Breast-feeding experiences in women with postnatal depression

Thesis submitted in partial fulfilment of the
Doctorate in Clinical Psychology
for the University of Leicester

by

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School of Psychology- Clinical section.

June 2006
Declaration

This thesis submitted for the degree of Doctorate in Clinical Psychology, entitled Breast-feeding experiences in women with postnatal depression, is based on work conducted by the author in the School of Psychology – Clinical Section, at the University of Leicester between 2004 and 2006. All of the work recorded in this thesis is original unless otherwise acknowledged in the text or by the references.
Breast-feeding experiences in women with postnatal depression

Ellen Homewood

The aim of this study was to develop an account of the relationship between breast-feeding and postnatal depression.

A review of the literature revealed that postnatal depression has a negative effect on mother-infant interaction and specifically, on breast-feeding experiences. It has also been hypothesised that whilst breast-feeding contributes to the development of depression in some mothers, it may also help to improve mother-infant interaction. These findings suggest that infants of depressed mothers who do not breast-feed, are at an increased risk of negative interactive experiences with their mothers, which might contribute to the poorer developmental trajectories of depressed mothers' infants. Since research into the association between breast-feeding and postnatal depression has mainly been based on questionnaire and observational approaches, existing understandings do not necessarily reflect mothers' reported experiences. This indicated the need for qualitative research to further the psychological understanding of this complicated area of the literature.

In this study, a grounded theory methodology was used to analyse interviews of nine women who had received diagnoses of postnatal depression. A core category, termed 'Becoming occluded', and a process model, were developed. Becoming occluded referred to mothers' sense of being eclipsed in their attempts to meet their infants' needs, specifically through breast-feeding. Difficult breast-feeding experiences exacerbated mothers' sense of inadequacy, contributing further to experiences of depression. However, some mothers welcomed the dependency fostered by breast-feeding and found it an affirming experience in spite of their depression.

Implications for clinical practice include the need for greater breast-feeding support for women considered vulnerable to depression and a broader need for psychological support of mothers suffering from postnatal depression.
Acknowledgements

I would like to thank Alison Tweed, Michelle Cree and Jon Crossley for their invaluable guidance and support throughout the course of the study, and Dave Clarke, whose intervention was pivotal to its progress.

I would also like to thank staff involved in recruitment at the Mother and Baby Unit, Childbearing and Mental Health Service, Derbyshire Mental Health Services NHS Trust, and Doctor Lazarus in Perinatal Screening Services, University Hospitals Leicester NHS Trust.

Most importantly, I would like to thank the nine women who shared their difficult and sometimes painful stories, in that hope that other women with diagnoses of postnatal depression could be understood better.

My final thanks are for Craig, who has been my rock.
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1.1 Abstract

The aim of this review is to consider the current state of evidence for the relationship between postnatal depression and breast-feeding.

Postnatal depression has been conceptualised in cognitive, psychodynamic and biological terms. However, research most strongly supports the stress-vulnerability model of depression, which predicts the development of postnatal depression in those who are vulnerable, for example, because of adverse life circumstances and psychopathology. Research has also demonstrated the negative effects of postnatal depression on mother-infant interaction and infant development, and highlighted the possibility that experiences of interaction may contribute to, as well as reflect, maternal depression.

Literature on breast-feeding has mainly focused on predicting feeding duration in relation to cognitive styles and social determinants. Observational studies have shown that breast-feeding, when compared with bottle-feeding, is associated with more positive dyadic (mother-infant) interaction.

Differing associations between postnatal depression and breast-feeding have been identified. Research has revealed a positive relationship between maternal depression and breast-feeding, but has also shown that depression has a negative effect on breast-feeding. This latter finding suggests that for infants of depressed mothers, the adverse effects of depression on their dyadic (mother-infant) experiences may be further compounded by their mothers’ decisions not to breast-feed. In spite of these findings, some research has indicated that the beneficial effects of breast-feeding on the mother-infant relationship may hold irrespective of maternal mood. On the basis of these findings, it has been hypothesised that breast-feeding may represent a useful intervention for depressed mothers in order to buffer against the negative effects of depression on her interaction with the infant. However, the mechanisms by which this might happen remain unclear.
It is concluded that since current evidence for the relationship between breast-feeding and postnatal depression has predominantly been deduced from correlational studies, qualitative research exploring mothers' subjective experiences is needed to help explore the psychological process that gave rise to current findings.

**Key Words:** Postnatal depression, postpartum depression, breast-feeding, breastfeeding, mother-infant interaction.
1.2 Overview

A literature search of English language journals was conducted, using the Web of Science, Medline and PsychInfo databases and the keywords, postnatal/postpartum depression and breast-feeding, to search for articles published between 1990 and 2006. In addition, citations in articles considered relevant to the topics of interest were sought. The initial search generated approximately 450 articles. The main body of these articles was quantitative in nature, addressing the identification of postnatal depression, the impact of postnatal depression and/or breast-feeding on infants, and/or issues of clinical (in particular, pharmacological) intervention.

The search was narrowed using inclusion and exclusion criteria. Criteria for eligibility included a study focus on psychological aspects of postnatal depression and/or feeding method. Papers were excluded on the basis of having a physiological or pharmacological focus, relating to non-human species, focusing on interventions, and relating to mental health problems other than postnatal depression. The resulting body of literature comprised 97 articles. The majority of these related to the aetiology of postnatal depression and factors predicting infant-feeding behaviours. 25 articles addressed the relationship between postnatal depression and breast-feeding.

The first section of this review relates to postnatal depression. Cognitive and psychodynamic conceptualisations of postnatal depression are discussed. This includes an examination of the role of mother-infant interactions on maternal depression. Biological explanations of postnatal depression are briefly discussed. Findings from qualitative studies are then outlined.

In the second section, research related to breast-feeding is examined. Social and cognitive influences on infant-feeding behaviour, and differences in interaction relating to feeding method are discussed. The section ends by drawing on qualitative reports of mothers’ breast-feeding experiences to illustrate mothers’ various psychological reactions to breast-feeding and the influence of wider cultural discourses.
In the third section, the limited existing literature on the relationship between depression and breast-feeding is explored. The negative effect of depression on breast-feeding practices and the possible effects of breast-feeding on maternal mood are outlined. Observed interactive differences between depressed and non-depressed mothers and their infants are then discussed. The section ends with a review of the evidence suggesting that breast-feeding may be protective against some of the adverse effects of postnatal depression on mother-infant interaction.

In the last section, it is concluded that psychological processes that mediate postnatal depression and breast-feeding behaviour cannot be deduced from existing literature. It is suggested that mothers' accounts of their experiences of breast-feeding in the context of depression should be explored more systematically, as a first step toward clarifying the apparent relationship between depression and breast-feeding.
1.3 Postnatal depression

1.3.1 Definition

Definitions of what constitutes depression vary within the literature, and no consistent agreement exists about criteria for diagnosis (Pilgrim & Bentall, 1999). For these reasons, postnatal depression as an objective psychiatric diagnosis has been questioned (Nicolson, 1999). In spite of these difficulties, a wealth of research has been conducted into postnatal depression, and it is recognised in the International Classification of Mental and Behavioural Disorders (F53.0, ICD-10; World Health Organisation, 1992), as denoting a non-psychotic, sustained depressive disorder in women following childbirth, commencing within six weeks of delivery. Although necessary and sufficient criteria for diagnosis have not been agreed consensually, the condition is described as being characterised by low, sad mood, lack of interest, anxiety, sleep difficulties, reduced self-esteem, somatic complaints and difficulty coping with day-to-day tasks (Cox & Holden, 1994). Postnatal depression is distinguished in the literature from postpartum ‘blues’ and postpartum psychosis to reflect differences in severity and symptoms of postpartum psychiatric illness (O’Hara, 1997).

1.3.2 Incidence

Postnatal depression is believed to affect between 10 and 15% of mothers (Cox, Connor, & Kendell, 1982; O’Hara & Swain, 1996). However, in a further challenge to its validity as a discrete psychiatric disorder, it does not represent a higher incidence of depression than that found at other times in women of childbearing age, and risk factors for postnatal depression are similar to those found in other studies of depression (O’Hara, Neunaber & Zekoski, 1984). Risk factors mainly relate to indications of social adversity, such as conflict within marital relationships, poor social support and stressful life events (Da Costa, Larouche, Drista & Brender, 2000).
1.3.3 Theoretical conceptualisations

Cognitive conceptualisations of postnatal depression mirror mainstream theories that predict the development of depression in terms of a stress-vulnerability model (Beck, 1967). Vulnerability factors include depressive symptomology, such as dysfunctional attributional styles (Abramson, Seligman & Teasdale, 1978) and adverse social conditions, and stressors include a number of variables such as negative life events and transitions requiring adaptation. Research has supported the predictive validity of this theory in the development of postnatal depression (O’Hara, Schlechte, Lewis & Varner, 1991).

Postnatal depression has also been conceptualised according to psychodynamic models, which tend to relate the conflictual relationship between mother and infant to the mother’s past familial conflicts (e.g. Cramer, 1997) and emphasise the role of depression in defending the mother from overwhelming emotions (Milgrom & Beatrice, 2003). However, due to difficulties testing the definitions upon which the theories rely, limited supporting evidence exists.

Theories of mother-infant interaction pivot on the idea that mother and infant regulate interaction and this mutual activity helps the infant to regulate its own behaviour (Tronick & Weinberg, 1997; Stern, 1997, 2005). Research has shown that interaction with a depressed mother adversely affects infant behaviour (Field, 1995), and might explain the more negative trajectory of those infants’ development.

Biological theories focus on the role of hormones associated with childbirth, and posit that hormones have a causal role in the development of postnatal depression (e.g. Dalton, 1980; George & Sandler, 1988). However, no consistent evidence for the role of hormones in postnatal depression has been found (O’Hara et al. 1991).

1.3.4 Cognitive theories

The stress-vulnerability model of depression (Beck, 1967) has strong predictive validity in research on postnatal depression. Specifically, lack of social support around childbirth and previous
psychopathology has repeatedly been found to predict postnatal depression (O'Hara et al. 1984; O'Hara et al. 1991; O'Hara and Swain, 1996).

Support for the view that cognitive style can increase vulnerability to postnatal depression has emerged from studies of self-esteem. For example, Fontaine and Jones (1997) found that self-esteem, described as resulting from feelings of internal competency and worth, was associated with lower severity of depressive symptoms during pregnancy and at two weeks postpartum. The authors suggested that mothers' beliefs in their internal competency reflected a stable and protective trait against depression. However, the self-reported rather than clinically identified symptomology used, limits the applicability of the findings to clinical populations. Furthermore, the authors assumed that comparing postpartum symptoms with symptoms during pregnancy was sufficient to indicate psychological 'traits', but pregnancy has also been associated with elevated symptoms of distress (Da Costa et al. 2000).

A related finding by Milgrom and Beatrice (2003), indicated that clinically depressed mothers had more irrational beliefs, and were more likely to believe that powerful others had control over their lives than non-depressed women. Whilst mature defences and rational beliefs appeared to be state-dependent, 'immature defences' and 'irrational beliefs' associated with depression were more stable (traits), because they were evident even when mothers were no longer depressed at 24 months. This suggested the presence of 'depressogenic' cognitive styles that may render women more vulnerable to stress in dealing with their infant, and predispose them to depression in the postnatal period.

These small-scale studies offer some empirical support for the idea that negative and distorted cognitive styles associated with depression apply to postnatal depression. However, the studies illustrate the difficulties in providing evidence for the stress-vulnerability model. Correlational studies cannot separate out causal factors from the outcome (depression), so it is not clear whether all women who develop postnatal depression are already vulnerable. Although this was addressed
more thoroughly in a prospective study by O'Hara et al. (1991), which found support for the stress-vulnerability model, prospective studies cannot explain why childbirth might represent a stressor in some women and not others, nor can they explain the cognitive mediators that account for the interaction between vulnerability and stress.

1.3.5 Maternal perceptions and interactions

Demonstrating the interaction between what might constitute a ‘stressor’ and cognitive vulnerability, research suggests that maternal mood is influenced by perceptions of self-efficacy and mothering experiences. For example, Porter and Hsu (2003) found that the severity of depressive symptoms was negatively related to a pre- and post-natal sense of self-efficacy. Postnatal maternal efficacy showed a gradual dissociation from psychosocial variables and shifted toward mothers’ first-hand experiences of their infants and perceptions of their infants’ temperament.

The findings indicated that perceived infant difficulty influenced maternal self-perception and mood, and supports the stress-vulnerability model of postnatal depression as far as more difficult experiences of interaction may be stressful. However, it remains unclear how far maternal perceptions are influenced by cognitive style and how far they are influenced by puerperium experiences, or broader contextual variables such as social support. More objective measures are needed of infant temperament, maternal mood and social contexts to strengthen these findings. It is therefore suggested that the stress-vulnerability model may not account fully for the wide variation in women’s experiences.

1.3.6 Theories of mother-infant interaction

It is important to consider the relative contributions of infant and mother on the quality of interaction, which has been shown to influence maternal self-appraisal and mood. This is because depressed mothers’ perceptions of their infants may reflect genuine difficulties presented by their infants.
1.3.6.1 Infant contributions.

According to the stress-vulnerability model, difficult infant behaviour may lead to feelings of helplessness and depression in mothers who are vulnerable because of their negative appraisal style. In support of this hypothesis, an association has been found repeatedly between maternal depression and difficult infant temperament (Beck, 1996; Da Costa et al. 2000). For example, Murray, Stanley, Hooper, King and Fiori-Cowley (1996) found that poor motor-functioning and neonatal irritability at two months strongly predicted maternal mental state. This is consistent with other research indicating that childcare-related stressors such as infants' health, accounted for 19% of the variance of mothers' depressive symptomatology (O'Hara et al. 1984).

However, it is important to consider how far difficult infant temperament pre-existed maternal depression, and how far it reflected exposure to a depressed mother.

1.3.6.2 Maternal contributions.

When compared with non-depressed mothers, depressed mothers have been observed to display a reduced quality of interaction with their infants, express more controlling attitudes toward child rearing, and show less 'optimal' interactions with their infants (Field, Sandberg, Garcia, Vega-Lahr, Goldstein, & Guy, 1985).

In addition, compared with non-depressed mothers, depressed mothers have been found to be less affectionate and responsive (Fleming, Flett, Ruble & Shaul, 1988), and less sensitively attuned to their infants at two months (Murray, Fiori-Cowley, Hooper & Cooper, 1996). Righetti-Veltema, Conne-Perreard, Bousquet and Manzamo (2002) found that depressed mothers' negative ratings of their infants correlated with observations of reduced communication, reduced physical interactions and reduced smiling in interaction.

Although small in sample size and difficult to compare due to different measures of interaction and depression, these studies suggest that the interactive style of depressed mothers is qualitatively

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different from that of non-depressed mothers, and may not simply be a reflection of infant ‘stressors’.

1.3.6.3 Secondary effects on infant behaviour.

The impact of maternal depression on infant-mother relationship has been explored by looking at infant variables. Diego, Field, Jones and Hernandez-Reif (2006) found significantly different patterns of infantile brain activity considered indicative of regulation and expression of negative affect, between infants of depressed and non-depressed mothers. Their findings support the hypothesis that infants of depressed mothers may be more temperamentally negative as a consequence of exposure to a depressed mother whose behaviours fail to evoke positive behavioural responses from them. However, infant negative reactivity may elicit feelings of helplessness in depressed mothers, contributing further to a cyclical pattern of negative interaction. Although the methodology produced more objective findings than other studies, they are weakened by the use of brain activity correlates to speculate about psychological states.

In further support of the negative impact of maternal depression on infant behaviour, Hart, Field and Roitfarb (1999) found that depressed mothers rated their newborn infants more negatively than independent examiners on irritability and lability. After one month, the examiners’ ratings were as negative as those of the depressed mothers, whereas, infants of non-depressed mothers rated their infants higher than examiners on social interaction, and a month later examiners’ ratings were as positive. The authors suggested that at one month postpartum, interpersonal influences, such as maternal mood, might shape the infants’ development and behavioural responses to others.

Although it is possible that adverse contextual influences could have explained the mothers’ depressed mood at birth as well as the differences found later in infant behaviour, these findings support other studies showing depressed mothers’ more negative views of their infants (Field,
Morrow & Adelstein, 1993), and without specifying how, they suggest that maternal perceptions, shaped by mood state, have a real effect on infant behaviour.

1.3.6.4 Mutual regulation of interaction.

Tronick and Field (1987) offered one explanation of how negativity is transmitted from depressed mothers to their infants. They proposed that in the absence of external regulation of its conscious experience with its depressed mother, the infant is forced into self-regulatory patterns of behaviour to stabilise its affective state. They also suggested that as part of the process of development and learning, the infant adopts the negative expressions of the depressed mother, such as hostility, withdrawal and disengagement.

In support of this hypothesis of reciprocated negativity, Field, Healy, Goldstein, and Guthertz (1990) found that depressed mothers, and their infants, matched negative behaviour states more often and positive behaviour states less often, than non-depressed dyads. The total amount of time spent in matching behaviour states was less for the depressed than for the non-depressed dyads. The authors suggested that depressed mothers’ emotional state impeded their ability to regulate their infants’ stimulation and share in responsive communication.

In spite of the difficulties with the small sample size, the non-clinical population, and the fact that data was only collected from one video-taped interaction at three months postpartum, these findings go some way to explain how maternal depression may be reinforced through negative experiences of mother-infant interaction.

1.3.6.5 Postnatal depression and later development

A number of studies have shown that the interactive difficulties arising within depressed dyads may have a persistent effect on the child’s socio-emotional development in later childhood.

