis. Abridged transcript and moderators' verbal summary, plus field and summary notes analysed.</p> <p>Provisional code list from interview guide applied to data; coded to descriptive categories. Differences in codes between groups considered.</p>	<p>Differences identified between the perceptions of mothers and fathers regarding: knowledge relating to child development, use of discipline, expectations of paternal role. Both groups believe physical punishment appropriate for children, but at different ages. Fathers recognise that arguing in front of children can be damaging, identifying that the most important paternal behaviour is providing emotional support. Fathers want to engage in enjoyable in activities with their child. Mothers feel that the fathers most important behaviour is to be available to the child, and that paternal activity should centre upon the traditional provider role, sharing in activities alongside mother and child.</p>	<p>85%</p> <p>Only one session of focus group interviews provided. Further field work/individual interviews useful to explore the perceptions of the parents in more detail.</p> <p>No consideration of researcher impact.</p>
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<p>DEGOTARDI et al. (2008) 'He's got a mind of his own : the development of a framework for determining mothers' beliefs about their infants' minds.'</p> <p>Australia</p>	<p>'To analyse the ways in which mothers talked about their infants in order to determine the kinds of statements which could be usefully be taken as belief expressions.'</p> <p>'To develop a system of categorization which incorporates the full range of belief expressions in a way that would benefit current understandings of the relationships between beliefs and children's development':261</p>	<p>Longitudinal qualitative study. Data collected when infant aged 12, 18 and 24 months. Data were collected using semi-structured interviews.</p>	<p>N=25 mothers with infants aged 12 months at the start of the study.</p> <p>Mothers recruited from Longitudinal Infancy Study of 100 families of diverse socioeconomic background.</p>	<p>Grounded theory analysis.</p>	<p>Conceptual framework developed that demonstrates maternal beliefs about their infants' minds. Two categories generated that whereby mothers describe 1. The actions of their child, so non psychological descriptions. 2. Their child's person, the psychological view of their infant's mind. Psychological action categorised into three areas: 1. Mothers describe the child's psychological experiences (non-representational), 2. Mothers describe the child's ability to construct psychological experiences (representational), 3. Mothers describe the subjective wants of the child (representational).</p>	<p>85%</p> <p>Study design initially unclear, further information regarding sampling required. Some reflexivity demonstrated in terms of researcher's professional backgrounds but requires further development.</p>
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<p>DONOVAN et al. (2007) 'Maternal self-efficacy, knowledge of infant development, sensory sensitivity, and maternal response during interaction.'</p> <p>USA</p>	<p>'To determine whether mothers varying in illusory control, potentially moderated by knowledge of infant development, showed differential sensitive responding in a feeding task, each mother with her own infant' :866</p>	<p>Longitudinal, survey, data collected when infant aged 6 and 9 months. Assessment of maternal tasks, video observation.</p>	<p>N=70 mothers with infant aged 6 months at start of study.</p>	<p>Inferential statistics.</p>	<p>Mothers ability to interpret positive and negative facial infant expressions related to illusory control and knowledge of infant development. Generally moderate illusory control associated with greater behavioural sensitivity and affect.</p> <p>Low maternal knowledge and low illusory control associated with less behavioural sensitivity. Moderate illusory control and high knowledge showed greater sensory sensitivity, compared with those with low and moderate knowledge. High illusory control and low knowledge associated with greater sensory sensitivity than if high illusory control with medium or high knowledge.</p>	<p>86% Further information regarding sample required.</p>
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<p>HANE et al. (2006) 'Contextual basis of maternal perceptions of infant temperament.'</p> <p>USA</p>	<p>'To illustrate that the relations between maternal and observer based ratings of infant temperamental positivity and negativity are moderated by the infant's affective state during routine home based interactions with mother': 1079</p>	<p>Cross sectional survey. Data collected when infant aged 9 months. Data were collected using assessments in lab, questionnaire and video observation at home.</p>	<p>N=59. Mothers and infants recruited from larger longitudinal study when infant aged 4 months.</p>	<p>Inferential statistics.</p>	<p>Agreement of mother and observer ratings of infant negativity when infants demonstrated high levels of negative emotion during routine home based activities. Agreement of mother and infant positivity when low mutual positive emotion between infant and mother during play.</p>	<p>81%</p> <p>Further information required regarding sampling strategy.</p>
<p>HARWOOD (1992) 'The influence of culturally derived values on Anglo and Puerto Rican mothers' perceptions of attachment behavior.'</p> <p>USA</p>	<p>'To examine the influence of cultural values on mothers' perceptions of attachment behaviour': 823</p> <p>A two-part study: Part 1: 'indigenous concepts of desirable versus undesirable toddler behaviour were elicited using open-ended probes.</p>	<p>Part 1: cross sectional survey. Data collected using structured interview and maternal assessments.</p> <p>Part 2: cross sectional survey. Data collected using structured interview and maternal assessments. Questions/assessments based upon data gathered from part 1.</p>	<p>Part 1: N=48 mothers with at least one infant aged between 12-24 months. 16=lower class Anglo mothers 16=middle class Anglo mothers 16=Puerto-Rican mothers, resident in mainland USA.</p>	<p>Part 1 Coding of concepts. Inferential statistics.</p> <p>Part 2 Coding of concepts Inferential statistics.</p>	<p>Anglo mothers focused on characteristic/behaviour associated with individual autonomy.</p> <p>Puerto Rican mothers focused on behaviour/characteristic associated with respectfulness.</p>	<p>83%</p> <p>Further information regarding study design required. No mention of sample size calculation.</p>

	Part 2: 'built on study 1 in that mothers' perceptions of Strange Situation behaviour were compared using the vignettes and descriptors generated on the basis of mothers' responses in Study 1':823.		Part 2, fresh recruitment. N=48 mothers with at least one infant between 12-24 months. 16=lower class Anglo mothers 16=middle class Anglo mothers 16-Puerto-Rican mothers, resident in mainland USA.			
HARWOOD et al. (1996) 'Culture and class influences on Anglo and Puerto Rican mothers' beliefs regarding long-term.' Mainland USA and Puerto-Rico	'To examine cultural differences in parental beliefs regarding desirable and undesirable long term socialization goals and child behaviour; to attempt to disentangle the role played by culture and socioeconomic status as simultaneous	Part 1: cross sectional survey. Data collected using semi structured interview of four open ended questions. Part 2: cross sectional survey. Data collected using semi structured interview. Closed and open questions.	Part 1 N=100 mothers with infant aged between 12-24 months 20= middle class island Puerto Rican 20=island lower class Puerto Rican 20=middle class Puerto Rican Island	Part 1: Coding of interview data. Inferential statistics. Part 2: Coding of interview data. Inferential statistics.	Part 1: Culture and socioeconomic status contribute independently towards beliefs about long term socialisation goals for children. Culture associated more strongly with long term socialisation goals for children. 'Proper Demeanour' the most commonly used ideal for all three groups of Puerto	80% No estimate of power size of sample.