Murray, Hipwell, Hooper, Stein and Cooper (1996), found that infants of depressed mothers performed worse than infants of well mothers on assessments of cognitive functioning at eighteen months, and were significantly less sociable with a stranger. Furthermore, severity and chronicity
of maternal depressive symptoms has been found to relate to more behaviour problems and lower vocabulary scores in children at five years (Brennan, Anderson, Hammen, Bor, Najman, & Williams, 2000). At five years, the infant’s relationship with the mother appeared to be mediated by the quality of infant attachment at eighteen months (Murray, Sinclair, Cooper, Ducournau & Turner, 1999). Similar findings were reported by Stein, Gath, Bucher, Bond, Day and Cooper (1991), who found that mothers who had been depressed at two months postpartum showed reduced interaction with their infant at nineteen months, even when the depression had lifted.

Although it is difficult to disentangle the effects of depression on infant development from other contextual variables that might explain both maternal depression and the more negative trajectory of their infants’ development, these studies support the idea that early experiences with a depressed mother may set up negative patterns of interaction that have lasting adverse effects on infant development.

1.3.7 Psychodynamic theories

Psychodynamic explanations of postnatal depression emphasise the projection of mothers’ unresolved conflictual relationships on their perceptions of, and interactions with, their infants (e.g. Cramer, 1997).

In support of this, Pajulo, Savonlahti, Sourander, Piha and Helenius (2004) found that the difference between depressed and ‘well’ mothers lay in the stability and positivity of their perceptions of themselves and of their similarity to their own mothers. That is, ‘well’ mothers had more consistently positive identifications with their own mothers. The authors hypothesised that emotional conflicts with participants’ own parents were reactivated by the birth of their child. It follows that pre-existing negative maternal representations influenced mothers’ interaction with their own infants, contributing to their negative perceptions and depressed mood.
Although the findings support the correlation between depression, difficult interactive experiences and relationships with participants' own mothers, measuring unconscious variables to support this hypothesis presents difficulties.

1.3.8 Biological approaches

The hormonal dysfunction hypothesis rests on evidence linking symptoms of depression to hormonal changes associated with childbirth, and posits that hormones have a causal role in the development of postnatal depression (Dalton, 1980; George & Sandler, 1988). However, no consistent evidence for the role of hormones in postnatal depression has been found (O'Hara et al. 1991), and given the stronger evidence for the correlation between postnatal depression, social variables and infant factors, it has been suggested that a purely hormonal aetiology may only apply to a minority of cases (Hagen, 1999).

1.3.9 Conceptualisations developed from qualitative research

To date, the major body of work on postnatal depression has assumed that it represents an objective psychiatric phenomenon, and has focused on identifying risk factors for its development. Such perspectives have been criticised for pathologising women's negative feelings after birth as an 'illness', reducing women's experiences to evidence of dysfunctional cognitive styles, and conceptualising women's social contexts only in reference to stressful life events and social support, thereby ignoring the role of wider constraints (Oakley, 1980; Nicolson, 1999; Mauthner, 1999; Romito, 1990, 1998; Stoppard, 1999).

To redress the balance, a qualitative body of literature has emerged from the social sciences that offers understandings of postnatal depression based on women's reported experiences. These studies aim to explore the influences of women's socio-political, cultural and historical contexts on the meaning of their experiences, and understand postnatal depression as a social construction rather than a pathology (Nicolson, 1989, 1999; Romito, 1990; Stoppard, 1999).
In a meta-analysis of 18 qualitative studies on postnatal depression, Beck (2002) identified four main themes. The first theme referred to the conflict between expectations of motherhood and mothers' actual experiences (Mauthner, 1999). Women's cultural contexts were considered influential in communicating idealised representations of motherhood and pathologising maternal unhappiness. The second theme, 'spiralling downwards', described various emotional manifestations of worsening maternal distress. The third theme, 'pervasive loss' emerged from 15 of the studies, representing a central component of women's experiences. Loss was experienced in relation to many aspects of the mothers' lives, including their sense of control. The final theme, 'making gains' conceptualised recovery. It captured the difficulties of seeking help, adjusting expectations and undergoing change.

Beck's review highlighted the influence of cultural, idealised representations of motherhood on women's evaluation of their maternal capacities. Issues of disillusionment, loss and self-reconstruction were salient to experiences of depression. Since these themes emerged from other qualitative studies of motherhood (Schmied & Lupton, 2001; Rogan, Schmied, Everitt, & Wyllie, 1997), experiences reported by depressed women may reflect 'normal' adjustment difficulties experienced by many women after the birth of a child. Although the studies usefully embody intrinsic and extrinsic contributory factors on experiences of depression, many qualitative studies are weakened by their descriptive rather than conceptual quality, and related difficulties in evaluating their validity.

1.3.10 Summary

The literature on postnatal depression broadly supports the stress-vulnerability model of depression, in that childbirth constitutes a stressor in those with depressogenic cognitive styles and/or adverse circumstances. Specifically, data suggests that mothers' perceptions of their infants and the quality of interaction may influence and be influenced by their mood. The establishment of negative patterns of interaction in depressed mothers and their infants may account for the more
negative trajectory of those children's psychosocial development, although it remains unclear whether other factors are involved.

1.4 Breast-feeding

Breast-feeding has been recognised as conferring benefits on the physical health of mothers and their infants, and is promoted both nationally and globally as the best method of infant feeding (Malik & Cutting, 1998; Kramer & Kakuma, 2002). Reflecting this agenda, most literature on breast-feeding addresses factors that influence initiation and termination of breast-feeding. However, much of this research may be undermined by failing to provide clear definitions of 'breast-feeding' as exclusive or partial/mixed with formulated milk. A related consideration is that because of widespread health promotion of breast-feeding over bottle-feeding, when mothers participating in research are not asked to clearly define their feeding behaviours, they may report that they are breast-feeding when they are only partially breast-feeding. This may lead to an inflated estimation of breast-feeding rates, and conclusions drawn from studies without clear definitions of feeding practices must be reviewed with these methodological limitations in mind.

1.4.1 Statistical findings

National infant feeding surveys have shown an improvement in breast-feeding rates since 1990 in all countries within the U.K., with overall initiation rates of 66% in 1995 and 69% in 2000 (Hamlyn, Brooker, Oleinikova, & Wands, 2002). However, breast-feeding practices in England are believed to be among the lowest in Europe, despite global and national promotion campaigns. The most recent survey revealed that 21% of mothers gave up breast-feeding within two weeks postpartum, 64% were still breast-feeding at six weeks, and 44% by four months. The main reasons for cessation within the first week were 'baby rejected breast' (37%) and 'painful breasts/nipples' (27%) (Hamlyn et al. 2002).
1.4.2. Psychological conceptualisations

Research has emphasised the influence of social and cognitive factors on infant feeding behaviour. Quantitative findings suggest that self-efficacy (Dennis & Faux, 1999), working models of feeding (Pridham, Schroeder, Brown & Clark, 2001) and perceptions of social support (Tarkka, Paunonen & Laippala, 1999) influence mothers’ breast-feeding experiences. Qualitative research has furthered understanding of these findings by documenting women’s negative as well as positive breast-feeding experiences (Nelson, 2006), and demonstrating that breast-feeding is embedded in dominant cultural discourses about ‘good mothering’ (Murphy, 1999). However, it remains unclear how the discrepancy between mothers’ actual feeding experiences and their expectations may affect their mood, self-perceptions and relationships with their children.

1.4.3. Social and cognitive influences

First-time mothers’ beliefs in their efficacy influence their breast-feeding behaviour. Dennis and Faux (1999) found that mothers with low self-efficacy were less likely to breast-feed, whereas efficacious mothers were more likely to persevere with breast-feeding at six weeks postpartum. Breast-feeding self-efficacy was also found to be a significant predictor of breast-feeding duration at one and four months (Blyth, Creedy, Dennis, Moyle, Pratt & De Vries, 2002). However, the predictive validity of these two studies is limited by not addressing external influences on breast-feeding behaviour.

Tarkka et al. (1999) offered a more contextualised substantiation of the role of maternal self-perceptions on their breast-feeding practices. They found that mothers who coped better with breast-feeding gave themselves higher scores of competency than those who did not to cope as well, and importantly, women who coped better received more affirmation from members of their social network. This suggests that social support, in addition to internal beliefs of self-competence, influence breast-feeding practices, and fits with evidence suggesting sociodemographic variables influence feeding practice and duration (Thome, Alder & Ramel, 2006)
1.4.4. Mothers’ experiences of feeding

Successful breast-feeding has been associated with positive maternal perceptions and more optimal interactive behaviour. Pridham et al. (2001) found a significant positive relationship between a mother’s working model (that is, her expectations and intentions of feeding), positive affect, responsivity and sensitivity to her infant during breast-feeding. A significant negative relationship was found between working model attunement and symptoms of depression. These findings suggest that the extent to which mothers’ expectations of feeding their infants matched their actual experiences was important in mediating mothers’ emotional state and their abilities to interact responsively with their infants. Although the sample sizes are small, and different measures were used, these data support other findings (VanDiver, 1997) of a positive association between breast-feeding, responsivity and positive self- and infant-evaluation. It also highlights the negative association between breast-feeding and perceptions of infant difficulty, which has been found to be mediated by mothers’ level of education (Thome et al. 2006). The mediating effects of education may relate to factors such as maternal self-confidence, or knowledge of breast-feeding benefits, and/or reflect the influence of other variables related to education, such as wealth and cultural expectations associated with different socio-economic groups.

One explanation of these findings is that successful breast-feeders have greater confidence in their caring abilities and find it easier to respond to breast-feeding difficulties than women with less self-confidence, who are more likely to wean when experiencing difficulties.

1.4.5. Infant characteristics

Infant behavioural differences that arise as a result of feeding method help to account for the importance of maternal cognitive styles on persistence with, and perceptions of, breast-feeding. Compared with bottle-fed infants, breast-fed infants have been described as ‘fussier’, found to cry more up to three months of age (Lavelli & Poli, 1998), are more irritable and more difficult to console when crying, between 17 and 56 hours postpartum (DiPietro, Larson & Porges, 1987).
DiPietro et al. (1987) suggested that these findings may be explained by breast-fed infants’ greater hunger; lactation takes time to establish after birth, whereas bottle-fed infants can be fed immediately, and can consume a greater volume of food than breast-fed infants in the same amount of time. This means that breast-fed babies are likely to demand more of their mothers, particularly in the early stages of infancy. Such evidence appears to predict that when mothers are establishing feeding patterns, those who are less confident are vulnerable to weaning because they are more likely to interpret their breast-fed infants’ fussiness as evidence of their maternal inadequacy, leaving more confident women to represent the breast-feeding population.

A contrasting finding is that, in spite of their comparable ‘fussiness’ (increased irritable reactivity) breast-fed infants, show more optimal physiological organisation in the early neonatal period compared to their peers (DiPietro et al. 1987). Breast-feeding mothers may therefore find it easier to establish responsive communication with their more ‘coordinated’ infants, facilitating a better quality of interaction. It follows that when breast-feeding has been successfully established, the interactive relationship may improve, reinforcing maternal confidence, and facilitating mothers’ more positive evaluation of their infants’ temperaments. In support of this idea, stable breast-feeding patterns have been related to perceived easier temperament of infants at a later age (VanDiver, 1997). These findings support the idea of a multi-directional relationship between breast-feeding, positive interaction and optimal physiological development.

1.4.6. Infant-feeding and interaction

Differences observed between the interactions of bottle- and breast-feeding dyads suggest that breast-feeding may have a positive effect on dyadic interaction, which influences the mother’s self-appraisal and that of her infant.

Supporting this hypothesis, but using small sample sizes, Mezzacappa and Katkin (2002) found breast-feeding mothers reported significantly less stress than bottle-feeding mothers. Breast-feeding was associated with a decrease in negative mood, and bottle-feeding with a decrease in
positive mood from pre- to post-feeding. Since no differences in trait anxiety were found between bottle- and breast-feeding mothers, the authors argued that the differences were due to feeding method and individual differences. They hypothesised that the positive mood change may be rewarding for the breast-feeding mother, influencing positive perceptions of her infant, with secondary beneficial effects on their relationship and interactive behaviour. They also suggested that breast-feeding might protect against negative mood through a reduction in stress and induction of positive experiences with the infant.

A possible critique of this study may apply to other observational studies in this field: since breast-feeding is promoted globally as being superior to bottle-feeding, bottle-feeding may exacerbate negative feelings in those vulnerable to negative self-assessment. Different mood states may not be a function of feeding method, but reflect the way mothers feel about their feeding method in an observed research setting. However, in support of the above findings, it has been suggested that oxytocin, released by breast-feeding in mother and baby, may induce a more relaxed state in mothers (Uvnas-Moberg, 1998), and breast-feeding women have been observed to be less stressed than bottle-feeders (Susman & Katz, 1988).

A hormonal hypothesis may represent a partial explanation, since interactive differences relating to feeding method also seem to influence maternal well-being. For example, Lavelli and Poli (1998) found in a study of 32 primiparous mothers that, in contrast to bottle-feeding pairs, breast-feeding dyadic interaction was based on mutual touch, breast-feeding mothers gazed at and caressed their infants more than bottle-feeders, and 'mutual gaze bouts' were significantly longer during breast-feeding than during bottle-feeding. Importantly, these interactive differences remained when mothers weaned, suggesting that the interaction between maternal style and method elicited positive interaction, rather than strictly the method or hormones associated with breast-feeding.
Although simplistic, the most obvious explanation of these findings is that individual differences such as mothers’ confidence and tactile style, determined both choice of feeding method and the observed differences in breast- and bottle-feeders’ interactions. Alternatively, the increased contact involved in breast-feeding may be responsible for the improved quality of interaction. Breast-feeding mothers may learn to detect and regulate their infants’ affective state more readily through skin-to-skin touch and the close physical proximity that breast-feeding involves. In support of this hypothesis, it has been suggested that breast-feeding allows greater opportunity for interaction, as one of the mother’s hands is available for greater tactile communication, sensitivity and responsivity (Dunn & Richards, 1977). It may be that the more intimate nature of breast-feeding reinforces an affectionate style of reciprocal interaction, which persists even when mothers change feeding method. Therefore, feeding method, in addition to individual differences, may shape maternal care-giving style, and the quality of interaction with her infant. However, as suggested previously, widespread endorsement of breast-feeding relative to bottle-feeding, may differentially reinforce maternal confidence, and be reflected in the contrasting interactive styles of mothers who establish it successfully and those who do not.

Therefore, it remains unclear from these studies which psychological factors account for the differences in mothers’ feeding experiences and quality of interaction. Analyses of women’s accounts of breast-feeding in the context of wider cultural influences may offer broader insights into the association of breast-feeding and positive mother-infant interaction.

1.4.7. Qualitative studies

In a metasynthesis of 15 qualitative breast-feeding studies, Nelson (2006) found that, whether positive or negative, breast-feeding represented a personal journey that required commitment, adaptation and support. In relation to the ‘embodied’ experience, women commonly reported uncertainty about their ability to sustain their infants through breast-milk, the sensory experience of, and various feelings about, connectedness (Nelson, 2006). Illustrating cultural representations of
the ideal mother, breast-feeding was experienced as validating of women as 'good' mothers
(Bottorff, 1990) and as harmonious (Schmied & Lupton, 2001). On the other hand, not all women
successfully adapted to breast-feeding (Nelson, 2006). Schmied and Lupton (2001) found a
difference between mothers who found breast-feeding pleasurable and intimate, and those who
experienced it as disruptive, intrusive and representing a loss of control. However, research
suggested that because of the close association of breast-feeding and 'good' mothering, women
demonstrated a commitment to breast-feeding in spite of pain, discomfort and unhappiness, leading
to a concern about how these contradictions may be reinforced by health professionals’ promotion
of breast-feeding (Schmied, Sheehan & Barclay, 2001).

Hoddinott and Pill (1999) hypothesised that dissonance between women’s expectations of
breast-feeding and their actual experiences was responsible for depleting women’s confidence and
seemed to be a determinant in mothers’ changing feeding practice. This was borne out in a study by
Shakespeare, Blake and Garcia (2004), who reported that among five themes relating to breast-
feeding difficulties, high expectations of success and unexpected difficulties were salient.

From a more sociological perspective, Murphy (1999) reported that mothers face great moral
pressures to breast-feed, and suggested that mothers’ decision to formula-feed may contribute to
feelings of inadequacy and guilt. Mothers appeal to negative cultural discourses (such as the pain
involved in breast-feeding) to protect themselves from accusations of ‘deviancy’ in decisions to go
against the notion of what is ‘best’ for their infants. Supporting this hypothesis, negative social and
cultural discourses about breast-feeding have been found to override women’s knowledge of the
benefits, in determining their feeding behaviour (Shaw, Wallace & Bansal, 2003).

A main theme arising from qualitative studies is women’s need for support and the role of their
social environments in managing the difficulties associated with breast-feeding (Nelson, 2006). In
particular, experiences of breast-feeding were commonly influenced by concerns about others’
disapproval, and the need to be accepted (Bottorff, 1990). Ending breast-feeding also constituted an
important aspect of women’s experiences; positive and negative feelings, and issues of control were identified (Nelson, 2006).

Qualitative findings suggest that psychological difficulties relating to breast-feeding are similar to the broader experience of care-giving in depressed mothers. It follows that the relationship between postnatal depression and breast-feeding could be bi-directional: negative experiences of breast-feeding could contribute to the onset of depression in vulnerable women, and breast-feeding is likely to be particularly difficult for depressed women.

1.4.8. Summary

Breast-feeding has been associated with mothers’ positive self-appraisal and positive perceptions of their infants, and more positive mother-infant interaction, when compared to bottle-feeding. Difficulties with breast-feeding may emerge when mothers’ experiences differ from their expectations, contributing to low self-esteem, depleted sense of competency, or alienation from their child.

Individual differences relating to mothers’ cognitive style and confidence do not adequately explain these findings, primarily because they ignore the role of wider political, societal and moral contexts on mothers’ behaviour, and secondly because research suggests that the act of breast-feeding may in itself enhance positive dyadic interaction.

1.5 Breast-feeding and postnatal depression

In contrast to the wealth of research relating to postnatal depression and breast-feeding as separate topics, little research has focused specifically on the relationship between them. Given that infants of depressed mothers are at risk of more dysregulated interaction with their mothers (Field, 1995), it is important to identify whether breast-feeding can be beneficial to them, as it has been associated with more positive interaction in non-depressed dyads (VanDiver, 1997) and easier temperaments later in infancy (Field, Hernandez-Reif & Feijo, 2002; VanDiver, 1997). However,
depressed mothers are less likely to breast-feed (Cooper, Murray & Stein, 1993; Galler, Harrison, Ramsey, Forde & Butler, 1999) and this pattern is reflected in the dearth of research on this topic.

Literature on the relationship between postnatal depression and breast-feeding reveals a number of contradictory associations and overlapping explanatory hypotheses to explain them. The first posits that breast-feeding contributes to the development of postnatal depression through hormonal variations associated with breast-feeding (Alder & Cox, 1983; Susman & Katz, 1988). Secondly, research has repeatedly demonstrated the adverse effects of postnatal depression on breast-feeding experiences (Tamminen, 1990), and duration (Henderson, Evans, Straton, Priest & Hagan, 2003; Cooper et al. 1993; Fleming et al. 1988; Galler et al. 1999; Field et al. 2002), and are generally explained with reference to a number of psychosocial variables such as mothers' 'depressogenic' thinking styles. A third hypothesis emerged from a study that indicates breast-feeding may be advantageous to depressed mother-infant relationship, and may therefore have a protective effect against some of the interactive difficulties typically observed in depressed dyads (Jones, McFall & Diego, 2004).

1.5.1. The hormonal hypothesis

Hormonal changes associated with breast-feeding have been hypothesised to play a role in the development of postnatal depression (Susman & Katz, 1988). For example, women who breast-fed exclusively for three months were found to have a higher incidence of depression (Alder & Cox, 1983), and breast-feeders showed slightly higher levels of depression at three months postpartum compared with bottle-feeders (Alder & Bancroft, 1988). Difficulties in accurately measuring hormonal levels to control for variations in time and frequency of breast-feeding (Dunnewold & Crenshaw, 1996), and reliance on correlations between psychological states and biochemicals, exclude the possibility of identifying other explanatory factors and undermine the strength of these findings.
Challenging this hypothesis, postnatal depression has been repeatedly found to precede cessation of breast-feeding (Cooper et al. 1993; Henderson et al. 2003; Misri, Sinclair & Kuan, 1997), calling into question the idea that depression develops as a consequence of hormonal changes associated with weaning, and indicating that women may wean as a consequence of becoming depressed. Although these findings do not disprove the relationship between hormonal variations and breast-feeding, they highlight the possibility that the relationship is more complex. In two independent samples, Cooper et al. (1993), found that a number of psychosocial variables, as well as depression, were associated with early termination of breast-feeding, warning against the idea of a simple, bi-directional association. Henderson et al. (2003), who used a larger sample size and comparable, but more precise, methodology, supported the findings of Cooper et al. (1993) of a significant association between duration of breast-feeding and depression. However, hormonal variables were not measured in either study, and data were gathered retrospectively. In addition, neither study could identify whether the onset of depression was a consequence of difficult breast-feeding experiences, whether weaning occurred because mothers were depressed, or whether other factors were implicated.

1.5.2. Breast-feeding in ‘depressive’ women

In support of the stress-vulnerability model of postnatal depression, differences in maternal cognitive style predict vulnerability to negative appraisals and depression in the face of a stressor, such as breast-feeding. Breast-feeding cessation has been associated with negative maternal self-appraisal: depressed mothers scored lower on a breast-feeding confidence scale, and weaned earlier in infancy (Field et al. 2002). Tamminen (1990) found that depressed women reported more difficulties with breast-feeding and more negative attitudes than non-depressed mothers, and concluded that depressed mothers showed ‘over-idealistic’ attitudes toward breast-feeding during pregnancy, but had attitudes that were more negative after birth. This supports the hypothesis that a discrepancy between women’s expectations of mothering in women with depressive cognitive
styles, and their actual experiences might contribute to their depleted sense of efficacy and lead to depression. Cessation of breast-feeding may be due to feelings of maternal inadequacy (Murphy, 1999) and difficulty interpreting infants' cues of hunger and distress (Henderson et al. 2003).

However, the small sample size and self-reported (rather than clinically defined) nature of the data, weakens these findings. Furthermore, neither of these studies prospectively established that depressed women had rigid expectations and stable negative self-percepts before their pregnancies, and therefore, only tentative conclusions can be drawn about the role of breast-feeding as a stressor in women with depressive cognitive traits.

Although research has not clearly identified the interaction of depressogenic cognitive vulnerabilities and breast-feeding experiences contributing to postnatal depression, there is evidence that depressed mothers' mood and more negative attitudes toward breast-feeding reflect genuine feeding difficulties. For example, women who describe breast-feeding as problematic are more likely to be depressed (Hewat, 1999), and maternal ratings of infant temperament have been repeatedly found to predict postnatal depression (Da Costa et al. 2000). Reflecting the more general association between postnatal depression and negative mother-infant interaction, it is difficult to know how far feeding difficulties contribute to the development of postnatal depression, and how far they reflect more negative interaction associated with maternal depression.

1.5.3. Depression, breast-feeding and interaction

The following studies highlight the possibility that mothers' interactive experiences with their infants may be mediated by feeding method and in turn, influence mood.

As noted earlier, breast-feeding has been associated with more positive mother-infant interaction (VanDiver, 1997; Lavelli & Poli, 1998) and evidence suggests that this holds for depressed as well as non-depressed mothers. Fleming et al. (1988) found that depressed mothers were less affectionate with their infants, and regardless of mood, bottle-feeders were observed to show less affectionate behaviour toward their infants. However, since most depressed women
weaned by three months, the authors could not compare nursing behaviour in depressed and non-depressed mothers, pre-empting the possibility of identifying whether interactive style was a function of feeding method. Field et al. (2002) found that although depressed women were more likely to wean earlier than non-depressed women, independent of depression, mothers who breast-fed rather than bottle-fed had higher confidence levels and rated their infants as less irritable during feeding.

Since sample sizes were small and data came from retrospective self-reports, these studies lend tentative support to the idea that breast-feeding enhances positive interactive experiences in depressed as well as non-depressed mothers. However, the idea that breast-feeding method alone is beneficial to depressed mothers is weakened by evidence that in some cases breast-feeding represents a stressor. Hewat (1999) found that mothers of problematic breast-feeders (defined as those who frequently detached from the breast) were more likely to be depressed, and touched their infants less frequently and more roughly than non-problematic feeding dyads. This finding suggests that breast-feeding difficulties affect maternal mood, although again, the causal direction is unclear. In this study, mothers themselves rated their infants, potentially confounding the objectivity of findings as depressed mothers are more likely to assess their infants negatively. However, the finding does suggest that any positive effect of breast-feeding is mediated by the perceived success of the interactive experience.

These studies go some way to suggest an association between positive maternal mood, affectionate or positive interaction, and breast-feeding. One possible explanation is that successful breast-feeding enhances positive dyadic interaction, which improves the quality of depressed mothers’ experiences and self-esteem, and protects non-depressed women from negative interpretations of their mothering ability that may contribute to depression. However, this hypothesis is necessarily speculative since the sample sizes of cited studies were small, populations diverse and various measures were used, preventing reliable comparisons between studies.
Furthermore, the studies did not identify what factor(s) enhanced more positive responsiveness in breast-feeding women, and questions about how negative breast-feeding experiences or positive bottle-feeding experiences influence mood could not be addressed using the methodologies employed.

In further support of the hypothesis that feeding experiences both influence and are influenced by the quality of interaction, Jones et al. (2004) found in a study of 78 mother-infant pairs, that more positive dyadic interaction was associated with infants of non-depressed mothers and infants of depressed mothers with stable breast-feeding relationships, than with infants of depressed mothers who bottle-fed. Infants of breast-fed, depressed mothers had less dysregulated interaction patterns than those of depressed mothers who bottle-fed. Furthermore, mother-infant interactions became more positive by three months in the depressed group with stable breast-feeding, but not the depressed group who bottle-fed. The authors suggested that breast-feeding may facilitate positive interaction, particularly through enhancing the regulatory abilities of the infant.

These findings support previous suggestions that breast-feeding may be beneficial to depressed dyads by improving the quality of interaction. Although breast-feeding may benefit infant development and dyadic interaction, the study did not indicate whether the more positive interactive experiences simultaneously affected maternal mood, because depression was only assessed one month postpartum. It is possible that another, unmeasured factor could explain the differences between depressed breast- and bottle-feeders. This warrants larger scale research to measure maternal mood and dyadic interaction objectively and simultaneously.

These studies support the idea of mutual affective responsivity in early dyadic interaction (Tronick & Weinberg, 1997). When successful, breast-feeding may enhance positive interaction, which then becomes self-reinforcing as mother and infant respond to each other reciprocally. It follows that breast-feeding dyads are less likely to establish negative patterns of interaction that
may contribute to low maternal mood, and even when a mother is depressed, the quality of dyadic interaction may be improved by breast-feeding.

1.5.4 Summary

A comprehensive understanding of the relationship between postnatal depression and breast-feeding has not emerged from this review of the current evidence.

Existing literature suggests that, in line with the general effects of postnatal depression on interaction, maternal depression has a specifically negative effect on mothers’ self-appraisals of breast-feeding ability, negative experiences of feeding, and feeding duration. This relationship seems bi-directional, as negative breast-feeding experiences may also contribute to maternal depression. However, research also suggests that successful breast-feeding, in contrast to bottle-feeding, enhances the quality of dyadic interaction and maternal confidence in both depressed and non-depressed mothers.

1.6 Conclusions

In this review, an association was found between depressed mood and interactive behaviour in the postpartum period. Depression was found to have a negative effect on breast-feeding practices, and some evidence suggested that difficult experiences of breast-feeding might contribute to depressed maternal mood.

Specific literature highlighted a relationship between breast-feeding and positive dyadic interaction. Evidence suggested that breast-feeding enhanced maternal responsivity and sensitivity, which in turn affected the quality of dyadic interaction, maternal self-perception and perception of her infant, and her mood. The benefits conferred on dyadic interaction through the practice of breast-feeding appeared to hold, irrespective of maternal mood-state.

1.6.1 Evaluation

This review has considered existing evidence for a relationship between postnatal depression and breast-feeding. Most of the findings reviewed in this article were based on correlations between
postnatal depression, feeding practices and interactive behaviour, impeding interpretations about causal relationships. Furthermore, the research reviewed was based mainly on non-clinical populations of women reporting symptoms of depression, so may not apply straightforwardly to clinical populations.

Research has established a negative association between postnatal depression and breast-feeding, but does not explain the psychological mechanisms at work, or the exception to that finding; that breast-feeding confers interactive benefits on depressed as well as non-depressed mothers. This latter finding may be clinically useful, as breast-feeding may represent a crucial ‘intervention’ for depressed mothers whose infants are already at risk of adverse interpersonal experiences. Furthermore, relative contributions of internal and external factors on postnatal depression and breast-feeding were not apparent from the existing literature.

The limitations and contradictions of current findings support the need to take an exploratory approach to investigating the relationship further. Existing literature has tried to understand the relationship between postnatal depression and breast-feeding by establishing a causal direction. In doing so, the complexity of the lived experience of postnatal depression has been reduced to a set of predictive factors and behaviours measured across arbitrary time points. Contradictory results reflect the complex nature of experiences of breast-feeding, which differ between women. To understand the psychological processes involved in the experiences of breast-feeding and postnatal depression, and to help clarify existing findings, a qualitative methodology is required. This is because qualitative studies aim to access the lived experiences of individuals, explore psychological processes, address the role of contexts in which experiences occur, and account for the similarities and variations between experiences. In relation to this topic, qualitative research could be used to explore women’s own accounts and explanations of the effects of feeding on their mood, and their maternal experiences. Explanations constructed from depressed mothers’ accounts of breast-feeding may help to identify the role of internal factors (such as self-esteem and feelings
of control) and external factors (such as cultural notions of mothering and social support) on mothers' interaction with their infants.
1.7 References


Bottorff, J. 1990: Persistence in breastfeeding: A phenomenological investigation. *Journal of*
Advanced Nursing, 15, 201–209.


Dennis, C. and Faux, F. 1999: Development and psychometric testing of the breastfeeding self-


conducted on behalf of the Department of Health, the Scottish Executive, the National Assembly for Wales and the Department of Health, Social Services and Public Safety in Northern Ireland. London: The Stationary Office.


O’Hara, M. 1997: The nature of postpartum depressive disorders. In Murray, L. and Cooper, P.,


Porter, C. and Hsu, H. 2003: First-time mothers' perceptions of efficacy during the transition to motherhood: Links to infant temperament. *Journal of Family Psychology*, 17 (1), 54-64.


*Community Practitioner*, 76 (8), 299-303.


Stoppard, J. 1999: Why new perspectives are needed for understanding depression in women.

*Canadian Psychology*, 40 (2), 79-90.


Section 2
Research Report

Breast-feeding experiences in women with postnatal depression
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Note on style

This research report and associated papers have been written with a view to submission to the journal, Qualitative Research in Psychology. In accordance with the guidelines for contributors, the recommended Harvard system of referencing and prescribed heading conventions have been used. However, the journal guidelines have not been adhered to where they contravene specific requirements of formatting and structure for theses submitted in partial fulfilment of the doctorate in clinical psychology. See Appendix 4.1 for further details on style.
2.1 Abstract

Objectives: This qualitative study aimed to investigate mothers' experiences of breast-feeding in the context of postnatal depression, and to develop an account to represent the psychological processes involved.

Methods: In-depth, semi-structured interviews were conducted with nine mothers who had received diagnoses of mild or moderate postnatal depression. Transcripts were analysed using grounded theory methodology.

Results: A core construct, termed 'Becoming occluded', was identified in the analysis. This described participants' experiences of fragmentation in their transition to motherhood, whilst they attempted to sustain their infants. A process model was developed comprising five main phases. These represented participants' anticipation of their feeding practices during pregnancy; their sense of overwhelming responsibility; a phase of being fractured as they attempted to fulfil their mothering roles; self-evaluation on the basis of their experiences with their infants and perceptions of their social worlds; and a final phase, which represented emergence from distress.

Conclusions: Some participants felt that their experiences of breast-feeding contributed to their depression. This was because mothers evaluated their maternal adequacy against successful breast-feeding, and when breast-feeding was problematic, they perceived themselves as having failed as mothers. For others, breast-feeding was experienced as affirming and may have provided a buffer against negative self-evaluation. Remaining participants, who did not establish breast-feeding, also described processes of negative self-evaluation that mirrored those pivoting around breast-feeding. Clinical implications of the study include consideration of the impact of breast-feeding promotion on women's construction of motherhood, the potential benefits of breast-feeding for depressed mothers, their anticipated need for additional breast-feeding support, and the utility of psychological support for mothers suffering from depression.
2.2 Introduction

Childbirth has been identified as a vulnerable period in women's lives for the development of depression (O'Hara & Swain, 1996). Reflecting the ambiguity in the psychiatric and psychological literature on what constitutes 'depression', postnatal depression is generally characterised by a set of psychological phenomena. For example, in the International Classification of Mental and Behavioural Disorders (F53.0, ICD-10; World Health Organisation, 1992), postnatal depression denotes a non-psychotic, sustained depressive disorder in women following childbirth, commencing within six weeks of delivery. Due to the absence of definitive diagnostic criteria, estimates of its prevalence are varied, but generally it has been estimated to affect around 10-15% of women in the first year after delivery (Cox, Connor & Kendell; O'Hara & Swain, 1996).

Incidence of postnatal depression correlates with a number of biological, psychological and social risk factors. A recent meta-analysis of the literature supported previous findings (O'Hara & Swain, 1996), that the main predictors of postpartum depression were past history of psychopathology, psychiatric disturbance during pregnancy, poor marital relationship, low social support, and stressful life events (Beck, 2001). The best predictor of postnatal depression has repeatedly been confirmed to be prepartum depressed mood (Da Costa, Larouche, Drista & Brender, 2000).

In addition to mothers' immediate, subjective distress, postnatal depression has been found to have a negative impact on the mother-child relationship, physiological indicators of infantile affective states, and later infantile socio-emotional development (Field, 1995; Diego, Field, Jones & Hernandez-Reif, 2006; Murray, Sinclair, Cooper, Doucournau & Turner. 1999; Philipps & O'Hara, 1991). This highlights the need for early assessment and identification of postnatal depression in women at risk, and the development of interventions to minimise immediate distress and prevent lasting adverse consequences.
Different hypotheses have been offered to explain postnatal depression. Biological models emphasise the role of hormonal changes around childbirth (Dalton, 1980; George & Sandler, 1988). Psychological models drawn from the main body of literature on depression, emphasise a stress-vulnerability aetiology (Beck, 1967) wherein dysfunctional attributional styles (Abramson, Seligman & Teasdale, 1978) increase risk for depression around stressful life events, such as childbirth. In line with this model, research has focused on the predictive validity of social and personal adversity, such as socioeconomic status (SES), social support and life stress (Cooper & Murray, 1998; Beck, 2001). Biopsychosocial models attempt to integrate diverse factors, including genetic and hormonal factors, family experiences, cognitive styles and the role of social status and relationships (Milgrom, Martin and Negri, 1999). Evolutionary theories (Gilbert, 1992; Crouch, 1999; Hagen, 1999) speculate that human behaviour has evolved from experiences of interaction based on small, social groups, and postnatal distress is an adaptive response to the demands in early motherhood, and a means of eliciting support from the surrounding social network. Psychodynamic theories relate mothers’ distress to previous, unresolved conflicts projected onto their infants (e.g. Cramer, 1997).

The models outlined above are generally based upon evidence of correlations between variables and pay little attention to women’s reported experiences. This highlights the need for qualitative research to help advance the understanding of mothers’ postpartum experiences within a psychological framework. To date, such work has mainly emerged from sociological and feminist spheres, in which postnatal depression has been understood with reference to broader socio-political and cultural influences (e.g. Oakley, 1980; Romito, 1990; Mauthner, 1999; Nicolson, 1999).