	<p>sources for group differences in parental beliefs; to demonstrate that certain cultural constructs are central enough within each national culture to elicit general agreement and to manifest a broad level of shared discourse, despite within group variability': 2447</p> <p>2-part study. Part 1: purpose 'to examine culture and class as simultaneous sources for parental beliefs regarding desirable and undesirable long-term socialisation goals and child behaviour':2448).</p>		<p>20=lower class Anglo American 20=middle class Anglo American 20=migrant lower class Puerto Rican</p> <p>Part 2 N=40 mothers with infant aged 12-24 months. 20=middle class Anglo American 20=middle class Puerto Rican island resident</p>		<p>Rican mothers, whereas Anglo mothers described goals for their children that characterised 'Self Maximization.' Part 2: supports study 1. Anglo and Puerto Rican mothers place different values upon 'Self Maximization' and 'Proper Demeanour' even when SES controlled for.</p>	
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	Part 2: purpose 'to examine closely cultural differences in mothers' beliefs regarding desirable and undesirable child behaviour among middle-class Anglo and middle-class Puerto Rican mothers': 2456					
HUANG et al. (2005) 'Maternal Knowledge of Child Development and Quality of Parenting among White, African-American and Hispanic Mothers.' USA	'We sought to resolve some of the limitations in the literature and further investigate whether the association between maternal knowledge and parenting varies with race/ethnicity. Specifically, maternal knowledge was defined as maternal knowledge of developmental norms and milestones' :152	Longitudinal. Video observation, structured interview, questionnaire. Families surveyed when infants aged 2-4 months, and 16-18 months.	Recruited from a larger study of 5565 families. 658 families eligible to join study. N=378 families	Inferential statistics	56% = correct maternal estimate of child's development. White and Hispanic mothers had higher levels of child development knowledge than African American mothers. Maternal age, wealth, education, depression levels, and marital status associated with levels of child development knowledge. For example, lower levels of education associated with negative impact upon maternal knowledge of child development.	100%

					<p>Knowledge of child development not associated with measures of parenting behaviours. However lower levels of child development related to less sensitive interaction with child during a parent/child teaching situation.</p> <p>Maternal race/ethnicity associated with parenting behaviours.</p>	
<p>JESSEE et al. (2016) 'Maternal supportive behavior, cognitive talk, and desire/emotion talk at 24 months: distinct factors and differential antecedents.'</p> <p>USA</p>	<p>'Mental-state talk is an important parenting construct, yet it is not clear whether mental-state talk is distinct from other aspects of maternal behaviour, such as sensitivity and cognitive stimulation, or whether it coheres across different types of mental states</p>	<p>Longitudinal quantitative. Questionnaire, video observation.</p> <p>Mothers surveyed when infant aged 1 and 6 months. Video observation at 24 months.</p>	<p>Recruited from a larger study of 1364 children and families. 1114 families for whom data was available on maternal mental-state talk were included.</p> <p>N=1114 families.</p>	<p>Inferential statistics.</p>	<p>Confirmatory factor analysis demonstrates that mothering behaviours of supportive behaviour, cognitive mental state talk and desire/emotional state talk are distinct from each other. Higher levels of maternal depressive symptoms at 1 and 6 months were significantly associated with lower levels of supportive behaviour at</p>	<p>83%</p> <p>Further clarification regarding sample required.</p>

	(i.e., cognition, desire, emotion. The current investigation aimed to address these gaps': 63.				24 months. Mothers that reported progressive rather than traditional parenting beliefs at 1 month had higher levels of supportive behaviour and cognitive state and desire emotional state talk.	
KELLER et al. (2003) 'Warmth and contingency and their relationship to maternal attitudes toward parenting.' Germany	'We assessed the relationship between behavioural measures of maternal sensitivity, warmth, and contingency toward positive and negative signals of 3 month old babies and self reported maternal attitudes':277	Cross sectional survey. Questionnaire, video observation.	60 mothers and infants aged 3 months.	Video data coded for components of parental behaviour. Inferential statistics.	Maternal sensitivity associated with maternal response to infant cues (contingency). Maternal sensitivity not associated with maternal warmth. Warmth and contingency not associated with maternal attitudes towards parenting.	80% Study design not immediately clear. Require further information relating to choose of sample and development of Likert Scale.
KURTH et al. (2014) 'Responding to a crying infant - You do not learn it.' Switzerland	'To better understand processes underlying first time and experience mothers' responses to infant crying and their comforting	Longitudinal study. Data were collected at 6-8 and 12-14 weeks postpartum. Interpretive phenomenology, using participant observation and interviews.	15 mothers and infants. Infants aged 6-8 weeks onwards.	Case analysis. Thematic analysis exemplars.	With experience first time mothers perceived reasons/patterns to crying and used this information to manage their soothing techniques and personal stress.	80% Diversity of sample attempted, but sample includes mostly nurses. Reflexivity partial.

	practices during the first 12 weeks post birth' :743).					
MILLER and HARWOOD (2002) 'The cultural organization of parenting: change and stability of behavior patterns during feeding and social play across the first year of life.'	'How cultural structuring of mother-infant interactions during everyday contexts such as feeding and social play changes during the first year of life, or the ways in which such changes may represent universal versus group-specific influences':245	Longitudinal, data were collected when infants were 4, 8 and 12 months of age. Structured interview, video observation.	N=60 mothers and infants. 32 Anglo-American mothers and infants. 28 Puerto Rican mothers and infants.	Inferential statistics.	In identifying socialisation goals Anglo mothers perceived self-maximization to be important and their interactions with infants reflected this. Puerto-Rican mothers perceived placed more emphasis proper demeanour than self-maximization, interactions with infants emphasised interdependence of the infant upon the mother.	81% Study design not explicitly stated. Sample recruited via invitation.
USA mainland Puerto Rica						
MOSCARDINO et al. (2006) 'Cultural beliefs and practices related to infant health and development among Nigerian immigrant mothers in Italy.'	'To explore childrearing beliefs and practices among migrated Nigerian mothers of infants': 245	Ethnographic approach. Data were collected using semi structured interviews.	N=29 first generation immigrant Nigerian mothers and infants aged 2-12 months	Thematic analysis	Developmental goals linked with independence and learning the Italian culture. Health care practices linked to psychological and physical characteristics of child.	85% Further information on how sample recruited. Study design not clearly identified – described as ethnographic but appears to lack

Italy					Emphasis upon prolonged physical contact between mother and baby important. For example, co-sleeping until age 3-8 years.	participant observation. Authors integrated to local community
SEO (2006) 'A Study of Infant Developmental Outcome with a Sample of Korean Working Mothers of Infants in Poverty: Implications for Early Intervention Program.'	<p>'This study was designed to replicate the research design and methodology employed in a Conrad et al. (1992) study using a sample of Korean working mothers living in high-risk environments':254. The following questions were asked:</p> <p>'Are there both main and interaction effects between maternal knowledge and maternal self-efficacy on parenting behaviour?'</p> <p>'What are the predictors of infant</p>	Cross sectional survey. Questionnaires. Structured interview. observation.	N= 42 mothers with infants aged 0-12 months. Recruited from a larger study N= 92 mother-infant pairs.	Inferential statistics.	<p>Greater knowledge of infant development associated with more stimulating home environments, and infants with a higher level of development than mothers with a lower knowledge of infant development.</p> <p>Mothers with the most knowledge of infant behaviour showed better parenting behaviour.</p> <p>Maternal knowledge of infant development only significant predictor of infant development outcome.</p> <p>Although result not significant – higher</p>	80% Clarification required relating to study design and how sample recruited. Sample size seems small, no power calculation provided.
Korea						

	developmental outcome?':254				maternal self -efficacy in terms of parenting resulted in lower scores of maternal knowledge of infant development, and infants with lower developmental scores.	
STOIBER and HOUGHTON (1993) 'The relationship of adolescent mothers' expectations, knowledge, and beliefs to their young children's coping behavior.' USA	'Explores the consequences of a specific category of cognitions-parental constructs that are considered to mediate the child-rearing system experienced by young children':64	Cross sectional – survey. Questionnaires. Video observation.	N=4 0 mothers with infants aged 4 to 22 months.	Inferential statistics	Mothers who had more positive expectations for their own and their children's behaviour and emotions had children whose had more adaptive and effective sensorimotor and reactive behaviour coping; knowledge of child development and child rearing beliefs did not predict this. Interaction of maternal knowledge and child rearing beliefs and child's self- initiated coping behaviour. Higher levels of knowledge of child development and inflexible child rearing beliefs linked to the	86% Clarity required regarding study design. No power calculation for sample size.

					lowest level of self – initiated coping behaviour.	
TURNER et al. (2008) 'The relationship of maternal mentalization and executive functioning to maternal recognition of infant cues and bonding.' UK	'The relationships between maternal mentalization and executive functioning abilities and the recognition of emotion cues in infants and bonding in a non- clinical sample':501	Cross sectional survey. Questionnaires and assessment tools.	N=64 mothers with infants aged between 3-48 weeks.	Inferential statistics.	Almost significant relationship found between mothers cued ability to attribute and the ability to recognise infant expressions. This suggests association between mentalization and being able to perceive infant emotions :509.	90%

Appendix D Ethics approval

HRA letter of approval. Please note names are removed.