Correlations between postnatal depression and breast-feeding have been identified (Alder & Cox, 1983; Cooper, Murray & Stein, 1993; Misri, Sinclair & Kuan, 1997), although the nature of any putative causal relationship is unclear. Some research has suggested that breast-feeding
contributes to depression; for example, through hormonal variations associated with breast-feeding (George & Sandler, 1988; Susman & Katz, 1988; Alder & Bancroft, 1988; Ingram, Greenwood & Woolridge, 2003). However, little conclusive evidence has been found for this hypothesis (O'Hara, Schlechte, Lewis & Varner, 1991) and, in a review of the literature, Dunnewold and Crenshaw (1996) concluded that breast-feeding did not increase the risk of developing postnatal depression.

Depression does appear to reduce the likelihood of exclusive breast-feeding (Thome, Alder & Ramel, 2006; Field, Hernandez-Reif & Feijo, 2002). Depressed mothers are at an increased risk for premature weaning (Cooper et al. 1993; Misri et al. 1997), depression has a negative effect on breast-feeding experiences (Tamminen, 1990), and weaning has been associated with negative maternal self-appraisal (Field et al. 2002).

The greater demands involved in breast-feeding may act as stressors that contribute to negative mood in mothers with depressogenic cognitive styles. Breast-fed newborns appear more temperamentally irritable and difficult to soothe (DiPietro, Larson & Porges, 1987) whereas bottle-fed infants are satisfied more quickly (Lavelli & Poli, 1998). Therefore, exclusively breast-fed babies are likely to demand more time of their mothers, contributing to tiredness which has been associated with maternal distress (Thome & Alder, 1999). Supporting this hypothesis, postpartum mood has been associated with maternal perceptions of infants’ difficult temperaments (Da Costa et al. 2000). In explanation, it has been suggested that women who have difficulties breast-feeding may interpret this as a reflection of their maternal inadequacy, leading to feelings of depression, which may result in early weaning (Henderson, Evans, Straton, Priest & Hagan, 2003; Thome et al. 2006; Murphy, 1999; Schmied, Sheehan & Barclay, 2001).

The associations between breast-feeding and postnatal depression therefore appear to be bi-directional, and suggest that postnatal mood both mediates and is mediated by experiences of mother-infant interaction, and specifically, feeding. Supporting this, some evidence suggests that breast-feeding, in comparison to bottle-feeding, is related to better maternal mental health.
(Mezzacappa, 1997), and has been associated with more positive dyadic interaction (Field et al. 2002; Lavelli & Poli, 1998) independent of mood state (Jones, McFall & Diego, 2004). This suggests that breast-feeding may be a way of preventing interactive difficulties for depressed mothers and their infants.

The existing literature therefore offers a conflicting picture of the relationship between postnatal depression and breast-feeding. One means of gaining clarity is by asking women themselves about their experiences of breast-feeding in the context of postnatal depression. Qualitative research has been used increasingly to understand postnatal depression from mothers’ perspectives. Such studies have highlighted the socially constructed nature of motherhood (Romito, 1990); cultural meanings attributed to breast-feeding (Murphy, 1999); and maternal emotional reactions to breast-feeding (Schmied et al. 2001; Nelson, 2006). The objective of the current study was therefore to explore the meaning of breast-feeding to women who had received diagnoses of postnatal depression, and to develop a theoretical account of the processes involved. Grounded theory methodology was chosen because the main objective was to use data ‘grounded’ in mothers’ lived experiences to construct a process model that offered a psychological formulation of their experiences.
2.3 Method

This section describes the methodology used in this study and offers the rationale for its use. Details of recruitment, data collection and analysis are outlined.

2.3.1 Design

The aim of this study was to develop an understanding of breast-feeding experiences for postnatally depressed women. Most research in postnatal depression has assumed it to be an objective psychiatric disturbance, paying little attention to the actual experiences of depressed women, and little research has focused specifically on its relation to breast-feeding. These factors indicate the need for an exploratory, qualitative investigation.

Qualitative data provide a richer understanding of the meaning of experiences than would be obtained from quantitative data, by exploring the ‘insider’s’ perspective, rather than attempting to verify theory through objective systems of knowledge (Henwood & Pidgeon, 1992; Guba & Lincoln, 1994). For these reasons, qualitative research is considered suitable to answer research questions concerned with understanding the meanings, processes and contexts of lived experiences, particularly in areas what have not been well explored (Henwood & Pidgeon, 1992; Charmaz, 2006; Strauss & Corbin, 1998).

2.3.2 Rationale for use of grounded theory methodology

Grounded theory methodology (Glaser & Strauss, 1967; Strauss & Corbin, 1998) was selected as an appropriate form of investigation for the following reasons:

This methodology is designed to generate theory from unstructured data, through an explicitly defined process of systematic analysis (Strauss & Corbin, 1998). Its structured methodology is useful for guiding novice researchers through the research process, and offers a clear model for the finished product (McLeod, 2001; Backman & Kyngas, 1999).

Secondly, grounded theory methodology aims to generate theory by uncovering complexity and looking at processes of change (McLeod, 2001; Charmaz, 2006). This means that the focus is
more developmental and theoretically focused than other qualitative methods (Holloway & Todres, 2003) such as Interpretative Phenomenological Analysis (Smith, 2004).

Thirdly, grounded theory aims to produce a clarifying framework for understanding complex human experiences in a way that can be communicated publicly, and is relevant to those involved (Glaser & Strauss, 1967; McLeod, 2001; Backman & Kyngas, 1999).

2.3.3 Main features of Grounded Theory

A grounded ‘theory’ is developed inductively from the data (Charmaz, 2006) because the aim is to reveal the basic social processes that underlie experiences (McLeod, 2001) in a way that is as free as possible from assumed systems of meaning (Henwood & Pidgeon, 1992).

Grounded theory methodology is iterative. The researcher moves between conceptualisation and data collection simultaneously (Pidgeon & Henwood, 1997; McLeod, 2001) by constantly comparing each item of data with every other item, to create and integrate categories (Glaser & Strauss 1967). In contrast with other qualitative methodologies, sampling is ‘theoretical’, in that data collection is progressively shaped to explicate the dimensions of the developing conceptual framework (Strauss & Corbin, 1998). Ideally, theoretical sampling continues until no new properties of categories emerge and ‘saturation’ is achieved.

2.3.4 Participant selection procedure

Women who had received a psychiatric diagnosis of mild or moderate postnatal depression from a consultant psychiatrist, and who were receiving ongoing care from one of the recruiting sites, were targeted for participation. Women with severe depression or puerperal psychosis, and women judged by the recruiting agencies to have had difficulty providing consent were excluded from the study. Nine participants were recruited in total. All had received a diagnosis of mild or moderate postnatal depression and had provided consent. Details of participants are summarised in Appendix 4.12.
Initially, selection was open and inclusive, because the available clinical population was limited in size and it was anticipated that depression could have an adverse effect on willingness to participate. Since recruitment was based on a small, but experientially diverse clinical population, theoretical sampling mainly took the form of shaping questions to test out concepts relating to the emerging theoretical framework. This was justified on the assumption that aspects of each interview differed sufficiently to provide the basis for discovering variations (Strauss & Corbin, 1998). Following Silverman (2000), after the fifth interview, cases were chosen to test out the developing theory. For example, the ninth interviewee was invited to participate because breastfeeding was thought to play a contributory role to her experiences of depression. In this way, theoretical sampling was used to increase the richness of data (McLeod, 2001).

2.3.5 Data collection procedure

The data collection procedure is represented diagrammatically in Appendix 4.3, and described below.

2.3.6 Recruitment

Participants were recruited from one of two NHS specialist mental health services. Recruiting clinicians distributed recruitment packs to potential participants under their care. Packs included formal letters of invitation (Appendix 4.4), information sheets (Appendix 4.5) and a self-addressed envelope in which to return a slip expressing interest in participation. They were then contacted directly by the researcher to arrange a convenient time and location to conduct the interview and to clarify any queries regarding the study.

2.3.7 Ethical approval

Ethical approval was obtained from the relevant local research and ethics committees (Appendix 4.2).

2.3.8 Interview procedure
The researcher conducted semi-structured interviews in participants’ homes after participants and the researcher had signed a consent form. Interviews were recorded with participants’ permission and transcribed verbatim. Interviews lasted between 40 and 60 minutes.

An example of the interview schedule is presented in Appendix 4.6. The schedule was not adhered to rigidly. Rather, the researcher adopted an open-ended conversational style, in order to generate ‘rich’ material (Pidgeon & Henwood, 1997). Pertinent issues emerging from data were explored further in subsequent interviews in accordance with the need for theoretical sampling.

2.3.9 Data analysis procedure

2.3.9.1 Position of researcher

Grounded theory can be applied within a number of different epistemological stances, on a continuum from realism to constructivism (Henwood & Pidgeon, 1992; Madill, Jordan & Shirley, 2000). Constructivist stances prioritise the lived context of participants’ experiences and the contribution of both researcher and participant in producing meaning, whereas more ‘objectivist’ grounded theory treats data as ‘real’ representations of a knowable world, attending less to the influence of the researcher (Charmaz, 2006).

A ‘critical realist’ epistemology was adopted for analysing data in this study. This stance shares with social constructionism the idea that concepts can be studied within their historical and social contexts, but assumes that whilst reality is not socially constructed, theories about reality are shaped by social contexts, and are therefore open to critical scrutiny (Pilgrim & Bentall, 1999; Madill et al. 2000). To illustrate, recruitment and interview procedures reflected a critical realist stance. Participants were recruited from psychiatric services in which they were receiving treatment for ‘depression’. At interview, the construct of ‘depression’ was not questioned, instead, the researcher focused on the theories participants held about their depression.

2.3.9.2 Transcription
Interview recordings were transcribed verbatim by the researcher to improve familiarity with, and sensitivity to, the data (McLeod, 2001). To ensure anonymity, pseudonyms were assigned to each interviewee and identifying material was altered. Transcripts were numbered to represent the chronological order of interviews. Lines of transcripts were numbered to facilitate referencing.

2.3.9.3 Open coding

The aim of the first stage of analysis was to scrutinise the transcripts line-by-line, to identify and label concepts potentially relevant to the study. The transcript was dissected into segments of text referred to as ‘meaning units’ (Rennie, Phillips & Quartaro, 1988). Each meaning unit was given a label considered to represent the data well, and was written in pencil on the right hand side of the transcript.

2.3.9.4 Focused coding

The next stage of analysis involved linking earlier codes along the lines of common properties to create more abstract codes (Strauss & Corbin, 1998). Resulting codes were used to sift through larger amounts of data and explore similarities and differences. Each of the emerging codes describing a concept was recorded on computer file with illustrative excerpts of textual data.

2.3.9.5 Category development

As additional interviews were conducted, higher order category development began. Conceptually similar codes were abstracted from other emerging themes and elevated to a higher order to represent their relative conceptual importance. Categories were labelled to reflect activities and processes (Strauss & Corbin, 1998), because the goal of the research was to produce a theory of psychological processes.

Connections between categories and their dimensions were explored through axial-coding (Strauss & Corbin, 1998) and theoretical-memo writing (Pidgeon & Henwood, 1996). These activities helped refine categories conceptually by identifying gaps in understanding, informing
subsequent data collection, and explicating levels of saturation. As categories became theoretically
developed, focused codes were split, integrated and relabelled.

‘Constant comparison’ and ‘theoretical sampling’ constituted pivotal features of coding.
Consistently identifying variations within and between data, and checking interpretations against
new data, advanced conceptual understanding and facilitated the development of a well-grounded
theory. In the interest of theoretical sampling, the interview schedule was adapted for each
interview to explore emerging concepts and gaps in accounts arising from previous interviews.

2.3.9.6 Selective Coding and Development of Core Category

In the latter stages of analysis, a diagram was developed to represent the links between
concepts. This represented the initial development of a theoretical process model. A core category
was developed to conceptualise all the data. In grounded theory methodology, the core category
represents the central phenomenon of the study, to which all lower level categories are related.

2.3.10 Quality criteria

Criteria for assessing grounded theory research vary according to idiosyncratic adaptation of
the methodology. This study was conducted following evaluative frameworks provided by Elliott,
Fischer and Rennie (1999). In summary, the researcher enhanced the rigour of the study by
maintaining awareness of the social context in which the data was embedded. A reflexive journal
was used to facilitate reflective thought, and the researcher attended a regular qualitative research
review group, in which peer coding of transcript excerpts and methodological issues were
discussed.
2.4 Analysis

2.4.1 Overview

In this chapter, the analysis of the data is described. The core category is presented in the first section. This represents the central theme that conceptualised the nine participants’ accounts of breast-feeding and postnatal depression. This is followed by a description and explanation of the psychological process model identified in the experiences of the nine participants (Figure 1). Detailed accounts of the major categories that comprised the process model are presented in the following section. Diagrams are used to represent the hierarchical structure of the analysis throughout the chapter.

The main categories were developed from experiences of all nine participants and therefore represent the most highly saturated categories. Intermediate level categories were derived from the experiences of at least five participants. Lower-level categories represented at least two participants’ experiences. Negative case examples are also referred to within the text, to illustrate experiences that deviated from the main findings.

2.4.2 The core category: ‘Becoming occluded’

The core category identified in the analysis was termed ‘Becoming occluded’. This represented the pivotal theme of nine mothers’ experiences of postnatal depression and breast-feeding. The word ‘occluded’ was chosen to emphasise participants’ experiences of being eclipsed, obstructed and diminished in their attempts to sustain their infants.

“...I felt that I’d got nothing more to give anybody... I’d been completely stripped... of everything that I got and I just couldn’t give any more... when he was poorly and the midwife said... it’s ‘cause your milk’s not good enough... that was one of my lowest points.”

(LB p57, L1265-127)
The process of 'Becoming occluded' is depicted in Figure 1. Initially, the symbol of the infant is smaller than its mother, representing participants’ anticipation of motherhood. In the next phase, the mother’s form is almost entirely eclipsed by the infant, and this represented participants’ sense of overwhelming responsibility for keeping their infants alive. The green circle represents the mother’s social world, and illustrates her awareness of external pressures surrounding her. In the next phase of the model, the mother’s form is fractured and lies eclipsed behind the infant, but remains within a social context. This represented participants’ feelings of entrapment and suffering, fuelled by perceptions of a potentially hostile world and the desire to withdraw from others. In the following phase, the mother evaluates herself. Negative self-evaluation feeds back into her sense of overwhelming responsibility and fracturing, establishing a negative cycle of perceived failure. The final phase represents emergence from occlusion, stemming from less negative self-evaluation.

This is shown by the more well-defined boundaries of the mother and infant, and the infant’s size relative to the mother. The positioning represents the mother’s incorporation of the infant’s ongoing dependency, and their participation in the social world, without being subsumed by it.
Figure 1. Diagram of the core category 'Becoming occluded' and the process model.

ANTICIPATING → OVERWHELMING RESPONSIBILITY → BEING FRACTURED → RE-EMERGING → SELF-EVALUATING
2.4.3 The process model

The process model comprised five main categories, representing different aspects of participants' experiences (Figure 1). Main categories were termed 'Anticipating', 'Overwhelming responsibility', 'Being fractured', 'Self-evaluating' and 'Re-emerging' (Figures 2, 3, 4 and 5). The model represented participants' experiences as temporally linear, in the sense that it followed mothers' experiences from pregnancy to 'recovery'. Linearity was a function of both the researcher's attempts to impose structure on the data and participants' narratives. However, accounts revealed that women moved between the different phases of this abstract model. The model was cyclical in that self-evaluation fed back into mother's experiences of overwhelming responsibility and fracturing. Therefore, no necessary end position was assumed. Each of the five categories is described in turn.

2.4.4 First main category: 'Anticipating'

The first main category (Figure 2) concerned participants' ideas about feeding their infants before they gave birth. Two aspects of decision-making were defined in contrast to one another and formed two intermediate level categories described below.

2.4.4.1 Intermediate category: 'Being decided'

'Being decided' referred to participants' reported clarity about the feeding method they intended to use: "I planned that I would [breast] feed him first so that he got all the goodness to start with." (SM, p232, L173-174)

This category reflected mothers' determination to give their infants the best start in life that they could provide, and reflected their confidence in being able to do so. For most, decisions about feeding method were influenced by the reported understanding that breast-feeding is beneficial to mother and infant, and some communicated idealised views of the experience. Although most mothers had decided to breast-feed, for 'Caroline', practical difficulties breast-feeding her first child led to her decision to bottle-feed her second.
[I was] more relaxed 'cause I just decided to bottle-feed this time... because your hormones are all over the place anyway and I don't want to have to think about she's not doing it properly. (CM, p84, L585-589)

The category comprised three lower-level aspects of being decided: 'Doing what's best', 'Being pragmatic' and 'Romanticising'.

2.4.4.2 Intermediate level category: 'Being uncertain'

This category better represented the experiences of women who bottle-fed their infants, rather than those who breast-fed. It comprised two lower level categories: 'Experiential learning' and 'Fearing failure'.

In contrast to experiences of 'Being decided' about feeding methods, this category reflected mothers' uncertainties about their abilities to nurture through breast-feeding, and their appeals to the role of experience in guiding their behaviour. For example, 'Jennifer' expressed a concern about committing to breast-feeding for fear of later letting her infant down.

"I... thought, well, I'll see how it goes. I don't want to say yes, I'm going to breast-feed, then something happens and I can't... I didn't want to build it up to be yes, that's definitely what I'm going to do." (JN, p183, L291-294)

In the absence of certainty, these participants looked for evidence of their potential for failure or success from their mothers' experiences. Their mothers' behaviour provided a contextual framework for their own understanding of, and decisions about, mothering. Other participants were explicit about 'Fearing failure' to nurture their infants through breast-feeding.
Figure 2. Anticipating

1 ANTICIPATING

1A BEING DECIDED

1A.1 DOING WHAT'S BEST

1A.2 BEING PRAGMATIC

1A.3 ROMANTICISING

1B BEING UNCERTAIN

1B.1 EXPERIENTIAL LEARNING

1B.2 FEARING FAILURE
2.4.5 Second main category: 'Overwhelming responsibility'

The second main category identified in the analysis was termed 'Overwhelming responsibility' (Figure 3). This represented participants' experiences of shock at the demands and pressures of motherhood. The category related specifically to breast-feeding practices, and more generally to the impact of motherhood in the initial days and weeks after giving birth. The three main aspects of the category are described below, and are depicted diagrammatically to represent three perceived sources of mothers’ overwhelming responsibility: social, mother and infant.