27 September 2016

Dear Mrs Peters

Letter of HRA Approval

Study title: An exploration of the factors that influence maternal perceptions and use of knowledge relating to their infant's mental health
IRAS project ID: 199133
Protocol number: N/A
REC reference: 16/SW/0163
Sponsor Plymouth University

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal

confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.

- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document “*After Ethical Review – guidance for sponsors and investigators*”, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the [HRA website](#), and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the [HRA website](#).

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at <http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/>.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please email the HRA at hra.approval@nhs.net. Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

Your IRAS project ID is **199133**. Please quote this on all correspondence.

Yours sincerely

Assessor

Email: hra.approval@nhs.net

Copy to:

Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

<i>Document</i>	<i>Version</i>	<i>Date</i>
Copies of advertisement materials for research participants [Advert for social media/clinics]	2:0	22 June 2016
Covering letter on headed paper [Cover letter]	1:0	08 May 2016
Covering letter on headed paper [Cover letter]	2	22 June 2016
GP/consultant information sheets or letters [letter for health care professional]	1:0	08 May 2016
Interview schedules or topic guides for participants [Interview schedule]	1:0	08 May 2016
Interview schedules or topic guides for participants [Guidance to complete diary for participants]	1:0	21 June 2016
IRAS Application Form [IRAS_Form_18052016]		18 May 2016
IRAS Application Form XML file [IRAS_Form_18052016]		18 May 2016
IRAS Checklist XML [Checklist_18052016]		18 May 2016
IRAS Checklist XML [Checklist_24062016]		24 June 2016

Letter from sponsor [Sponsor letter]		10 May 2016
Letters of invitation to participant [Reply slip for researcher contact]	2:0	22 June 2016
Other [Email from sponsor clarifying validation point re: children]		17 May 2016
Other [Employers Liability Certificate]		
Other [Statement of Activities]		27 September 2016
Other [Schedule of Events]		27 September 2016
Participant consent form [Consent form antenatal]	2:0	20 June 2016
Participant consent form [Consent form postnatal]	2:0	21 June 2016
Participant information sheet (PIS) [Participant information sheet full version]	2:0	20 June 2016
Participant information sheet (PIS) [Initial information sheet]	1:0	08 May 2016
Research protocol or project proposal	2:0	22 June 2016
Summary CV for Chief Investigator (CI) [Jane Peters research CV]	1:0	08 May 2016
Summary CV for supervisor (student research) [Heather Skirton (DOS) CV]		22 March 2016
Summary CV for supervisor (student research) [Julia Morgan CV]		22 March 2016
Summary CV for supervisor (student research) [Maria Clark CV]		

Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments

2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The sponsor intends that the statement of activities acts as the agreement between the site and the sponsor.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the

For information on how the sponsor should be working with participating NHS

organisations in

England, please refer to the, *participating NHS organisations, capacity and capability and Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria) sections in this appendix.*

Section	HRA Assessment Criteria	Compliant with Standards	Comments
			activities expected of them for this research study.
4.3	Financial arrangements assessed	Yes	No funds will be provided to participating organisations.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments

5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	Provisional Opinion request for further information was issued on 13 June 2016. This was followed by Further Information Favourable Opinion issued on 08 July 2016.
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

HRA assessment criteria

Participating NHS Organisations in England

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

This is a student (PhD) study and there is one site type.

Potential participants who meet the inclusion criteria will be identified by midwifery staff (direct care team) and given an initial information sheet. Participants will be asked to contact the researcher via telephone or email, or sign a permission slip for the researcher to make contact with them. The researcher will then contact those interested and give them a full participant information sheet. Written consent will be recorded before research activities begin.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.

Participating NHS organisations in England **will be expected to formally confirm their capacity and capability to host this research.**

- Following issue of this letter, participating NHS organisations in England may now confirm to the sponsor their capacity and capability to host this research, when ready to do so. How capacity and capability will be confirmed is detailed in the *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* section of this appendix.
- The [Assessing, Arranging, and Confirming](#) document on the HRA website provides further information for the sponsor and NHS organisations on assessing, arranging and confirming capacity and capability.

Confirmation of Capacity and Capability Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).

No Principal Investigator or Local Collaborator is expected at each participating organisation.

GCP training is not a generic training expectation, in line with the [HRA statement on training expectations](#).

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

No Letter of Access is expected since access arrangements are not needed for this study.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix E Participant Information Sheet

Researcher: Jane Peters

Title of the study: How do mothers view their baby's emotional and social development?

I'd like to invite you to take part in my research study. Joining the study is entirely up to you. Before you decide I would like you to understand why the research is being done and what it would involve for you.

I will go through this information sheet with you, to help you decide whether or not you would like to take part and answer any questions you may have. This should take about 15 minutes. Please feel free to talk to family/friends or others about this study. If you do decide to join the study, you may choose to leave at any point.

The first part of the Participant Information Sheet tells you the purpose of the study and what will happen to you if you take part. Then I give you more detailed information about the conduct of the study. Please ask if you need further information.

What is the purpose of the study?

The purpose of the research is to explore the ways in which babies develop, how you as mothers view this and how you chose to use this information when caring for your baby.

I am really interested in what mothers think and feel about their baby's social and emotional development. One way to do this is to get to know a group of mothers like yourself by interviewing them over the course of a 12-15 month period as their baby develops. I hope to find out more about your life with your baby at regular intervals.

Who is organising and funding the research?

My name is Jane Peters; my professional background is in nursing, midwifery and health visiting. I work at the University of Plymouth, where I teach student nurses. I am a PhD student at the University of Plymouth, the research forms part of those studies. My employer the School of Nursing and Midwifery is supporting this research.

Why am I asking you to help?

You are expecting a baby in the next few weeks. I would like to meet you during your pregnancy, and then continue to visit you and your baby during the first 12 months of his/her life.

If you want to be involved, with your permission I will need to check with your Midwife that all is well with your health and the health of your baby both now and soon after your baby is born. This is so I can make sure that I am contacting you at the right time for you and your baby.

What's involved?

I will contact you by telephone or email and ask if I may visit you at home before your baby is born. At that visit I will discuss the study in more detail and ask you to sign a consent form. During the visit I will ask you a few questions about yourself, your

family and your baby. This initial visit will last approximately 1 hour. All interviews will be audio-recorded; to protect your confidentiality you will be allocated an identification number; your name will not be used on any recorded or written materials.

The rest of the study will involve visits to your home (or another place of your choice) after your baby is born. Below is some further information regarding the timing of visits and what to expect:

- With your consent I will contact your midwife soon after the birth of your baby, and check that all is well for me to make further contact with you. You may choose to contact me at any time.
- At the first visit following the birth of your baby, I will answer any questions you have, and ask you to sign a second consent form.
- Visits will be to your home when your baby is approximately 4-6 weeks, 3 months, 6 months, 9 months and 12 months of age.
- I will conduct all of the visits.

What will happen during the visits?

During each visit I will talk with you about topics relating to your baby's development, each visit will last approximately 30-60 minutes. The timing of visits is flexible, to fit in with you and your baby's requirements. It is up to you as to what you would like to tell me during our conversation about your baby and their emotional development. When appropriate, I will observe you and your baby together, this is so I can develop an understanding of how mothers and babies develop their relationships.