2.4.5.1 Intermediate category: 'Experiencing social intrusion'

This category represented participants’ perceptions of external pressure in relation to their roles as mothers. The defining theme of ‘intrusion’ referred to participants’ perceived helplessness in the face of judgement, pressure or instruction, irrespective of feeding method. Perceived loss of power in relation to their changed status, and diminishing resources in the transition to motherhood, were central aspects of participants’ experiences.

Contributory lower-level categories conceptualised intrusion that occurred at different times. ‘Pressure to perform’ related to participants’ experiences of breast-feeding before or around birth. ‘Being judged’ occurred later and reflected perceived negative judgements from others about their feeding practices. Social judgements were perceived mainly in subtle forms, such as limited provision for women to breast-feed publicly.

"Why these places assume that breast-feeding has anything to do with going to the toilet, I will never know...it’s absolutely ridiculous that they shove...breast-feeding mums in a toilet...it’s absolutely disgusting. You wouldn’t eat your butties in a toilet, would you?" (LB, p12, L169-173)

Some participants explained that their discomfort about publicly exposing their breasts, and the anticipated negative judgement, stopped them from breast-feeding in public. Even participants who chose to bottle-feed their infants experienced negative social judgement. This category related to the
main category of self-evaluation in that some participants described how perceived negative judgement contributed to their negative self-evaluation, and negative self-evaluation may in turn have increased their perceptions of external judgement.

'Pressure to perform' related specifically to messages about breast-feeding, associated mainly with midwives and other health care professionals. Participants expressed frustration at what they perceived to be an unbalanced presentation of feeding choice. The implication for these participants was that they were perceived as deviant by health professionals if they did not breast-feed, and perceived as deviant socially if they did.

2.4.5.2 Intermediate category: 'Confronting absolute dependency'

Infant dependency represented a source of pressure, which contributed to participants' overwhelming sense of responsibility and occlusion. This category comprised two lower-level categories: 'Fearing capacity to harm' and 'Needing to succeed'.

Breast-feeding fostered infant dependency, because infants became reliant on breast-milk for survival.

"With breast-feeding you have no choice, you've got to feed that baby when it wants feeding... and that's a very big pressure on you... unless you can manage that pressure... [you] will end up getting very depressed about the whole situation...you've got no life, you haven't even got your body." (LB, p31, L631-640)

Accounts of infants' vulnerability emerged in the context of decision-making and seemed to represent an indirect expression of participants' fears of their potential to harm. For example, 'Dina' was unable to satisfy either of her sons by breast-feeding, and she felt that this constituted a significant part of her depression. Her distress was partly ameliorated by a move to bottle-feeding, because it relieved some of her responsibility for her infant's survival.
Figure 3. Overwhelming responsibility

2A EXPERIENCING SOCIAL INTRUSION
- 2A.1 BEING JUDGED
- 2A.2 PRESSURE TO PERFORM

2C CONFRONTING ABSOLUTE DEPENDENCY
- 2C.1 FEARING CAPACITY TO HARM
- 2C.2 NEEDING TO SUCCEED

2B EXPERIENCING INFANT INTRUSION
- 2B.1 ENCOUNTERING COMPLICATIONS
- 2B.2 NOT GETTING IT RIGHT

SOCIAL WORLD
MOTHER
INFANT
Whilst dependency was not always anticipated or wanted, 'Jo' represented a 'deviant' case, because she welcomed her daughter's dependency as a reason to carry on living. In contrast to other participants, Jo's distress pre-dated her pregnancies, and motherhood offered her a sense of purpose.

"I had so much unhappiness in my life and I'd got a little human being who was relying on me to do the best for her, and I think from the day she was born, it was like, she comes first."

(JW p206, L41-44)

The pressure some participants placed on themselves to breast-feed was understood to reflect the importance of breast-feeding to participants' sense of maternal adequacy. For some, successful breast-feeding seemed more important than their own well being.

2.4.5.3 Intermediate category: 'Experiencing infant intrusion'

This category, defined in contrast to participants' experiences of intrusion from the social world, represented the reality of breast-feeding, which, for some, clashed with fantasies of harmonious feeding experiences. It comprised two lower-level categories: 'Encountering complications' and 'Not getting it right'.

Most, but not all, participants' experienced breast-feeding as complicated. Difficulties were attributed to the infant's role, as well as to that of the mother: "I had problems trying to breast-feed him 'cause he was so lazy" (CM, p62, L27-28).

A related aspect of intrusion was represented in the sense of 'Not getting it [breast-feeding] right'. 'Dina' for example, described that her sons dramatically lost weight whilst they continually fed from her.

"Rory ... was also losing weight... he was feeding the whole time. People think I exaggerate but he wasn't off for more than twenty minutes at a time for two weeks and I was getting so frustrated because I had tried everybody and anybody to help and they all said, well check the fix. It's not the fix!" (DE, p255, L89-93)
2.4.6 Third main category: ‘Being fractured’

‘Being fractured’ (Figure 4) represented participants’ experiences of fragmentation as they battled with distressing and ambivalent feelings. Four intermediate categories were identified: ‘Isolating’, ‘Suffering’, ‘Splitting off’ and ‘Satisfying’.

The category incorporated general experiences of being with the infant, and breast-feeding in particular. Isolation and loss dominated experiences of fracturing, but occurred alongside positive interactive experiences.

2.4.6.1 Intermediate category: ‘Isolating’

‘Isolating’ comprised two facets of social isolation - ‘Feeling alone’ - and breakdown of communication and connection with the outside world - ‘Not being understood’. Participants felt isolated from their friends, partners and families, and the social world continued to be perceived as potentially hostile.

“...daggers are drawn and everybody’s got this face on and everybody’s acting as if they can rule the world and the trouble is when you’ve got depression, you just see that image and you think, I’m never gonna be as good as this, I’m rubbish.” (LB, p26, L517-521)

Experiences of isolation were exacerbated by feelings of not being understood.

“I think it’s something that [others] don’t understand. I certainly didn’t understand it for an awfully long time and I still don’t and I still struggle to explain how I feel, so somebody that hasn’t gone through it, it’s very difficult for them to understand and to know what to do.” (NP, p102, L279-283)
2.4.6.2 Intermediate category: ‘Suffering’

This category represented sacrifices participants made for their infants. The dominant theme was that of ‘Becoming trapped’. However, the concept was also defined by experiences of ‘Being depleted’ and ‘Collapsing’.

For ‘Caroline’, who bottle-fed, suffering related to a broad loss of independence. For breast-feeders, being constantly available for feeds and an inability to escape from those demands exacerbated entrapment:

“She was never satisfied, never seemed settled on [breast-feeding]... I could feel myself sinking fast and I needed to get away from her and while I was feeding, I couldn’t go anywhere, she had to come with me and I couldn’t take it any longer.” (SH, p147, L109-113)

Another aspect of suffering was ‘Being depleted’. In this, breast-feeding drained participants of energy, and they expressed resentment at how their own needs were sidelined for their infants.

“I just perceived them as demanding all the time and demanding more than I could give... I hated the way that they were making me feel. I hated the fact that I couldn’t do anything other than feed them. I’d be feeding and feeding and feeding and then maybe I’d get a chance to go to the loo and if I was really lucky, I’d make a drink, then I’d be feeding again.” (DE, p260, L212-218)

Some participants described breaking down when pressures and distress felt unsustainable. For ‘Susan’, who felt her distress was exacerbated by breast-feeding experiences, ‘Collapsing’ related specifically to a point of absolute exhaustion, when she ceased breast-feeding.

“After four weeks he started crying again one evening and I snapped. I said, I cannot sit and feed him any longer. I can’t do it... It was too much. It was physically and emotionally too demanding to sit and do nothing else for 24 hours a day but feed a baby when you have two other children who are demanding your time and attention.” (SH, p166, L573-579)

2.4.6.3 Intermediate category: ‘Splitting off’
‘Splitting off’ represented participants’ sense of emotional separation from the world around them, including their infants. The category comprised four lower level categories: ‘Disconnecting’, ‘(Contemplating) escape’, ‘Contemplating self-destruction’ and ‘Ambivalence’. Part of the experience of ‘Being fractured’ was participants’ sense of disconnection from those around them, including the infant.

“It's like being in another world, a parallel world... so you functioned but you couldn’t actually feel.” (SM, p235, L237-240)

In this, disconnection was understood as a means of protecting self and others, and as an indication of fragility. Participants’ fantasies of, or actual, escape, captured a more active element of managing distress.

“It was great going back to work. From about three months after she was born, I was looking forward to going back to work so I didn’t have to be with her... and it fortified me for the couple of hours that I had to spend with her in the evening.” (NP, p92, L47-54)

The third aspect of splitting off involved ‘Contemplating self-destruction’. This related to four participants’ thoughts of being hurt or killed as another means of escape from their distress and/or feelings of failure.

“I used to hope there would be a lorry coming in the opposite direction that would kill me outright and the baby would be fine, or that I’d fall down the stairs and that would be it”. (NP, p93, L70-71)

The fourth aspect of splitting off was participants’ feelings of ambivalence. Three participants described contradictory feelings toward their infants, whilst they loved their infants, some did not want to be near them. This seemed to be explained by participants’ needs to avoid feelings of responsibility and failure, which were accentuated by proximity to the infant.

“It was dead strange because I love him more than anything in the world, but I didn’t want him around... I felt such a failure that I couldn’t even get him dressed... and look after him
that I didn't want him there because I didn't want to start thinking about, I can't get him dressed, I can't change him, so I'd rather just blank it out.” (JN p180, L201-208)

2.4.6.5 Intermediate category: 'Satisfying'

Whilst feeling fragmented and disconnected from the rest of the world, four women nevertheless experienced breast- (and bottle-) feeding their infants as positive. In this sense, the category was 'deviant' in that it contrasted markedly from negative experiences of breast-feeding, reflecting feelings of connection rather than disconnection.

"I used to feed her and it was the time I got a little lump in my throat and thought, oh, perhaps she's not that bad, and I thought, this is perhaps how people feel a bit more of the time than I feel it.” (NP, p97, L171-174)

Whilst breast-feeding was experienced as difficult, demanding, and entrapping for some participants, three were able to find satisfaction by breast-feeding. In these latter accounts, feeding represented a haven from the distress of depression.

2.4.7 Fourth main category: 'Self-evaluating'

'Self-evaluating' (Figure 5), represented participants' assessment of self-worth, based on their mothering experiences. It comprised three intermediate categories, which were not mutually exclusive.

Whilst participants’ questioning of their maternal adequacy represented a dominant theme throughout the process model, negative self-evaluation represented the pivotal aspect of their depressive experiences. The cyclical nature of the model captures the sense of entrapment in negative self-evaluation, which epitomised experiences of depression. Participants negatively evaluated themselves as mothers on the basis of their experiences with their infants, and this contributed further to the sense of 'Overwhelming responsibility' and 'Being fractured'. Some participants drew conclusions about their abilities as mothers on the basis of how successful they perceived breast-feeding to have been. For mothers who bottle-fed, the pattern of self-evaluation
was similar, although they seemed less explicitly invested in breast-feeding as evidence of their adequacy.

In the diagrammatic representation of the process model (Figure 1), arrows indicate that participants' sense of self was influenced by their interaction with the outside world, their infants and their internal world.

2.4.7.1 Intermediate category: 'Defending self'

All participants defended themselves against perceived external judgement, particularly in relation to feeding practices. Two facets of self-defence were 'Ranking' and 'Rejecting intrusion'.
Figure 5. Self-evaluating

4 SELF-EVALUATING

4A DEFENDING SELF
- 4A.1 RANKING
- 4A.2 DENYING RESPONSIBILITY
- 4A.3 REJECTING INTRUSION

4B BLAMING SELF
- 4B.1 FEELING INADEQUATE
- 4B.2 STRUGGLING WITH GUILT
- 4B.3 REGRETTING

4C SEEKING AFFIRMATION
- 4C.1 FEELING SUCCESSFUL
Participants' accounts indicated that perceived social 'rank' was important in understanding the context of their distress. Three participants spoke negatively of others' feeding decisions. Employing a related defensive strategy, 'Lucy' illustrated her belief that someone would need to have extraordinary defences in order to achieve successful breast-feeding. In the analysis this was understood as Lucy's way of normalising her difficulties, and illustrated her sense of vulnerability related to breast-feeding.

"It's only the very strong willed women, the ones who couldn't give a damn about what anybody else thinks, that managed [breast-feeding]." (LB, p13, L190-192)

Participants also challenged and rejected others' opinions, advice or behaviour. For example, some participants who did not breast-feed challenged the cultural message that bottle-feeding represented something bad.

"If my husband's still here, and he is perfectly healthy, and he wasn't breast-fed, and that was thirty odd years ago, then [it] can't be that bad you know, not to breast-feed." (VJ, p140, L548-551)

2.4.7.2 Intermediate category: 'Blaming self'

This category label was used to refer to mothers' attacks on themselves. It comprised three facets (lower-level categories), which were conceptually similar but represented subtly different aspects of self-blame that emerged from participants' experiences of interaction with the infant and the social world around them. These were termed 'Feeling inadequate', 'Struggling with guilt' and 'Regretting'.

Feelings of inadequacy seemed to reflect participants' perceptions of failure relative to others. For 'Dina' guilt toward her infant, and her sense of inadequacy in relation to others, were associated with a perceived need to account for her performance.

"I was always carrying around a sense of guilt that I haven't been able to breast-feed and, even now, if I go somewhere and give Rory a bottle and other people are breast-feeding, I feel
bad because I’m not breast-feeding and I feel almost as if I have to explain myself.” (DE, p264, L318-321)

Guilt seemed to stem from participants’ perceived failure to nurture adequately, and was reported specifically in relation to breast-feeding. For example, ‘Susan’ described how her sense of inadequacy related to her inability to successfully breast-feed her child.

“I’d just got lower and lower to the point of giving up the breast-feeding, then I felt like a complete failure because I’d failed to achieve what I’d set out to do.” (SH, p148, L126-128)

Regret was associated mainly with weaning. This was expressed both by participants who bottle-fed, and ‘Lucy’ who felt the loss of a special bond with her infant when she stopped breast-feeding.

2.4.7.3 Intermediate category: ‘Seeking affirmation’

Most participants evaluated evidence for their maternal worth through interaction with their infants. For example, ‘Lucy’ interpreted her infant’s reduced dependency on her as evidence of no longer being wanted.

“...there was a time, after I stopped feeding Joe that I just felt, yeah you have him, whatever. I’m not bothered. I’m going out. Because you feel as if you’ve been rejected.”

(LB, p35, L729-732)

In contrast, Dina’s son’s perpetual demands for food made her feel unloved.

“As soon as he came near me it was, food!... That was hard because I wanted to be loved for something other than food... I just felt that Sam didn’t want me, he didn’t love me.” (DE, p261, L229-232)

Seeking affirmation comprised the lower-level category ‘Feeling successful’. For some, a connection through feeding provided evidence of their infants’ love and appreciation.
"I think there are times when I get, it’s almost like job satisfaction, you know, when I feed her and she eats for um, you know...it’s almost like um, I’m being praised for something that I’ve done." (NP, p110, L481-484)

2.4.8 Fifth main category: ‘Re-emerging’

The final main category termed ‘Re-emerging’, represented participants’ experiences of movement out of distress to a more psychologically congruent position. Data contributing to this category was identified in all participants’ accounts, although at interview, some participants did not consider themselves to be in ‘recovery’. The category was understood in contrast to the previous process of occlusion, represented in this phase by separation from the infant and an increased engagement with others.

2.4.8.1 Intermediate category: ‘Separating out’

This category represented participants’ psychological and physical movement from their infants. It comprised lower-level facets termed ‘Reprioritising’ and ‘Relinquishing responsibility’.

Participants described a shift in their prioritisation of needs and relinquishing some responsibility for their infants through physical separation, and through weaning. ‘Sophie’ described how weaning moved her out of her focus on herself as a failure, to a more balanced position.

“When I finished breast-feeding him and he was growing and thriving, I felt OK. I seemed happy that he was feeding properly, and I actually thought of him rather than me and that was the most positive part of the whole thing. Instead of going into, I can’t do this, it was almost as if someone had taken some responsibility off me somewhere along the line.” (SM, p233, L197-204)
A related aspect of weaning was a sense of loosening an emotional connection with the infant, which was referred to in the previous self-evaluation category as affirming. In this phase, it represented the mother becoming less important to the infant as it grew in strength and independence.

"It's sort of the end of something. Sort of the end of the babyhood in a way. There is something final about it. I'm trying to decide whether I'm ready for that yet." (DE, p270, L452-454)

2.4.8.2 Intermediate category: ‘Medicating’

The second intermediate level category represented participants’ reflections on how they thought antidepressant medication had contributed to their recovery. Whilst all participants took medication at some point during their depression, most expressed concern and/or reluctance about pharmacological interventions. Nevertheless, five participants perceived it as helpful in controlling distress.

"I've started taking antidepressants... I suppose I feel a little bit calmer in my head and can obviously talk about it without being in floods of tears now." (NP, p99, L204-209)

2.4.8.3 Intermediate category: ‘Recognition’

Eight of the nine participants described experiences of support through relationships, in which their needs were recognised and/or responded to. For some, this was part of their reintegration into the social world. This was labelled ‘Recognition’ and lower-level categories represented different sources of social contact (‘Partner’, ‘Professionals’, and ‘Peers’), who contributed to their sense of re-emergence.

In some accounts, partners’ lack of understanding contributed to the sense of isolation, but here, partners’ provision of unconditional support was an important part of mothers’ recovery. Participants found it supportive to talk through their experiences of depression with professionals
who they believed could understand their distress. This included a general practitioner, a psychiatrist, clinical psychologists, health visitors and community nurses. These supportive experiences contrasted with unhelpful interactions with professionals, represented in the category ‘Not being understood’ and which contributed to participants’ distress. Perceptions of the social world were influential throughout the process model. In this phase, peers provided a means of normalising difficulties and helping participants to feel understood.

2.4.9 Summary

In the first category, decisions to breast-feed were framed within participants’ desire to provide the best start for their infants and reflected participants’ differing levels of confidence. The second main category reflected a tension between internal and external pressures to meet infants’ needs, and fears of doing harm. In the third main category, a sense of loss predominated within participants’ experiences. Whilst breast-feeding involved suffering and entrapment in the context of participants’ emotional disconnection, it also represented affirmation. The fourth main category represented the pivotal phase of the model. Participants’ feelings of inadequacy and failure were particularly grounded in difficult experiences of breast-feeding, and fuelled a downward spiral of self-evaluation. The fifth main category reflected a dispersal of the earlier process of occlusion and fracturing. Re-emergence involved a loosening of the connections with infants, which for some participants was a relief, and for others, represented a loss.

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2.5 Discussion

2.5.1 Overview

This chapter includes a discussion of the main themes arising from the analysis. The thesis is explicated by drawing upon the stress-vulnerability model of depression, feminist sociological research, evolutionary and psychodynamic theories. Theoretical and clinical implications of the findings are discussed against the backdrop of existing research on breast-feeding and postnatal depression. Limitations of the study are also addressed.

2.5.2 Interpretation of the analysis

The aim of the study was to develop a psychological understanding of the relationship between breast-feeding and postnatal depression by exploring nine women’s experiences. Qualitative analysis identified a core category of experience, termed ‘Becoming occluded’: within this a process model was developed comprising five phases.

‘Becoming occluded’ represented participants’ attempts to sustain their infants in the context of paradoxical and distressing feelings. Cyclical movement between the three central phases of the process model represents participants’ growing sense of occlusion. In the first phase, participants anticipated their feeding practices before giving birth. In the second, some participants experienced responsibility for their infants’ lives as overwhelming; they doubted their maternal adequacy and feared their capacity to harm. For some, breast-feeding represented an integral part of their ideal self-image as mothers. However, since breast-feeding fostered infant dependency, it gave rise to feelings of intrusion and anxieties about doing harm, particularly when it was unsuccessful. Perceptions of pressure and judgement from the outside world intensified some participants’ feelings of intrusion. For others, breast-feeding imparted a sense of control over their infants’ discomfort and diminished participants’ fears of inadequacy.

The third phase of the model represents most participants’ feelings of entrapment by their infants. Participants split off physically and emotionally from relationships, perhaps to protect
themselves from ambivalent feelings toward their infants and from feared charges of maternal inadequacy. Since feelings of maternal unhappiness and resentment clashed with cultural and internalised expectations of maternal pleasure, participants' distress was borne out in feelings of guilt and shame, and they became trapped by negative self-evaluation. This is represented by the fourth phase of the model, which feeds back into the second and third phases, representing participants' deepening experiences of occlusion.

The final phase represents re-emergence from occlusion, and involved participants' individuating their needs from those of their offspring, facilitating a re-identification with others. This seemed to free participants from their anxieties about not fulfilling internalised maternal ideals.

2.5.2.1 First main category: 'Anticipating'

This initial phase reflected participants' thoughts and feelings about feeding, before giving birth. In line with previous qualitative research (Schmied & Lupton, 2001; Shaw, Wallace & Bansal, 2003; Nelson, 2006), most participants' narratives upheld the notion that 'breast is best'ix. However, varying degrees of commitment to breast-feeding were expressed: whilst some embraced the idea of breast-feeding, others seemed uncertain, and appealed to prior experience when making feeding decisions. Intentions were later borne out in behaviour, and those who recalled ambivalence about breast-feeding during pregnancy fed their infants using commercially-formulated milkx.

Supporting this finding, research has indicated that breast-feeders have higher self-esteem, self-efficacy and self-confidence than bottle-feeders (Blyth, Creedy, Dennis, Moyle, Pratt & De Vries, 2002; Dennis & Faux, 1999; Tarkka, Paunonen & Laippala, 1999). However, this focus ignores contextual influences on feeding-decisions. Participants in this study responded within a cultural context, which imbued feeding decisions with notions of morality (e.g. Murphy, 1999; Mauthner, 1998). For them, breast-feeding epitomised a fundamental aspect of the maternal ideal: the notion
of a sacrificing mother who is fused with her baby (Parker, 1995). One hypothesis for the findings of this study is that by allying themselves to some extent with this 'good' maternal image, participants distanced themselves from a polarised position of bottle-feeding as 'bad'. Arguably, this discourse can lead to a romanticised view of motherhood (Schmied & Lupton, 2001) such as that reflected in some participants' accounts. For example, 'Lucy' described her fantasy of constantly breast-feeding her infants and, in doing so, held it up as a symbol of good mothering. However, she described later disappointment that she was not the 'perfect' mother she had wanted to be. One interpretation is that participants' determination to breast-feed may have reflected polarised perceptions of breast-feeding and motherhood.

A second aspect of participants' attempt to find a fitting image of motherhood was evident in their self-assessments of maternal capacities (specifically breast-feeding abilities) by identifying with, rejecting, copying, competing and differentiating from their own mothers. This resonated with Cramer's (1997) psychodynamic view, that women's identification with motherhood is shaped by their relationship with their own mothers.

A third aspect was 'uncertain' participants' appeal to future experiences in making feeding choices. Generally, participants who did not breast-feed anticipated adopting this experimental approach. For example, 'Victoria' could not identify what she did not like about breast-feeding that underpinned her later decision to bottle-feed. For 'Jennifer', depression meant she had not been in the "right frame of mind" (JN, p184, L311-312) to breast-feed. From the literature, these participants may have assessed themselves as relatively less able to 'succeed', or may not have welcomed the image of interconnectedness represented by breast-feeding. However, one explanation of their anticipatory uncertainty, is that participants were unable to express their concerns or preferences openly, because intending to bottle-feed when the benefits of breast-feeding are known, may be perceived as 'deviant' (Murphy, 1999).
The notion of moral ‘deviance’ in failing to conform to an ideal maternal image offers support to Gilbert’s theory (1992), that worth is determined by relative social rank. Mothers who prefer to bottle-feed may fear social judgements of inferiority, and therefore hide their reluctance to breast-feed by employing excuses and justifications (Murphy, 1999). By appealing to experience, participants minimised their control over feeding method, whilst maintaining an adequate social ranking as mother.

2.5.2.2 Second main category: ‘Overwhelming responsibility’

In this phase, participants were caught between pressures to conform to expectations from the external world and the intrusion of infants’ demands to be nurtured, resulting in a sense of overwhelming responsibility.

Social intrusion represented two temporally distinct experiences. Participants experienced negative judgement within society in relation to both breast-feeding and bottle-feeding. Whilst ‘Lucy’ felt ostracised by other mothers for breast-feeding, ‘Caroline’ described others’ negative judgements about her bottle-feeding. These experiences can be understood with reference to ideas from an evolutionary perspective: mothers’ evaluate their worth through their perceived ranking amongst other mothers (Gilbert, 1992) and their anxieties are focused around issues of feeding and crying because these are central indications of infants’ survival (Crouch, 1999). This means that mothers may be attuned to others’ judgement of their feeding practices as an indication of their maternal adequacy. The hypothesis is complicated by the meanings different cultures place on feeding practices: the findings of this study suggest that breast-feeding carried negative as well as positive connotations. For example, participants expressed reluctance to breast-feed in public because they felt breast-feeding was sexualised, whilst one bottle-feeder felt judged for not conforming to the self-sacrificing maternal ideal.

The data in this study indicated participants’ perceptions of having fallen short of an ideal, and their attempts to resolve this without attributing blame to themselves or their infants were manifest
in their perceptions of hostility from the social world. According to psychodynamic theory, feelings of ambivalence toward infants are intolerable for some women (Parker, 1995), and in this study, perceptions of judgement and pressure might have partly reflected participants’ projected feelings of resentment about the infants’ intrusion, which enabled participants to resent the maternal ideal they were also trying to live up to. For example, ‘Caroline’ spoke angrily of the social pressure to breast-feed:

“I didn’t breast-feed and there’s nothing wrong with my kids...too many people are [made to feel] as though it’s not right if you don’t do it.” (CM, p88, L685-693)

However, she also said that when she could not breast-feed, she felt “awful” for letting her infant down (CM, p28, L687). This apparent contradiction suggested that she projected her negative feelings about not breast-feeding onto those around her, who were then perceived as judgmental.

A second aspect of ‘Overwhelming responsibility’ pivoted on participants’ realisation of infants’ dependency. Participants communicated a paradoxical sense of powerlessness to external pressures and an unwelcome powerfulness over their infants’ survival. According to Parker (1995), such responsibility for infants’ survival feels overwhelming when mothers’ fears of their infant being harmed stem from their own destructive impulses. Breast-fed infants’ dependency on their mothers magnified fears of doing harm, which were exacerbated further by breast-feeding difficulties. However, the current study suggested that in spite of their negative experiences, some participants were determined to persist with breast-feeding. One hypothesis is that these participants were caught between fears of harming their infants through unsuccessful breast-feeding, and fears of failing to do what they (and others) believed was best for their infants.

In explanation, breast-feeding fosters infantile dependence on the mother, which means the mother is responsible for sustaining it through her breast-milk. In contrast, bottle-feeding infants’ survival is mediated by formulated milk, distancing the mother from direct responsibility for its survival. Bottle-feeding may therefore represent a means of managing ambivalence, and alleviating
fears of harming the infant. To illustrate, in a non-depressed population, Schmied and Lupton (2001) found that when the infant’s encroachment on the mother’s body was experienced as unbearable, women sought to regain control by weaning. However, this current study suggested that, whilst differentiating from the infant by weaning was a relief, for some, it also evoked feelings of guilt and failure, which prompted negative self-evaluation.

A final aspect of this phase is that participants’ difficulties in making choices may also have reflected their fears of harming the infant, and perhaps fuelled determination to attain internalised ideals (e.g. through breast-feeding): a strategy that closed down ambivalent feelings, yet paradoxically highlighted them.

To summarise, women became trapped between motivations and pressures to conform to internalised ideals, and feeling overwhelmed by their infants’ dependency, particularly when breast-feeding was difficult. These pressures may have been resolved by attributing them to external social expectations.

2.5.2.3 Third main category: ‘Being fractured’

For most participants, this phase occurred some months after giving birth, and represented powerful feelings of distress and a loss of sense of self: Whilst continuing to mother their infants on ‘autopilot’, participants disconnected psychologically and physically from those around them. Fracturing seemed partly to be the consequence of unsustainable attempts to manage pressures described in the previous category, and was also understood as participants’ defence against those pressures. Withdrawal from social interaction protected participants from perceived messages of comparative failure, and was also motivated by some participants’ sense that others could not understand their experiences. In this, the data echoed Mauthner’s (1998) findings, that depressed mothers actively silenced themselves because they feared invalidation from others.

Social isolation contributed to feelings of entrapment, and was experienced acutely by breast-feeding participants. This was perhaps because breast-fed infants are dependent on mothers’
physical presence (DiPietro et al. 1987), and concerns about public breast-feeding further exacerbated some participants’ sense of isolation. However, in spite of experiences of intrusion and alienation, some women who breast-fed, persisted, apparently driven by a fear of failing internalised representations of motherhood.

A related aspect of ‘Being fractured’ was participants’ emotional disconnection from their infants. Parker (1995) suggested that some women manage their ambivalence by distancing themselves from the infant. According to this hypothesis, participants’ emotional disconnection from their infants may have been a way of shutting out negative feelings so that they could continue to meet their infants’ basic needs. A related example of fracturing was participants’ fantasies of dying or escaping, perhaps also reflecting a desire to separate from the infant, although this may be a function of depressed mood.

An important finding of this study was that some participants experienced breast-feeding (as well as bottle-feeding) as satisfying, in spite of their sense of occlusion and experiences of depression. In this sense, the finding supports the notion of mothers being fractured. The experience affirmed them as mothers and, when successful, gave them a power over their infants’ survival. This paralleled Schmied and Lupton’s findings (2001) that, for a minority of non-depressed mothers in their study, breast-feeding represented a welcome harmonious connection with the infants.

2.5.2.4 Fourth main category: ‘Self-evaluation’

This fourth phase represented participants’ self-assessment. Participants often judged their ‘fit’ as mothers firstly by comparing their behaviour to others’, secondly by reflecting on their feelings about motherhood and thirdly, in relation to affirmation from their infants. This behavioural-affective distinction underpinned the multi-layered self-evaluation process.

Some mothers compared their behaviour with that of others. For them, relative maternal adequacy seemed to be connected to breast-feeding ability. Some denigrated women who
represented alternative or ‘deviant’ images of motherhood, perhaps to defend themselves from feelings of inadequacy. One participant, who bottle-fed, challenged the importance of breast-feeding, and used a devalued image of self-sacrificing mothers to diminish them. However, expressions of regret around breast-feeding suggested that bottle-feeding mothers continued to judge themselves on the basis of their infant-feeding behaviour and breast-feeding remained meaningful to them.

These findings support Gilbert’s (1992) emphasis on the social context of depression, which results from relative ranking within a competitive society. Participants’ perceived failure to live up to an ideal image was experienced in relation to their social context. From a sociological point of view, mothers’ social contexts paradoxically denigrate (Kitzinger, 1987), and at the same time idealise, the maternal role (Mauthner, 1998; Murphy, 1999).

Feelings of inadequacy resulting from negative experiences of mothering in general, and breast-feeding in particular, underpinned participants’ self-defensiveness, and were also expressed in self-reproach and blame, which indicated feelings of shame and guilt. According to Gilbert (2003), shame is a feeling of inadequacy in relation to others, which motivates withdrawal from social competition, whereas guilt is experienced in relation transgressing a moral duty, for example, caring for a dependent. In this study, participants expressed shame simultaneously in relation to their perceived failure to live up to internalised images of motherhood (perhaps expressed through defensiveness), and guilt toward their infants in relation to perceived inadequacy to nurture or enjoy nurturing.

It was interesting to contrast the above feelings with the accounts of participants who enjoyed breast-feeding. Some interpreted their experiences as evidence of the infant’s need and appreciation. One way of understanding this finding was in relation to the concept of projection; that is, affirming breast-feeding represented the satisfaction of mothers’ projected need to feel loved, recognised and nurtured. Additionally, these participants believed that they made their
infants happy through breast-feeding, and therefore enjoyed the experience. By this, their feelings of resentment diminished, bringing them closer to their internal representation of motherhood. An alternative explanation is that these mothers did not experience the same breast-feeding difficulties as other mothers, and it was their ability to satisfy their infant, rather than the method of feeding, that was important. This is supported by the finding that experiences of affirmation were also reported by participants who bottle-fed.

Participants communicated that in spite of their depression, happiest moments with their infants involved activities such as bathing and feeding, which were mutually pleasurable, rather than experiences of sacrifice. One participant's comment attested to the influence of a maternal ideal, which denies maternal enjoyment (Parker, 1995) and against which mothers evaluated themselves:

"How selfish! Yeah, in some ways [I] only enjoy having her when I get something back that's... not the way it's meant to be is it?" (NP, p110, L495-497)

2.5.2.5 Fifth main category: 'Re-emerging'

This final phase of the model captured participants' move from occlusion toward individuation. Following Klein (1940, cited in Hinshelwood, 1991), Parker (1995) has argued that acceptance of ambivalent feelings is necessary for a mother to separate from her infant. Recognition of both love and hatred diminishes the mother's need to idealise and denigrate herself and baby. Research with non-depressed mothers (Rogan, Schmied, Barclay, Everitt & Wyllie, 1997; Schmied & Lupton, 2001) has indicated themes of self-evaluation, which also emerged in this study. Given this, one possible explanation is that depressed mothers have difficulty accepting their ambivalent feelings and ongoing attachment to an ideal, and therefore remain occluded by their infants’ needs, and trapped within the depression.

'Re-emerging' can be understood as a process of maternal psychological adaptation, involving acceptance of ambivalent feelings and re-adjustment of boundaries. Occlusion
encompassed self-evaluation, isolation and splitting. As the infants grew, their dependence and perceived fragility reduced, diminishing participants' sense of overwhelming responsibility. This reassured them of their adequacy, and enabled them to develop more integrated maternal identities.

In this phase, participants communicated their attempts to balance their own needs with those of their infants. Weaning represented the beginning of this differentiation. Echoing previous qualitative findings (Nelson, 2006), it elicited a number of different emotions in mothers from relief to guilt and shame. Participants who had resented the intrusion of breast-feeding experienced weaning as a release from entrapment. For others, it represented a loss of the affirmation their infants offered.

As boundaries with the infant became differentiated, participants felt recognised and understood by others. This social identification facilitated self-acceptance and a resistance of the ideal maternal image (Mauthner, 1998) and mirrored an evolutionary perspective, in which postnatal depression is understood as functional, in eliciting supportive responses from others when maternal responsiveness is threatened or diminished (Crouch, 1999). However, in contemporary western societies, mothers rarely live in closely knit social groups, and when social structures do not provide immediate support, women are likely to suffer alone.

2.5.3 Conclusions

For the participants of this study, motherhood was associated with experiences of depression. The analysis suggested that most of the participants were trying to conform to their maternal ideals, but when experiences transgressed them, they evaluated themselves negatively. Echoing previous qualitative findings of the equation of breast-feeding with being a ‘good’ mother (e.g. Schmied et al. 2001), some participants persisted with breast-feeding, even when it caused them further suffering. Negative feelings were intensified primarily by a perceived inability to satisfy their infants and, secondly by a failure to enjoy motherhood. In order to manage internal conflicts, some
participants split off from their negative feelings and underwent an experience of fracturing that contributed further to their sense of occlusion.