Do I have to take part?

No. You may also choose to withdraw from the research at any time. Deciding not to take part or withdraw from the research, will not affect provision of you or your baby's health care or the relationship you have with the professionals that provide your care.

What are the possible disadvantages and risks of taking part?

The main disadvantage is that the study involves committing some of your time. It is unlikely but sometimes discussing families and relationships can trigger feelings that you find upsetting. If you become upset during an interview I will stop the interview and discuss what you would like to do. You can choose to stop the interview or continue. If you wish I will call a family member or friend to be with you. You may wish to discuss your feelings further with your GP or health visitor. If you have concerns or need advice regarding health care services, then I will encourage you to contact the appropriate Patient Liaison Service (PALS). Contact details for PALS are provided at the end of this information sheet.

What are the possible benefits of taking part?

We know very little about how mothers view their baby's development. I want to find out what you think and feel about this topic, so we can help to improve the services available to support mothers and babies. Taking part in the research may also help to increase your knowledge of your baby's emotional and social development.

Will my taking part in this study be kept confidential?

All information will be kept confidential. Only I will have access to your personal details, and this will be for the sole purpose of arranging interviews. Any information

relating to your personal details will be destroyed following completion of the research. With your permission I would like to inform your health visitor, GP and midwife, that you are taking part in the study. The interviews will be recorded; the interviews will be identifiable from your identification number; your name will not be used. The recordings will be destroyed within three months of the completion of the project. You will not be identifiable from transcripts of the interviews, or the research report I write as a result of this project.

The only reason that I will tell someone of your details is if it seems that you or your baby or other children may be at some risk of harm. If possible, I will discuss this with you and I may have to inform another health or social care professional.

What will happen to the results of the research study?

I will provide you with a summary of the results of the study so far, when I visit you when your baby is 12 months. After this I will provide you with ongoing reports/summaries of the results as further progress is made, until I reach my final findings. When the research is complete you will receive a lay summary of the findings. The findings from the study will be published in health and social care journals and presented at professional conferences. You will not be personally identifiable from any publications, all findings associated with the research will be anonymised.

Who has reviewed the study?

Information removed, for reasons of anonymity.

Full ethical approval has been given.

Contact for further information.

Jane Peters, PhD Student, University of Plymouth.

You can contact the researcher at:

Alternatively, you can telephone or text me on: (please leave a message on the answer phone with your contact details).

Further questions or complaints.

If you have any questions or concerns about this study, please contact my research supervisor Professor Heather Skirton.

Thank you for your interest in this study.

Contact details are provided below for agencies that can provide practical and emotional support for you and your family. Please note local information provided and removed for inclusion into PhD thesis.

Health Visiting Services

National Childbirth Trust

Web: <https://www.nct.org.uk/>

Helpline: 0300 330 0700

Patient Advice and Liaison Services

Appendix F Interview schedule

Research Objectives

1. Consider how mothers perceive their infant's development, and the significance they place on infant mental health and well-being.
2. Explore maternal perceptions of infant mental health: to what extent are these influenced by their personal narratives and societal influences?
3. Explore the extent that maternal behaviours with their infants are shaped by perceptions and knowledge of infant mental health.
4. Reflect on infant behaviour with their mothers and explore how they believe this behaviour is shaped.

Antenatal

How are you feeling?

Tell me about your pregnancy so far?

When you think about your baby, what do you think he/she will be like? (1)

How do you feel when you think about caring for your baby? What will be important?

(3)

When you think of your baby's health, what do you think of? (1, 2)

What qualities will you try to encourage in your baby? Why? How do you think you will do this? (1, 2, 3)

Who or what do you turn to for advice about your pregnancy and baby? How much influence do you think this has on you? (4)

How do you feel your experiences as a child will influence your relationship/behaviour with your baby? (2)

When you think about how your baby will react to certain situations, how do you hope he or she will react? Do you think about any ways you could encourage that? (1, 2, 3, 4)

6 weeks

How did the birth go? How are you feeling?

Tell me about your baby. What is she/he like? (1, 4)

How has your baby changed/developed in the last few weeks? How have you responded to these changes? (1, 3)

When you think of your baby's health, what do you think of? (1, 2)

What makes your baby happy/causes him/her distress? (4)

What qualities are you trying to encourage in your baby? How are you trying to do this? (1, 3)

What or whom do you turn to for information/or to discuss your baby's development? (2)

3 months

Tell me about your baby. What is she/he like? (1, 4)

How has your baby changed since we last met? How have you responded to these changes? (1, 3)

When you think of your baby's health, what do you think of? (1, 2).

What kinds of feelings/emotions do you notice in your baby? How does your baby express these? (Ask for examples). How do these emotions/feelings make you feel? (1, 4)

How do you respond to your baby's differing feelings/moods? (Go on to ask why they respond in the way they do?) (2, 3)

What qualities are you trying to encourage in your baby and why? How do you try to do this? (1, 2, 3, 4)

Do you discuss your baby's development and wellbeing with anyone? Do you think this has an influence on your parenting? (2)

6 months

Tell me about your baby. What is she/he like? (1, 4)

How has your baby changed since we last met? How have you responded to these changes? Which, changes do you view as most important to your baby's development? (1, 2, 3, 4)

When you think of your baby's health, what do you think of? (1, 2)

What makes your baby particularly happy or sad? (Ask for examples). What do you think about this? How do you respond? (1, 3, 4)

Does your baby express other feelings? How do you recognise these, and respond to them? (1, 3, 4)

What qualities are you trying to encourage in your baby and why? How do you try to do this? (1, 2, 3, 4)

In what way do your own experiences influence the way you look after your baby? (2)

Are there are other factors that influence the way you view your baby's development?

What are these, and why are they important? (1, 2)

9 months

Tell me about your baby. What is she/he like? (1, 4)

How has your baby changed since we last met? How have you responded to these changes? Which, changes do you view as most important to your baby's development? (1, 2, 3, 4)

When you think of your baby's health, what do you think of? (1, 2)

What makes your baby particularly happy, angry, or sad? (Ask for examples). What do you think about this? How do you respond? (1, 3, 4)

Does your baby express other feelings? How do you recognise these, and respond to them? (1, 3, 4)

What qualities are you trying to encourage in your baby and why? How do you try to do this? (1, 2, 3, 4)

In what way do your own experiences influence the way you look after your baby? (2)

Are there are other factors that influence the way you view your baby development?

What are these, and why are they important? (1, 2)

12 months

Tell me about your baby. What is she/he like? (1, 4)

How has your baby changed since we last met? How have you responded to these changes? Which, changes do you view as most important to your baby's development? (1, 2, 3, 4)

When you think of your baby's health, what do you think of? (1, 2)

What makes your baby particularly happy, angry, or sad? (Ask for examples). What do you think about this? How do you respond? (1, 3, 4)

Does your baby express other feelings? How do you recognise these, and respond to them? (1, 3, 4)

What qualities are you trying to encourage in your baby and why? How do you try to do this? (1, 2, 3, 4)

In what way do your own experiences influence the way you look after your baby? (2)

Are there are other factors that influence the way you view your baby development?

What are these, and why are they important? (1, 2)

Reflect on the last 12 months with your baby, how do you feel about the progress that you and your baby have made? What hopes/wishes do you have for your baby?

Appendix G Hanna's case profile

Please see the following pages for an example of a case profile. In this instance Hanna and Freddie.

On the case profile, I recorded the following: identity, mother-infant relationship, infant development, relationships, emerging narratives, and researcher reflexivity.