Participants’ accounts suggested that ambivalence toward their infants reinforced their attachment to an ideal maternal image, as well as an increasingly polarised negative self-evaluation, which contributed further to feelings of guilt and depression. Whilst some enjoyed breast-feeding, which may have mitigated against more negative self-evaluation, it seemed insufficient to ameliorate depression.

Generally, participants re-emerged from occlusion when their infants’ dependency diminished. They became more able to tolerate ambivalence toward motherhood when others understood their feelings. This facilitated a move away from the idealisation of motherhood.

2.5.4 Evaluation

Critical realism indicates generalisability and inter-rater reliability in assessing the objectivity and reliability of analysis. The rationale for these procedures is based on the assumption that findings are objectively true.

The canon of research generalisability does not apply in a straightforward way to qualitative findings, because it is based upon different epistemological assumptions. Findings from this study emerged from participants’ subjective experiences, and therefore the research was not deemed reproducible. Rather, they were evaluated on the basis of their ‘transferability’ (Lincoln & Guba, 1985) and ability to explain what might happen in a contextually similar situation (Strauss & Corbin, 1998). The core category and process model developed represented an idiosyncratic interpretation of nine women’s experiences of depression. However, these concepts were developed ‘ground up’ from rich data, and as such, represented common experiences that may apply to other depressed mothers.

Hesitation in asserting the model’s transferability stemmed from the fact that participants in this study were not considered representative of the depressed population of mothers. If, as some
research suggests (e.g. Small, Brown & Lumley, 1994), postnatally depressed women are unlikely to seek professional help, clinical populations of postnatally depressed women may be unrepresentative of depressed mothers as a whole. In this study, sample size was necessarily small, selection was purposeful, and participants had received psychiatric help, and responded voluntarily to an invitation to take part in the study. Given this, participants may have represented women who felt that breast-feeding was salient to their depression. The selection procedure therefore screened out non-depressed women and possibly, depressed mothers who bottle-fed. Additional data from bottle-feeding mothers would have added value. In addition, an important question arising from the findings was how far, the process model related to non-depressed women.

Inter-rater reliability is based on the assumption that categorisation of data can be ‘discovered’ objectively (Guba and Lincoln, 1994). However, in this study, it was not assumed that different researchers would describe the derived categories in the same way. Hence, reliability was assessed in terms of ‘consistency of meaning’ (Madill et al. 2000). Consistency of analysis was tested out both in research supervision and in a qualitative method group of researchers, where peers coded samples of transcripts. Respondent validation was not sought because data underwent a process of psychological interpretation, which would not necessarily accord with individual’s experiences (Barbour, 2001).

In conducting grounded theory, data collection ends when all the categories have been theoretically saturated; that is, when no new themes emerge from the data, when each category is well developed in terms of its properties and dimensions, and the relationship between categories is well established and validated (McLeod, 2001; Strauss & Corbin, 1998). In this study, saturation of four of the five main categories was achieved after the ninth interview. However, the final category ‘Re-emerging’, was not felt to be fully saturated because the population targeted for interview were still under, or in the process of being discharged from, psychiatric care, and were therefore not considered ‘recovered’. The analysis was considered to have met the aim of developing an initial
model to understand the relationship between breast-feeding and postnatal depression and account for variation not explained by existing theory.

2.5.5 Implications for theory

The general literature on postnatal depression and breast-feeding is ambiguous. Postnatal depression clearly has a general negative effect on mother-infant interaction, may adversely affect child cognitive and emotional development (Field, 1995; Cooper & Murray, 1998), and has a specifically negative effect on breast-feeding (Galler, Harrison, Ramsey, Forde & Butler, 1999; Cooper et al. 1993). However, research also suggests that breast-feeding may facilitate more optimal mother-infant interaction (Field et al. 2002; Jones et al. 2004).

This small-scale study offered a more complex account of the relationship between postnatal depression and breast-feeding. Data illustrated that, whilst most participants recognised the benefits of breast-feeding, experiences differed widely. Some did not establish breast-feeding, because they found it difficult or did not like it. For others, breast-feeding was part of a maternal identity, which they were trying to achieve. However, when breast-feeding was not successful, they felt guilty and blameworthy. Breast-feeding experiences therefore contributed to these mothers’ feelings of depression, because they felt compelled to persist with an activity that made them feel inadequate. In contrast when successful, breast-feeding offered some mothers a sense of affirmation. The differences between what breast-feeding and infant dependency represents to individual women may account for why some depressed women emotionally benefit from breast-feeding (Mezzacappa & Katkin, 2002).

Participants’ acknowledgements of the benefits of breast-feeding attest to the success of breast-feeding promotion, yet they also challenge public rhetoric. This is because some participants seemed to pursue the ideal maternal identity through breast-feeding, at the cost of their psychological well-being.
Findings of this study therefore support research proposing positive effects of breast-feeding on the mother-infant relationship in both non-depressed and depressed women (Jones et al. 2004). This challenges the notion of depression as a straightforward impediment to breast-feeding and suggests that, although breast-feeding may contribute to depression, it may also mitigate against it.

Of interest was the relative absence of participants’ discussion on themes of sexuality and fatigue, which may have been anticipated to emerge, given their apparent salience to mothers with postnatal depression, and to well mothers (e.g. Alder & Bancroft, 1988; Thome & Alder, 1999). The formal interview process with an unknown researcher may have impeded discussion of topics that felt ‘personal’, and may partly explain the absence of participants’ discussion around sexuality. This serves as a useful reminder of the contextual constraints around the content of narratives offered by participants. However, the absence of results typically found in questionnaire based research based on symptomological conceptualisations of depression, attests to the importance of adopting qualitative approaches to understanding lived experiences from clinical populations.

Fatigue emerged within discussion of general exhaustion, but interestingly, not all participants raised this as a major facet of their depressive experiences, focusing more on feelings of an agitated depletion and frustration.

2.5.5 Implications for practice

The process model developed in this study pointed to a number of implications for clinicians.

Firstly, participants’ various breast-feeding experiences offered a warning against health professionals’ assumptions that depressed women will not be able to breast-feed. In this study, in spite of their depression, four of the nine participants found breast-feeding an affirming and reassuring activity. However, an important observation was that those who did not enjoy breast-feeding experienced high levels of difficulty, and often felt unsupported in their attempts to satisfy their infants. For these participants, difficult feeding experiences contributed to depressed mood. Depressed mothers are likely to have less confidence in their ability to nurture (Field et al. 2002).
Therefore, in early infancy, they may be more likely to cease breast-feeding when the infant appears unsatisfied and frequently hungry (DiPietro et al. 1987). This suggests that women struggling with breast-feeding, and those vulnerable to depression, may need extra support. In the absence of reassurance, they may interpret infant discomfort as evidence of their maternal inadequacy and persistence with difficult breast-feeding may contribute to negative self-evaluation.

A second related point is the possibility that breast-feeding could provide a useful intervention for some depressed women. If depressed women can establish breast-feeding, positive experiences may help to affirm their value to their infant, reduce anxiety about doing harm, and confer feelings of relative social worth. Jones et al. (2004) suggested that, breast-feeding as a clinical intervention may benefit the socio-emotional interactions of depressed mother-infant dyads and lessen negative dyadic interaction associated with postnatal depression (Field, Healy, Goldstein & Guthertz, 1990), thereby reducing the risk of later affective problems (Field, 1995). Nevertheless, as shown in this study, mothers' feelings about breast-feeding were not simply an aspect of depression that could be overridden behaviourally, but a meaningful decision, shaped by their psychological histories, internalised values and social contexts.

A third point relates to professional intervention. For some participants, receiving a diagnosis of postnatal depression was considered helpful. Several expressed reluctance to take medication for their depression and although few mothers had received psychological support, those who had valued sharing their experiences and feeling understood. In the field of perinatal mental health, professionals in general, and clinical psychologists in particular, are suitably placed to facilitate mothers’ reflection on and exploration of both positive and negative feelings toward motherhood. The process model developed in this study highlighted the salience of women’s fears of harming their infants. At one level, this could be met by reassurance and explanation of breast-fed infants’ more difficult temperament, and distinguishing this behaviour from reflections of maternal in/adequacy. From a more psychodynamic perspective, it could be understood as relating to a
projected fear of destructive impulses toward the infant. Arguably, if these feelings could be explored, normalised and contained therapeutically, depressed women have less reason to split feelings off and suffer with the guilt often associated with postnatal depression.

A fourth point relates to breast-feeding promotion. Participants communicated the detrimental effects of the polarised presentation of breast- and bottle-feeding. Reluctance to breast-feed may not simply reflect ignorance, but may reflect strong internalised beliefs about motherhood and ability. This does not mean that promotion of breast-feeding practices should be abandoned but as Murphy (1999) suggests, it is a good reason for health professionals to work with mothers’ rationales, and support their needs, rather than challenge them. Furthermore, the promotion of breast-feeding as an integral part of the social construction of a ‘good’ mother, can lead to commitment to breast-feeding, which, for some mothers, may be detrimental to their health (Schmied et al. 2001) as was indicated in the current study. In this, health professionals may be party to conveying an implicit message that commitment to breast-feeding, in spite of difficulty, contributes to being a good mother. As some mothers stated, the pressure women feel to breast-feed contributed to their negative self-evaluation when breast-feeding was unsuccessful.

2.5.6 Implications for future research

This study was exploratory and, as such, pointed to a number of questions for further study:

Firstly, validity of the process model needs to be tested on a larger population of depressed mothers. For example, using structured interviews or questionnaires about breast-feeding experiences.

Secondly, the hypothesis that breast-feeding may offer an intervention for depressed women, in conjunction with psychological support, needs to be followed up. For example, experiences of depressed women who receive psychological support in addition to breast-feeding support could be compared against those who only receive psychological support or only receive breast-feeding
support. Observations of mother-infant interactions and standardised measures of mood could be used in addition to qualitative measures of mother-infant interaction.

Thirdly, the relationship between difficult experiences of breast-feeding and depression was unclear from this study and warrants further investigation. It may be that breast-feeding difficulties contributed to depression in already vulnerable people, or that women who were vulnerable to depression were more likely to experience difficulties breast-feeding.

Fourthly, it was not clear how far the model applied to the experiences of non-depressed breast-feeding women. Qualitatively different psychological processes may be at work in depressed women. For example, depressed women may perceive breast-feeding in a specific way, which relates to their affective state; and breast-feeding may represent, or function to fulfil, particular psychological needs. Therefore, the model needs to be tested on a non-depressed population.

A further qualitative study could usefully address the reasons for women who chose not to breast-feed at all. Given the small sample size of this study, it was not clear what the reasons were for bottle-feeding, and it may have been difficult for participants to give honest answers relating to this apparent cultural taboo.

2.5.7 Summary

This chapter provided a discussion of the main findings of this study and related the findings to current literature. Implications for both theory and practice were explored and ideas for progression of this work considered.

See appendix 4.13 for details of reviewed papers.
See appendix 4.14
For further background to the researcher’s theoretical interest, see Appendix 4.10.
For the transcription procedure and conventions used, see the Addendum.
For an example of open coding, see Appendix 4.7.
For an example of memo-writing, see Appendix 4.8.
For an expanded discussion of quality criteria employed for this study, see Appendix 4.9.
For brevity, lower-level categories are described as facets of intermediate-level categories. For examples of remaining lower-level category data, see Appendix 4.11.
Denoting the notion that breast-feeding is advantageous over formula feeding (For discussion see Murphy, 1999). Original reference, Stanway and Stanway, 1978.
Formula-feeding is referred to throughout the study as bottle-feeding to emphasise the difference in method. However, some mothers bottle-fed their infants expressed breast-milk.
Further, it was not planned for in the research design, for practical and clinical ethical reasons (re-visitation may have been distressing to participants).
2.6 References


Elliott, R., Fischer, C. and Rennie, D. 1999: Evolving guidelines for publication of


Gilbert, P. 2003: Evolution, social roles, and the differences in shame and guilt. *Social*


Ingram, J., Greenwood R. and Woolridge, M. 2003: Hormonal predictors of postnatal
depression at six months in breastfeeding women. *Journal of Reproductive and Infant Psychology*, 21(1), 62-68.


*Canadian Psychology*, 40(2), 162-178.

Oakley, A. 1980: *Women Confined: Towards a Sociology of Childbirth*. Oxford: 

Marting Robertson.


*Canadian Psychology*, 43 (3), 190-194.


Virago.


Pidgeon, N. and Henwood, K. 1996: Grounded Theory: Practical implementation. In


Smith, J. 2004: Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, 1, 39-54.


Section 3

Critical Appraisal
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3.1 Overview

This chapter provides a critical evaluation of the research process. It is based on a reflective journal, written throughout the course of the research project.

3.2 Development of research project

3.2.1 Choice of research area

As part of clinical psychology training, I welcomed the opportunity to develop my general interest in mother-infant relationships, and my specific interest in early mother-infant interaction (see also Appendix 4.10). Postnatal depression is a well-researched area. However, conclusions drawn from nomothetic, quantitative studies have explanatory dominance, and one limitation of this evidence-base is that individuals' experiences can be lost. One aspect of particular interest was the psychological meaning of the relationship between postnatal depression and mother-infant interaction. Whilst some negative effects of postnatal depression on mother-infant interaction have been established (e.g. Field, 1995; Murray, Firoi-Cowley, Hooper & Cooper, 1996), mothers' constructions of their experiences may be pivotal to understanding postnatal depression in a way that can contribute further to scientific knowledge and interventions offered by mental health services (Nicolson, 1995).

Initially, I was interested in exploring the relationship between mothers' mood and their maternal behaviour by analysing video-taped interaction. Pivotal research in the field of dyadic interaction has been conducted using this analytic method (e.g. Murray, Sinclair, Cooper, Doucourneau & Turner, 1999; Field, Healy, Goldstein & Guthertz, 1990; Cohn & Tronick 1983; Stern, 1977), and video-taping has been used as a therapeutic tool with mothers, to help them understand their child's experiences (Zelenko & Benham, 2000). However, it was considered unfeasible for a doctorate in
clinical psychology study, due to practical constraints of time, available supervision and limited experience of this methodology.

An alternative choice was to focus on a specific aspect of the impact of postnatal depression on mother-child interaction. Breast-feeding represented a more specific aspect of dyadic interaction, and this related to my existing interest in psychoanalytic theory.

There is a clear dearth of literature on breast-feeding in mothers with postnatal depression. However, it has been recognised that maternal feeding patterns are affected by 'external' social factors (Palmer, 1993) as well as internal factors. Therefore, as an important aspect of mother-infant behavioural interaction, it was decided to explore depressed mothers' understandings of their experiences of breast-feeding to identify salient factors. This was posed in the research question: what is the relationship between postnatal depression and breast-feeding from depressed mothers' perspectives. It was anticipated that this approach could enhance the understanding of depressive experiences offered by quantitative research (Nicolson, 1995), by offering a psychological conceptualisation of mothers' experiences.

3.2.2 Choice of methodology

The research question clearly indicated a qualitative method of enquiry. Grounded theory was chosen for two main reasons. First, it is a structured and systematic methodology considered suitable for novice qualitative researchers (McLeod, 2001); and second, because it produces a conceptual model of human experience, which could be usefully communicated to mental health professionals (Holloway & Todres, 2003) and form a basis for more directed research.

The epistemological stance from which the study was conducted, was developed in supervisory discussions about the extent to which interview data reflected the real
world (a 'realist' approach), and the extent to which knowledge was constructed in the process of generating and analysing that data (a broadly, 'constructionist' approach, represented, for example, by Charmaz, 2006; Pidgeon & Henwood, 1997). A middle ground position was adopted, which assumed that epistemologies can be accommodated on a spectrum ranging from realism to constructivism (Madill, Jordan & Shirley, 2000). This 'critical realist' position (Guba & Lincoln, 1994) was chosen for three main reasons. Firstly, it acknowledges that the perception of knowledge is shaped partly by subjectivity and social forces (Madill et al. 2000; Guba & Lincoln, 1994), and therefore does not assume that participants' accounts represent an objective reality directly. Secondly, the research question focused on a population who were defined by, and had sought help for, clinical 'depression'. It was therefore assumed that their psychiatric diagnoses were meaningful to them, and that 'depression' was assumed to exist as a valid construct. This was considered a more validating approach to take with a potentially vulnerable population. Thirdly, the aim of the study was to produce a framework that could be used clinically, and it was considered that this would best be done by adopting the language and constructions associated with psychiatric services.

3.3 Conducting research

3.3.1 Progress and time-scale

Anticipating that recruitment could have been impeded by participants' depression, potential recruiters from specialist services for postnatally depressed women in two NHS trusts were contacted early in the research process. The recruiter at the first site was a consultant psychiatrist, who confirmed her support for the study. This enabled me to seek local research ethics committee (LREC) approval, which was obtained several months later. The recruiter from the second site was a consultant
clinical psychologist. She was able to offer provisional support but took maternity leave shortly after initial discussions. Unfortunately, this meant that she was unable to confirm her team’s participation in the project until she returned to work. In the event, recruitment could begin earlier through the first site, so delayed recruitment of candidates at the second site was not problematic.

After LREC approval to recruit from the first site was obtained and information packs were given to the recruiter, practical difficulties arose in negotiating a research contract with the relevant NHS trust. This procedure required liaison by the recruiter, whose availability became limited, and recruitment was then delayed. This represented the most difficult phase of the project, because reliance on both recruiters meant that I effectively lost control over the progress and time-scale of the project.

At that point, it appeared that recruitment of suitable candidates would have to progress through the second site alone. After some consideration, the local Research and Development Manager was approached for advice. The issue was resolved swiftly following his intervention, and the recruiter from the first site then posted information packs to several potential participants.