	Interview 1	Interview 2 6 weeks	Interview 3 12 weeks	Interview 4 6 months	Interview 5	Interview 6
Identity	Did not recruit until 6 weeks PN.	Keen to maintain heritage and encourage baby to engage with this. Would have liked natural birth – but this didn't happen – accepting of the process, just pleased that baby is OK. Very close to family. Reflects on how she was parented – and clear about how she wants to go about it. Enjoyed work and business of it all- now trying to get used to life at home with baby. Found changes to body difficult to accept with pregnancy – did not like getting bigger/weight gain. Keen to regain fitness. Reads a lot – and engages with health professionals, uses them to help with anxieties and ensure she is on track with Freddie. However, feels happy to disregard advice related to sleeping. Trying to stay relaxed. Has not set out to make new friendships because of pregnancy/childbirth.	Maintains close links with mother and sisters- main source of parenting influence, what to do and how not to do it. Looks for confirmation that is doing OK as a mother from Freddie. If he is happy, then she knows that she is getting it right. Accepting of professional advice – regarding immunisations.	Feeling more confident in role now – feels that they are getting to know each other. Has less need of family now. Demonstrates independence in choices- for example with groups, will see how these go/work for them. Keeping xx links and language alive is important to Hanna.	More confident – rarely googles or uses child development apps. Likes to go with the flow. Relaxed. Refers to health professionals when she has concerns. But doesn't always agree with them. Mother and sisters a big influence on how she interacts with Freddie on a daily basis. Recognises similarities in their behaviours. Enjoying time spent with Freddie now he is more independent. Feels that it is her role to encourage Freddie to be curious about the world. Happy to let others (family members care for Freddie now. Continues to keep xx culture alive- songs/language.	Tried to encourage Freddie to play with mixed gender toys – which he didn't take to. But dad encouraging 'vroom vroom' in back yard. Has returned to work – is now enjoying the adult time, yet appreciates working part time and spending time with Freddie. Holidays with family and extended family. Appreciates their input with Freddie and influence but recognises that some of it is not up to date. Does not want to repeat some of the parenting she received from her mother. However, recognises that her mother was substantially younger than her – and things were different. Has a different approach to mothering than her

						<p>mother-in-law- beginning to appreciate that it is okay for people to have differences and to tolerate these.</p> <p>Her mother forms a bridge between herself and mother-in-law. Keen for Freddie to have his own space and identity. Is getting used to sharing him with other people and not always being in control.</p> <p>Has found it shocking the extent to which, people try to take ownership of pregnant woman and child. Body doesn't belong to self anymore and people feel the right to comment on childcare decisions.</p> <p>Maintaining xx language.</p>
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<p>Mother/infant relationship</p>		<p>Constantly talking to Freddie and kissing him during our interview. Feels that it is important for him to stay close to her, offering skin to skin contact during the day. Sleeping with him. Wants him to feel safe and loved. If he is with her then he knows that he is safe. Wants him to be curious and explore the world and is happy for him to do what wishes as he gets older. Believes that it's important to stay relaxed as her mood will project on to him. Though she is quite anxious about his health and wellbeing. Reflects on how upbringing – and on what was good/bad about this, and on how this will influence how she chooses to parent Freddie. Very keen to keep xx heritage alive for Freddie- so spends time talking and singing to him in xx.</p>	<p>Hanna is now finding it easier to interpret Freddie's cries- for a while she was worried as she found this difficult. It's easy to tell when he is happy because he smiles.</p> <p>He enjoys close physical contact with Hanna they sleep together. She has got stricter about the use of the sling due to back pain.</p> <p>When he is grumpy it makes Hanna feel emotionally vulnerable- she isn't sure what the problem is, or how to help. He wants constant contact when he feels like this, and Hanna who has got used to some space from him, can find this difficult.</p> <p>When Freddie is happy, he will now separate from Hanna and play in his bouncy chair or mat.</p> <p>Hanna reports instinctively knowing when Freddie is content or when he needs something.</p>	<p>Hanna responds to Freddie– by trying to find what makes him happy and repeating it. When he is unhappy responds by cuddling and feeding him.</p> <p>Enjoys trying to talk with him. He enjoys trying to talk back. When talking to her mother on the telephone he tries to join in – so that they all get louder and louder.</p> <p>Concerned for Freddie's health- in that something catastrophic might happen to him.</p> <p>He enjoys interaction with her- singing, talking, showing him things, however Hanna is sensitive to his need for space – to play by himself.</p> <p>Recognising love and joy in Freddie's eyes. Feels that he is a perfect baby compared with others.</p> <p>Encourages Freddie to feel curious about the world – recognises the influence she has here.</p>	<p>Freddie demonstrating growing independence and interest in other people.</p> <p>Hanna repeats things that make him happy to keep him interested. Play acts with him – for example blowing nose.</p> <p>Hanna is enjoying his independence – can now have a shower without worrying about him.</p> <p>Freddie is happy to be in the sitting room alone when Hanna is in the kitchen, however he likes to roly poly over to check on her.</p> <p>Continues with breastfeeding – as it comforts him and is convenient. However, at the time Hanna thinks it will never end.</p> <p>Tries to encourage Freddie to be curious about the world. Takes the time to explain things to him. Accepts that the first 12 months are a time when</p>	<p>Spent Freddie's birthday with her family skiing. Encourage them to participate in his care.</p> <p>Is happy continuing to breast feed Freddie and accepting that he wakes for breast feeding at night needing comfort. In some ways finds it odd because he isn't clingy towards her otherwise. Freddie is happy to be left at nursery, and to play with others without Hanna.</p> <p>He likes other children and will sometimes barely notice when Hanna arrives to pick him up from nursery. Is only doing half days at nursery – cared for by grandmother in between times.</p> <p>Happy for Freddie to have cow's milk when she is at work. Relaxed approach to breast feeding.</p> <p>Tries to distract him with cuddles and songs when he is sad. When he is</p>
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			<p>Seeks reassurance from family when dealing with a grumpy Freddie.</p> <p>Hanna tries to recreate situations that make Freddie happy.</p>	<p>Trying to have fun every day.</p>	<p>she will have the most influence over his life.</p> <p>Does activities to make life interesting for Freddie– she thinks it is important for him to realise that he is an equal member of the family – not a pet.</p> <p>Cuddles Freddie when he is sad, and tries to calm him, help him work it out when he is frustrated.</p>	<p>frustrated tries to help him solve the problem.</p> <p>Actively encourages him to play by himself – have privacy. Feels that this is important with return to work. Is happy for him to go off in the care of friends – trying to let go.</p> <p>Feels that it is important for Hanna to have his own boundaries.</p> <p>Sings and plays with Freddie. Uses xx language/nursery rhymes.</p>
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<p>Infant development</p>		<p>Freddie like a 'vegetable' to begin with. Now much more responsive now. Stimulates him with music, singing and talking. Feeding frequently and enjoys close contact with Hanna. Not smiling yet – but dad was apparently a late smiler. Some colic.</p>	<p>Much more responsive. Can find his hands. Smiles freely when happy. Has more than doubled his birth weight. Enjoys music, particularly African and tribal music. He is mesmerised by certain objects – will hold his gaze. He can become started and scared by things. Freddie is eating and growing well. This indicates to Hanna that he is healthy. 'Becoming a boy.' Sleeps well with Hanna.</p>	<p>Curious about the world, enjoys interacting with others.</p> <p>Especially likes to watch other children – they make him giggle.</p> <p>Trying to talk and mimic with parents.</p> <p>Development so rapid now that it is difficult for Hanna to recall everything. Enjoys standing up on her lap.</p> <p>Will occupy himself.</p> <p>Likes to play with an interactive toy called a jumperoo.</p> <p>Interested in food – starting weaning process tomorrow.</p> <p>Demonstrates recognition towards his dad and Hanna's family.</p> <p>Expresses happiness/unhappiness – usually when tired, hungry or unwell. Does become frustrated or angry at times- when things not going his way.</p>	<p>For the most part Freddie is content and happy. Becomes distressed when he is tired, hungry or in pain.</p> <p>Very engaging now – interested in playing 'kid's games' now a small boy.</p> <p>Interested in real books.</p> <p>Not interested in crawling but will roly poly to get what he wants.</p> <p>Interested in toys. Especially likes putting them in his mouth- gets frustrated and angry when he can't. Will throw the toy down or kick out.</p> <p>Will stand when supported.</p> <p>Sitting independently now. Enjoys playing with a variety of toys because of this.</p> <p>Enjoys being outside – and touching leaves/plants etc.</p>	<p>Freddie is described as a happy and relaxed baby. Is upset today – has had immunisations early.</p> <p>Freddie is funny – is capable of producing a fake laugh to charm people.</p> <p>Likes people and enjoys being the centre of attention.</p> <p>Doesn't like dolls- prefers toys with wheels.</p> <p>Likes music and to sing. First word a xx one. And is English for yummy, yummy.</p> <p>Cruising around the furniture – but hasn't walked independently yet.</p> <p>Enjoys food – definitely has favourite foods now.</p> <p>Has his own personality – a small human.</p> <p>Can communicate with him in a way he</p>
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					<p>Enjoys solid food.</p> <p>Some concern over weight gain by health visitor. However, parents both slight, and he is well and very active.</p> <p>Happy to be cared for by others.</p> <p>Will play independently for about 30 minutes.</p> <p>Enjoys attending sensory and play groups.</p>	<p>understands, and he can express likes/dislikes.</p> <p>Likes other children – is sociable and will spend time with other adults besides Hanna.</p> <p>Will play independently for periods of time.</p> <p>Loves balloons and hairdryer. Mimics drying his hair like mum.</p>
Relationships		<p>Family very important to Hanna- she knows that wherever she is in the world that they are there for her – she wants Freddie to have these feelings. Continually discusses Freddie with mother and sisters- uses social media to stay in constant contact. Mother-in-law very helpful just after birth, and continues to visit once a week. Uses health professionals</p>	<p>Family remains central for Freddie. Uses them as point of references – discusses her fears and concerns with mother and sisters. They are 'motherly' to her – reassuring.</p> <p>Listens to mother-in-law- finds her approach too English and cold.</p>	<p>Family is important – but more independent of them now. Recognises that there are gaps between the generations in terms of baby care.</p> <p>Mother-in-law not as responsive to Freddie as Hanna a different way of doing things. Does not pick up a crying baby unless she identifies a need. Hanna puts this down to her being English.</p> <p>Attending some groups –but these are fairly inconsequential.</p>	<p>Family continues to be important Hanna. Hanna recognises their influence in the way that she interacts and cares for Freddie, but not in the baby care that she provides. For example- diet. Recognises the difference between the act of caring for the child – the emotional, holding and engaging with to the every- day acts of</p>	<p>Family continues to be central. Holidaying with family. Influential in terms of how Freddie is cared for – but Hanna recognises limitations of this.</p> <p>Mother-in-law cares for Freddie and Hanna recognises both her strengths and the differences in their beliefs.</p>

		to discuss concerns regarding Freddie that family unable to help with. More to do with his physical wellbeing. Most friends do not have children –but with those that do – they share stories and experiences. Doesn't feel the need to make new friends with children.	Takes contact with health professionals seriously.	Most friends do not have children.	<p>childcare – for example diet, what cream to use.</p> <p>Mother-in-law cares for Freddie whilst Hanna takes a break.</p> <p>Continues to attend some groups.</p> <p>Consults with health professionals over Freddie's wellbeing – doesn't always agree with them.</p>	<p>Lots of friends without children – Freddie gets lots of attention. However, some friends find it difficult to understand about continuing with breast feeding. Hanna finds this difficult to accept at times.</p> <p>Becomes frustrated that family and friends and outsiders can overstep the mark with pregnant body and comments on childcare.</p> <p>Positive relationship with nursery staff.</p> <p>Consults with health professionals as needed.</p>
Emerging themes		<p>Staying close –feeling safe.</p> <p>Family</p> <p>Being there</p>	<p>Trying to find what he likes. Making Freddie happy.</p> <p>Recognising emotions.</p> <p>Family</p> <p>Having some space.</p> <p>Closeness</p>	<p>Independence</p> <p>Getting to know each other</p> <p>Becoming a person</p> <p>Physical closeness</p> <p>Differences between the generations.</p>	<p>Becoming expert.</p> <p>Independence for both mother and baby.</p> <p>Becoming a person</p> <p>Differences between the generations.</p> <p>Influences from the past.</p> <p>Differences between how you love and care for your baby – and those based upon acts of baby care.</p>	<p>Evolving maternal identity.</p> <p>Growing a person.</p> <p>Creating a safe space.</p>

Researcher reflexivity		I identified a little too much with Hanna birth story having had an emergency LSCS myself.	I found myself feeling defensive of Hanna's 'mother-in-law.' Probably, having two sons, I might find myself in this position one day. But I also think she seemed pressurised by Hanna's partner's father, and I wondered if she had some difficulty in dealing with this.	I felt I rushed this interview- it was well over an hour, but Hannah very keen to talk and spend time. I felt preoccupied, with work issues and a bit crowded.	Expert coming in at times. Annoyed with health visitor. Just silly. Had to watch what I said. Reassuring in places.	Immunisations –I felt that this put the interview to a difficult start. Offering the occasional professional stance on this.

Appendix H Examples of interview summaries – Natalie and Fran

Natalie summary: interview 1.

Interview 1

Finished PhD and went to Central America. Came back after 2.5 years for various reasons. Had first child, who is now just over 4. Always wanted more children, but older child is very active and with work, decided to have some space. Jacob will start school, whilst Natalie is on maternity leave, and she is pleased about being there to support the transition. Will take 6 or 7 months off work – for financial and career reasons. Is part of a xx – will stay in touch with this whilst on maternity leave.

(Evolving maternal identity/creating space/growing a person)¹⁹

Has found the pregnancy initially quite difficult – sick and tired and trying to cope with work, and Jacob. Feeling better now, that baby has dropped, more room and able to be more active with Jacob, something she has had difficulty with and felt bad about.

Natalie felt larger from an earlier stage, and this made life more difficult. With Jacob, labour began well and then needed induction from 8 cms. Delivered by forceps as he became distressed. Accepting of this. Originally Natalie would have like a water birth, but chose to deliver at a main hospital where this wasn't available. Hugo very anxious re midwife led idea. Would like a water birth this time. *(Evolving maternal identity)*

¹⁹ Cross comparison to theme. Completed later, as themes emerged.

The baby is a girl, she is more active than Jacob. Natalie thinks she will be like Jacob but wonders if she will be less active when born, as he was quieter in utero, but has turned into an active child. She found this a shock to begin with. He is interested in lots of things and ask questions about the baby. Natalie is preparing him for the arrival by involving in the preparations, such as getting out equipment. Jacob was a good baby – but was allergic to milk protein, this caused him to be unsettled at times. He was breast fed, until around the age of 9 months. There were some breast-feeding problems when he was around 3 to 4 weeks of age, but advice from health visitor and friends helped.

(Growing a person/creating space)

Natalie feels that it is important to make sure that the baby is happy. By this she means, that she is content, not crying. That all her needs are taken care of, that she has contact with both parents, Jacob and that she is stimulated, through talking to her, and a gradual introduction to toys.

(Growing a person)

Natalie felt very unsure with Jacob, would like to be more confident this time. Was worried about looking after him and concerned about cot death. Worried about getting things right and felt some pressure from outside sources to do so – although found midwife and health visitor very helpful. Started to feel more confident and able to make

own decision about what was working for them, when Jacob was about 4-5 months. However, still questions self now – regarding developmental milestones, when they should start potty training and so forth. (Evolving maternal identity)

Natalie found that the midwife and health visitor were supportive influences in the early days of looking after Jacob. Both her mother and mother-in-law are supportive, her mother-in-law doesn't speak English- being xx but communicates via Hugo. Natalie made friendships through the NCT and these have continued to be important to her. One friendship is particularly important. They parent in similar ways – or have ideas of how to do things. Natalie saw a lot of family after Jacob was born- her mother came down to stay from xx, and her in laws came over from xx to stay for 2 weeks when Jacob was 6 weeks. The support helped in her transition to motherhood. Her brother – visits with his children, he also lives in xx. She stays in touch with family via Skype.

(Evolving maternal identity/creating space/growing a person).

Health is associated with feeding, growing, being the right weight – meeting developmental milestones, interacting with people, moving around and so forth.

(Growing a person)

Encouraged Jacob to be respectful of others, be polite and listen to others. They are mindful that he is an active child, and her husband was the same – that he didn't always listen. They wanted to be thinking along the same lines in terms of managing his behaviour. They encouraged him to be an active child, to spend time outside, as they are both active people. They encouraged Jacob with toys and different play mats to stimulate him but tried to avoid over stimulation.

(Growing a person)

Very keen for Jacob to be confident, able to be independent. Natalie was shy and doesn't want this for Jacob. Encourages him to talk to adult friends – who haven't got children, they spend quite a bit of time with them. Wants to promote a close relationship with the baby, has a close relationship with her brother. Attended clubs as a child, and Jacob has started doing this as well, wants to encourage own interests but feels that children shouldn't be pressurized. Encourages Jacob to talk about things that might worry him – that he can go to them but doesn't wish to 'put words into his mouth.'

(Growing a person/creating space/evolving maternal identity)

Natalie feels that it is important for Jacob and the baby to get along with others. Returned to work, and her in-laws came over to help settle him into nursery and aid her return to work for 6 weeks. She found it hard to leave him and walk away but needed to return to work and that the social contact would benefit him, which it has, as he interacts well with other children.

(Growing a person/creating space/evolving maternal identity)

Hugo works irregular hours, sometimes he only has a Tuesday off in the week. He used to look after Jacob on Tuesday and that was beneficial for their relationship. He is looking for another job so that they can have more family time together. This usually involves getting out, walking, running or cycling as a family.

Creating space

Wants to try and maintain physical closeness with both children. Have the baby in a sling, whilst keeping Jacob close. The baby will sleep in Natalie's room for the first few months. When she had Jacob, she initially found the demand to manage his need for physical closeness hard to manage. With the pressure of trying to maintain the house, has now realised that this isn't a priority and wants to be more relaxed this time around.

(Growing a person/creating space/evolving maternal identity)

Fran Interview 3

Jessica is a relaxed baby, relaxed temperament. Appears to appreciate that mum cannot always respond quickly due to Toby. Is starting to teeth – but is relaxed. The only time she gets upset is when she has colic. Sleeps when out, and smiles and coos at people that talk to her. Compares Jessica to Toby. He wanted to feed more often – but she will sit on lap and be still, so can take part in activities such as chatting at a coffee morning or reading a story to Toby. Comparison is made because she is a girl with Toby by other people – she feels that gender isn't the answer, but the fact that she is more relaxed with her, wonders if genetics and environment are the answer here.

Growing a person/evolving maternal identity

Jessica is now more physically able- less colicky, but teeth appearing. Awake for longer periods, more expression and is more responsive. Maintaining eye contact for longer, eyes will follow Toby, likes watching him run and play. Trying to talk back. Finds it easier to interpret cries as they follow a cycle – not down to the type of cry, but the time of day. Gets confused at likeness between Fran and her mum. Jessica is more responsive, Fran responds to this, by spending more time engaging with her, talking to

her and trying to talk back, singing. Passing her objects to hold, trying to make her feel secure by knowing someone is around.

Growing a person

Fran likes the fact that she is a big baby – who can physically hold her own. That she has good colour. Goes to the GP and health visitor for the usual checks.

Growing a person

Jessica now recognises members of the family and responds with a smile. Cooing and smiling indicate that she is happy. Became very distressed on having ‘jabs’ screamed. Feels really pleased that she is so happy, but also feels able to cope with her crying better than Toby realises that she is not going to come to any harm if she cries for a few minutes. John is usually downstairs trying to soothe her anyway, whilst Fran is dealing with Toby. John is very relaxed and tries to cuddle her and show her around the room to settle her- he will often presume that she is hungry. He also appreciates that she is not really sad about anything – that helps Fran feel more relaxed, and she feels this has a positive impact on Jessica. Thinks that she mainly cries from a physical need from having colic. When this is relieved –then she is happy. This makes Fran think that as she appears not to remember this, then leaving her to cry for a bit is not as harmful as she thought. However, she will not be practising self-soothing.

Growing a person/creating a safe space

Fran responds– to Jess’s happiness by talking, using different pitch of voice, singing.

Jess responds to white noise when crying. Tries to use soothing tone and sing soothing songs when she is upset. Likes to be held a lot during the day – doesn’t like to be put down. Will sleep in Moses basket or next to me crib during the night – but in the day likes to be held. She will sit on a mat/chair for short periods of time.

Growing a person/creating a safe space

Fran and John are using a shift pattern to deal with sleep. They take it in turns during the night to sleep on the sofa with Jessica in the Moses basket downstairs. They swaddle her in muslin blanket at night – which she appears to recognise.

Creating a safe space

Fran tries to cultivate a loving relationship within the family – is really pleased with how Toby responds so gently to her. Being part of a close family – Fran’s mother cares for Toby on a Wednesday and Thursday – that’s important. Being responsive to her – so that she is aware that her communications are acknowledge, trying to show her that someone is listening to her by talking and responding to her. Can’t work out how long-term Jessica’s memory is – is the responsiveness to smiling, is it because she knows she gets a positive reaction or because it is automatic.

Growing a person/evolving maternal identity

Discusses Jessica's development and well-being with her mum and John. Health visitor is helpful – and uses her if family cannot help. Has made some good friends in the area- but wouldn't discuss health issues with them, relies on family and John. Family has a strong influence on parenting –from her grandmother, mother, father- cousins. Is aware of the influence, and sometimes with John needs to stand up to them, as doesn't think their view are always up to date – or in tune with how they feel. Mother looks after Toby for 2 days a week and Jessica will go to her, when she goes back to work. Doesn't use google as much this time around. Uses apps – to confirm development, and to remind herself which, side to breast feed.

Evolving maternal identity

Is keen for Jessica to be a confident child. Reflects on her own experience as a primary school teacher, and the children that struggle- and doesn't want that for her. Sees this process as a gradual one – for example taking her to play group and encouraging cuddles with her from an early stage. She hopes that this will give Jessica confidence with strangers. This will then have a knock-on effect to self-esteem, which she will encourage with praise, and giving her opportunities to do things by herself.

Growing a person/evolving maternal identity

Appendix I Theme: evolving maternal identity

This theme represents the shifting nature of identity. Maternal identity is an entity that responds not only to socio-cultural influences but to the needs of a developing individual, who is changing rapidly. There is a mutual exchange between mother and child. Influences on maternal identity depend upon past and present experiences. For each participant, this is an individual phenomenon with some commonalities. Mothers drew upon experiences of how they were parented, which gave some insight into how they wished to be as a mother and, in some ways, their perceptions of emotional and social development. Moving to the present, for some participants' their relationship with their mother and other members of the family (usually sisters) remained a key influence, whilst for others, friendships are of importance. However, all participants acknowledged the limitations of their mothers' knowledge in terms of modern-day thinking. There are some inherent characteristics in terms of how women respond to their babies that are hard for them to explain – these are usually described as instinct; however, the concept of instinct and maternal care is not an easy explain away for

maternal behaviour –see Chodorow (1999). It appears to be a balance of their own experiences of being mothered, combined with contemporary influences. Some participants are angry at the pressures placed upon them – for one first time mother (Hanna), the pregnancy and having a small child made her feel like she was no longer in control of her own body. She perceived a lack of boundaries. Whilst others (Natalie and Ruth) focused on the pressure placed upon them. Natalie felt with her first baby - she had to do everything correctly; she was keenly aware of the surveillance. Whilst Ruth is infuriated at the use of developmental milestones, which she felt undermines mothers' efforts, making them feel inadequate if their baby does not meet them. Tess felt that first-time mothers are not treated seriously by health professionals –as a result, she had a mistrust of midwives/health professionals and the information given. Second-time mothers report feeling more relaxed, using their experiences of their first baby to develop their mothering practice the second time around. They found it easier to interpret their baby's needs/signs from an earlier stage. First time mothers grow in confidence and expertise during the first year of the baby's life. All mothers reflected elements of 'intensive mothering' as described by Hays (1996). What stood out the most was their need to provide their child (or children) with constant attention for example, playing with them, helping them to manage their emotions etc. and the guilt they felt for taking some time away from this.

(Where do you get information about his diet from then?) Mostly the internet because, you know, because what my mum is telling me – Jesus Christ, it's all the, all the ideas from thirty years ago, thirty-five actually. Or even longer. It's not – and she says, "Oh, when you were a baby, I was – you were thin, and I was giving you rabbit stew." And I was like, "Ooh, thanks, mum! That's not going to happen." So yes, so yes, it's just that – so yes, we turn mostly to that. (Any particular sites?) No, I just Google it and whatever comes up—the NHS one mostly, but also xx websites. And then I kind of compare and see what's on both, and I kind of go with that. And also, really kind of my instinct, because

I try to give him mostly the same food as we do, just without all the spices we're putting in (Hanna, interview 4, 9 months, first baby).

'So I did take after my mum's attitude the fact that, you know, that you show everything around and it's never too early to start, you know, doing stuff like sightseeing, reading books and things like that. And it's, you know, my mum was always... 'as long as it stays in your mind, doesn't matter you were six months old when I took you there. It must be, you know, somewhere there.' Some would say they are not. But still, there's no harm in doing the same. So I'm definitely taking him out and about as my mum did to us. So I don't listen to much, or I don't follow much of what my mum was doing when it comes to the baby care or the, like, you know, what kind of creams she would be using or stuff like that – because obviously, it was completely different. But – or to, or to feed him – because it was like she used to do, yes, he'd be on solids from the age of three months. And would be having milk mixed with cornflour. And a few other bits. Crazy when you think about it, the early eighties.' (Hanna, interview 4, 9 months, first baby).

So, yes, I think there's certainly people that I will drift apart from and people that I would very much like to stay friends with. And I remember talking to my sister about this when she had young children. And she got very excited because she went to a playgroup or something. And she met this girl. And she said to me, "It's just brilliant because we would have been friends even if we didn't have children." And I think she's still friends with her. And I've certainly got at least one friend that I've met and though – the children are the situation which has brought us together, but actually our friendship is not based on the children. Whereas there's certainly lots of people who, our friendship is just because we have children the same age and we go to the park together and – and it's lovely. But quite aware that those friendships will disappear as you get new, new relationships, you know, when they start school or meet new people. You can't fit everyone in your life, can you? (Ruth, interview 6, 13 months, second baby).

'I think they're tactful. I'm sure that they, I've overheard my mum talking to her friends about how, you know, "All the girls these days, they just breastfeed for so long and it's all about this finger food and they're all, you know, they just, they all sleep in the same bed and it's, you know," it's just not the way that she was – it's not the official advice that she was given when she had babies. And, you know, she breastfed, my mum breastfed all of us for six months and then stopped. She said she just found it very hard to do a bit of, you know, do a bit, but what she just said was could either do all of it or nothing. So that was fine, that was her decision. None of us slept in their room for longer than a few days, I don't think. And then we were in our own rooms. But, so she's just quite – that's how she did it. And she doesn't necessarily, she wouldn't necessarily do it the way that I am. But she'd never interfere with what I was doing or pass judgement on it to my face. I've heard her talking about it. But it wouldn't be aimed at me. You know, she's not disapproving of it, I think she just thinks I'm making it harder for myself.'

(Ruth, interview 6, 13 months, second baby).

I think, you know, over the last four years, since having Noah and then Isla, I've probably got closer and closer with friends who have children the same age, the same kind of stages. And I think I've mentioned before having a very close NCT group, who are all very like-minded and we still see a lot of some of them. And they are probably big influences, probably on each other as well. We've discussed previously that we all breastfed for much longer than we might have done, because everyone else was still doing it. And so there was kind of a peer support or even a bit of peer pressure, I don't know, towards doing certain things. And those are probably the people that I have most parenting type conversations with. So, if I'm talking to people who don't have children or whose children are older and they're kind of past this particular stage, I might have fewer conversations about things like, 'What do you feed them and how do they sleep and how do you discipline them? How do you, what kind of activities do you do?' I'd still go to the NHS website for kind of medical advice or information. I talk to my sisters quite a lot. Both of, all, both of them have children who are older, but, as my children get a little older, I think I have more, I think I have more to talk to them about. I think the kind of baby stage is very specific to itself as is the toddler stage.

(Ruth, interview 6, second baby, 13 months).

Yes, I understand the need for developmental milestones and a ball park of – and, you know, a lot of the time it is about, at this time, about six months they'll sit up. But I think I've got this book, it's a day-by-day baby book. And I've had to stop reading it with Noah because it was so depressing. It used to make me really angry that it would say about, you know, 'your baby should be doing this at this point.' And it would suggest different games you could play with them at different points and – or what you should look out for and things you could try. And it was just always completely wrong with Noah. And I've looked at it a bit with her. And it's a bit more accurate in terms of, she did sit up at six months and she smile at about five or six weeks. And things like that. But I've just stopped reading it again because it always talks about sleep and it just makes me angry.

Why does it make you angry?

Because I, I'm actually angry that there is so much information which states what your baby should be doing at different points, and what makes me angry is how it then makes me, as a mother, feel, when my baby is not doing that. And I think I'm a reasonably confident person. I've got a lot of friends who have got babies around the same age, who give me lots of support. And I've got sisters who have got children who give me lots of support. And yet I still, it still makes me feel guilty or a bit inadequate or worried if my baby is not doing something which I've been told they should be doing. And so it makes me angry for people who don't have that support and confidence, how it must make them feel when it must be incredibly – I mean it's hard to be a mother anyway. And it must be incredibly difficult if you don't have that support and you still have this mummy guilt which is something I talk about – me and my friends talk about quite a bit – the mummy guilt on everything you just feel guilty about. And you feel that somehow, it's your fault if your baby isn't doing something.

(Natalie, interview 5, second baby, 9 months).

A bit torn really. I want to go back because sometimes I feel in a way that I'm missing out on the work, because I'm part of a big project and that's kind of carrying on without me there, which is good it's doing that, but I'm quite involved in it, so I feel like I'm missing little bits of it. But I'm also torn, I don't want to leave her. And with Jacob, he was eight or nine months by the time – I think he was about eight and a half months when he started nursery. So ideally, I'd like for Freya to be the same age. I don't really want to send her any younger than that. So a bit mixed emotions. It will be good to get back and get into a good routine. But, in other ways, it feels like that's it then, because I've had, I've got two children and we're not really planning any more. So long stretches of time with my children – so this kind of will be an end. (Natalie, interview 3, second baby, 3 plus months)