Contrary to the initial plan to recruit all participants directly, these first invitations reflected more of a ‘scatter-gun’ approach. Some respondents fell short of the planned selection criteria because, although they were receiving (or had recently received) follow-up support from the recruiting clinic, they had not received a diagnosis of depression within the last year. This required that their accounts were regarded as more anecdotal than those of later participants, who were chosen using theoretical sampling. However, the decision was made to include them, on the grounds of increasing sample size and diversity of data. Following this long period of anticipation, I promptly became engaged in conducting and transcribing interviews,
and carrying out a preliminary analysis of the data. Research supervision was valuable at this stage, especially in validating interpretations of data, preliminary codes and categories.

The recruiter from the second recruitment site, a consultant clinical psychologist, also acted as the project field supervisor. On her return to work, support for the project was quickly confirmed with the multi-disciplinary team. Communication about selection criteria was more effective, and subsequent participants were selected theoretically. This meant that I was able to gather a diverse range of participant experiences, to test out the developing theory. In practice, each potential participant discussed with the field supervisor represented a sufficiently different experience to warrant invitation to the study.

Main categories developed from the data were saturated after the ninth interview, which was conducted five months before the final deadline. This meant the study ran parallel to the projected time-scale, and sufficient time was available for write-up.

The sample size of nine participants was small, although their heterogeneous experiences provided a rich source of data, which covered a range of breast-feeding experiences. All participants were white, British women, of similar age. While this relatively homogenous profile was typical of the population accessing the two recruiting mental health services, lack of cultural diversity was recognised as a limitation of data used in this study. In addition to a more culturally diverse sample, I would have liked to interview more women who had not breast-fed. Women who bottle-fed were more difficult to recruit, perhaps because the study was ostensibly about breast-feeding experiences. On reflection, if the title of the project (stated in invitation letters) had referred to feeding experiences in general, more women with depression who had bottle-fed may have volunteered to participate.
3.3.2 Interviewing

Interviewing raised several interesting issues. First, whilst the research question used the psychiatric construct of postnatal depression, I did not want to impose a construction of depression experienced by women as pathological (Crowley, 1999) in the act of asking research questions. Therefore, a cautious style of questioning was employed in an effort to explicate participants' meaningful constructions of their experiences. As examples, participants were reminded that I was interested in their experiences, as part of the pre-amble to the interview. I also endeavoured to maintain an open stance to the meanings participants' attributed to depression.

Second, I assumed that both interviewer and interviewee were active in creating and interpreting meaning (Miller & Glassner, 1997), but was also aware that participants' depression might effect the flow and content of interviews adversely. Therefore, the interview schedule was constructed around open questions, to allow the interview to be shaped by and follow each respondent's narrative (Smith, 1999). I was also mindful of participants' possible assumptions about me as a health professional, perhaps allied with promotion of breast-feeding, and with those in psychiatric services from whom they had received input.

Another reflection on the interviewing process was that the topic of conversation was clearly emotionally difficult for all participants. Whist expected, this raised my awareness of the tension between researcher and clinician roles in conducting clinical research. I attempted to facilitate meaningful conversations whilst minimising distress, by carefully monitoring and shaping questions and, at times, offering containing, rather than exploratory, responses.

In the event, some participants considered themselves to be well at interview, while others described themselves as depressed and inevitably, this shaped their
narratives. I monitored observable signs and verbal responses indicative of distress throughout the interviews, and shaped questions accordingly. For example, a potential area of interest was participants' guilt about the effect of their depression on their infants. I asked participants about this, but on occasion, my impression was that pursuing that line of questioning further would have been interpreted by the participant as confirmation of a reality, that would have proved unnecessarily distressing. A related point is that participants' perceptions of me as a clinician may have explained why I often perceived their responses as guarded, or defensive and perhaps shaped by their attempts to present themselves as competent mothers.

Another issue was the fact that some participants asked whether I had children, and I responded that I had not. My impression was that those participants took this into account and attempted to describe their experiences of motherhood more clearly. If so, then one possibility was that participants' awareness of me as a woman without children could have been advantageous, in that participants may have felt more able to talk about their difficult experiences of motherhood and other mothers' judgements relating to feeding practice. In addition, I did not have had to 'bracket' my own experiences to the same degree as a mother would, when making interpretations of participants' experiences of motherhood. Alternatively, a potential disadvantage was that familiarity with experiences of infant feeding could have enabled me to focus more precisely on issues meaningful to many mothers, and this may have facilitated greater engagement with the interviewee.

Contextual constraints on the interviewing process, described above, meant that theoretical questioning could not always be pursued directly. For example, it felt important for most participants to communicate their stories before I focused in on particular areas of interest to test out emerging themes. A crucial observation was that
women who had chosen to bottle-feed seemed, perhaps understandably, reluctant to talk about their experiences of breast-feeding and reasons for bottle-feeding. Instead, these participants’ accounts remained focused on their experiences of depression. To an extent, this tendency was reflected in all participants’ accounts, and reflected a difficulty in maintaining an interview focus on breast-feeding, when women seemed to want to talk more broadly about their experiences of postnatal depression. This was a focus of discussion in supervision and understood, as the interviews progressed, as important in communicating the broader context of depressive and feeding experiences.

One practical difficulty that was envisaged, was the presence of others at interview. When interviews were arranged, the advantages of a private and quiet setting were suggested. In the event, however, some interviews were conducted in the presence of infants, children and other family members. It was understood that some participants had chosen that context as more comfortable for them. However, extraneous noise and interruptions sometimes interfered with the flow and content of interviews.

3.4 Analysis and write-up

In accordance with grounded theory methodology, data collection and analysis were conducted in parallel (Strauss & Corbin, 1998). Initially, analysis followed an adaptation of the critical realist approach advocated by Strauss and Corbin (1998), but was later influenced by constructionist revisions (e.g. Pidgeon & Henwood, 1997; Charmaz, 2006). This was because the initial approach was considered too constraining of the data (Stern, 1994; Rennie, 1998), and failed to acknowledge the role of participants’ social contexts and social constructions of motherhood sufficiently (Rennie, 1998). In order to avoid a ‘thin’ and incomplete description of
the data, I shifted to a more constructionist epistemological position in analysis, which afforded greater consideration of the role of external forces on participants’ narratives. This was considered an attempt to be true to the data and develop a model that was potentially useful (Stern, 1994), rather than a form of what Cutliffe (2000) has termed ‘muddling methods’.

During development of the process model, a combination of narrative and diagrammatic strategies were used. For example, memo-writing facilitated a ‘ground-up’ exploration of themes, including how they related to other themes and new data, whilst diagrams were developed to simultaneously, conceptualise relationships between the themes visually. In the early stages, diagrams remained quite simple, and they became increasingly sophisticated as analysis proceeded. For an example, see Figure 1.

![Figure 1. Simplistic initial model of emerging data](image)

The final process model was developed after several stages of revision. This was to ensure that all categories related in a meaningful way, capturing the loosely chronological process (of becoming depressed, experiencing breast-feeding and emerging from difficulties) that participants had described. At interview, participants tended to describe the process of becoming depressed and emergence from it paralleled their infants’ growing independence. This linearity was considered a conceptually relevant aspect of participants’ experiences and was therefore incorporated into the process model.
Initial models developed during early stages of the analysis, depicted a general effect of depression in mothers' interactions with their infants. This effect was represented as a negative cycle of perceiving pressure, responding to pressures, and a higher-order self-surveying process, which generally led to negative self-evaluation. Breast-feeding, as one aspect of interaction, clearly mirrored this broader cycle, yet represented an exception to it; this was because breast-feeding led to less negative self-evaluations. Although conceptually similar to the final model, in the initial stages of analysis, breast-feeding appeared to be an adjunct to the process, rather than a central aspect of it. In order to enhance the centrality of breast-feeding in accordance with the research question, I focused on the role of breast-feeding within the wider process of participants' experiences of postnatal depression. This refinement meant that a proportion of data about participants' experiences of postnatal depression (particularly from mothers who did not breast-feed) was not incorporated into the final model. In supervisory discussions, considered judgements were made about which additional data needed to be included in the final model, in order to represent the experiences of breast-feeding within the context of postnatal depression. Decisions to include data were made primarily on the basis of their relevance to a psychological understanding of participants' experiences, and the meaning that participants' attributed to relevant aspects of their accounts. To illustrate, although antidepressant medication was mentioned by all participants, it did not emerge as a pivotal aspect of their experiences of breast-feeding. Therefore, it was included as an intermediate category in the analysis, to represent its relative importance in the context of participants' experiences.

Focused coding during the analysis highlighted a tension, between conceptualising participants' general experiences and remaining 'grounded' in their idiosyncratic...
accounts. At this stage, discussions in supervision provided useful parameters for revising themes and moving to a more abstracted level of understanding whilst remaining grounded in the data. This is known as the 'flip-flop' technique (Strauss & Corbin, 1998), in which concepts are examined from different perspectives and at different levels of abstraction, to identify significant themes and enhance researcher sensitivity to the data. As an example, the category ‘Overwhelming responsibility’ emerged from the amalgamation of two initial main categories- ‘Feeling responsible’ and ‘Experiencing pressure’- which had denoted the impact of the infant on the mother and her relation with the outside world separately. In that case, the purpose of merging categories was to represent that the incoming pressure from the baby and the social world were experienced simultaneously.

### 3.4.1 Supervision

Regular meetings were held with both academic and field supervisors throughout the study and their input was invaluable in guiding the research process. For example, the field supervisor’s clinical expertise in the field of postnatal depression and her knowledge of the local populations from where participants were recruited, added a culturally, contextualised view of the data, as well as psychological insights, and a forum for testing the validity of emerging interpretations. Academic supervision ensured that the emerging theory remained grounded in the data, and encouraged reflection and explication of the developing model. Discussions about the latter, and supervisors’ encouragement for the project, its potential utility and later dissemination, helped to maintain my motivation and interest in the project.

### 3.4.2 Reflexivity

The idea that grounded theory analysis can be a purely inductive procedure has been challenged (e.g. Dey, 1993; Silverman, 1993), and social constructionist
critiques have highlighted that the researcher inevitably shapes the inquiry through the experience and meaning they bring to it (Henwood & Pidgeon, 1992). Reflexivity refers to the researcher's observations of the way they conducted their research and informs the reader about the extent to which the researcher's stance and assumptions influenced the analytic process (Charmaz, 2006). Reflexivity guards against relativism, and helps validate findings, by rendering the process of analysis more transparent for the reader and objectifying researchers' subjectivity (Cutliffe, 2000). Researchers attempt to 'bracket' their own values (Backman & Kyngas, 1999) by engaging reflectively with the data, in order to represent the data more accurately. To facilitate this, I documented thoughts and decisions relating to the research process in a reflective journal. This contributed to a 'paper trail', also including transcripts, examples of coding, and memos, which opened the research process to wider evaluation (Lincoln & Guba, 1985; Henwood & Pidgeon, 1992).

Important influences on my interest in the research question included an interest in psychodynamic and feminist theories. Concepts relating to psychodynamic research, such as ambivalence, infiltrated and shaped my understanding of the data and the process model that was eventually developed. In addition, throughout the process of analysis, I came to realise the powerful influence of cultural forces on participants' experiences of motherhood, including the often contradictory constructions inherent in the concept of motherhood, which remain pervasive in contemporary British society.

3.5 Development of research knowledge

Six main learning points emerged from this study. Firstly, complications in recruiting to the study and negotiating the research contract highlighted the importance of working alongside individuals who share a professional understanding,
and appreciate and support the researcher's interest. Since it is not usually possible to
directly recruit from groups considered vulnerable, the researcher is necessarily
dependent on others' support. The doctorate in clinical psychology research project is
constrained by rigid time parameters, and it was therefore important that others
involved in the study were aware of the need to balance constraints and limitations
with the goals. If I were to conduct further related research, I would seek out
clinicians who had a supportive interest in conducting research into the psychological
aspects of postnatal depression, rather than attempt to conduct a project as an
independent researcher.

Secondly, the role of reflexivity, understood mainly through its application to
therapeutic endeavours prior to the study, was appreciated as central to the process of
conducting qualitative research. I became more aware of the influence of my
theoretical interests during the analysis. It was therefore important to be explicit about
the origin of these ideas, and to reflect upon how my own construction of participants'
accounts influenced the shape of the interviews and development of the model and
core category.

Thirdly, my basic assumptions about the respective roles of internal and external
worlds on psychological well being and distress were challenged by the findings of
the study. Of particular interest was the suggestion that experiences of breast-feeding
were interpreted differently, according to mothers' differing psychological needs.
Although presented in summary form here, one hypothesis is that women who have a
fundamental fear of fragmentation in response to others' intrusion, may respond
differently to the relationship of a dependent than women who fear fragmentation
through abandonment and rejection. For the latter group, the dependent infant and
breast-feeding may go some way to nurturing their psychological needs and for the
former, it may represent a threat. However, individual psychological differences and
mothers’ internal worlds were insufficient in explaining participants’ distress, and the
data clearly illustrated the role of powerful external influences, such as societal
messages about breast-feeding and motherhood.

Fourthly, the study highlighted the constraints of time on research. A number of
potentially interesting avenues could have been pursued further in this study, (such as
mothers’ broader experiences of relating to others in the context of postnatal
depression), but time constraints meant they would have to be addressed in
subsequent projects.

A fifth points related to my development as a researcher over the course of the
project. Specifically, my interviewing style improved as the importance of structuring
the interview to meet theoretical requirements grew. Although it was considered
useful that initial interviews were relatively unstructured in order to facilitate the
generation of data meaningful to participants, the ability to impose structure and
direct interviews to areas of theoretical interest became clearer over time.

The sixth point related to what I learned as a clinician. The most helpful lesson
was the understanding of depressive experiences offered in participants’ accounts.
This provided a more contextualised and ‘human’ understanding of depression in
general and postnatal depression in particular. I anticipate that this will add to my
ability to respond to people presenting with such distress in clinical settings.
3.6 References


Appendices

4.1. Notes for contributors to Qualitative Research in Psychology

Qualitative Research in Psychology will publish the following types of paper:

- theoretical papers that address conceptual issues underlying qualitative research, that integrate findings from qualitative research on a substantive topic in psychology, that explore the novel contribution of qualitative research to a topic of psychological interest, or that contribute to debates concerning qualitative research across the disciplines but with special significance for psychology
- empirical papers that report psychological research using qualitative methods and techniques, those that illustrate qualitative methodology in an exemplary manner, or that use a qualitative approach in unusual or innovative ways

All papers are refereed by, and must be to the satisfaction of, at least two authorities in the topic. All material submitted for publication is assumed to be exclusively for Qualitative Research in Psychology, and not to have been submitted for publication elsewhere. All authors must assign copyright to Arnold (by completing the copyright assignment form). Priority and time of publication are decided by the editors, who maintain the customary right to edit material accepted for publication if necessary.

Article presentation
Manuscripts should be double-spaced throughout, especially the references. Pages should be numbered in order.
The following items must be provided in the order given:
1) Title Page
Authors and affiliations
Authors should include their full name and the establishment where the work was carried out (if the author has left this establishment his/her present address should be given as a footnote).
For papers with several contributors, the order of authorship should be made clear and the corresponding author (to whom proofs and offprints will be sent) named with their telephone/fax/email contact information listed.
Abstract
Please provide an abstract of approximately 150 words. This should be readable
Appendices

without reference to the article and should indicate the scope of the contribution, including the main conclusions and essential original content. This is not needed for observations or commentaries.

Keywords
Please provide at least 5-10 key words.

About the author
Please provide a brief biography to appear at the end of your paper.

2) Text
Subheadings should appear on separate lines. The use of more than three levels of heading should be avoided. Format as follows:

1 Heading
1.1 Subheading
1.1.1 Subsubheading

Footnotes should be avoided. If necessary they should be supplied as end notes before the references. Do not use programming to insert these.

3) References
The Harvard style of references should be used. The reference is referred to in the text by the author and date (Smith, 1997) and then listed in alphabetical order at the end of the article.

4) Acknowledgements
Authors should acknowledge any financial or practical assistance.

5) Tables
These should be provided on a separate page at the end of the paper and be numbered in sequence. Each table should have a title stating concisely the nature of information given. Units should be in brackets at the head of columns. The same information should not be included in both tables and figures.

6) Figure captions
These should be provided together on a page following the tables.

7) Figures
Figures should ideally be sized to reproduce at the same size. However, the typesetter can manipulate sizing where necessary.

All figures should be numbered consecutively in the order in which they are referred to in the text. Qualifications (A), (B) etc can only be used when the separate illustrations can be grouped together with one caption.
Appendices

Please provide figures at the end of your paper on a separate page for each figure.
Once accepted you will be required to provide a best quality electronic file for each figure, preferably in either TIFF, or EPS format.

Style

General:
Abbreviations should be spelled out when first used in the text. Full stops should be used in lower case abbreviations (e.g., i.e.,) but not for capitals (SAS, ANOVA).
Spelling can be either UK or US English but must be consistent throughout the paper.

Mathematical:
Numbers below 10 should be written out in the text unless used in conjunction with units (e.g., three apples, 4 kg).
Use spaces (not commas) within numbers (e.g., 10 000, 0.125 275).
Full points (not commas) should be used for decimals. For numbers less than one, a nought should be inserted before the decimal point (e.g., 0.125 275).
SI units must be used. English units may appear in parenthesis following the SI units.

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Proofs are sent to the corresponding author by pdf in an email to check for typographical errors. Modifications cannot be incorporated at this stage without incurring heavy costs hence the original text cannot be altered.

Offprints

The corresponding author only will be supplied with 25 offprints of his/her article. Additional offprints can be ordered at page proof stage.
Miss Ellen F. Homewood  
Trainee Clinical Psychologist  
University of Leicester  
104 Regent Road  
Leicester  
LE1 7LT

Dear Ellen

Re: A qualitative analysis of breast-feeding experience in women who have received a diagnosis of postnatal depression  
(05/Q2501/30)

Please find enclosed a copy of correspondence from the Leicestershire Local Research Ethics Committee (Committee One), confirming that following the submission of your amended documentation, the project has received formal ethical approval.

Under the Research Governance Policy of the Trust, confirmation of appropriate ethical approval is a necessary prerequisite for obtaining Trust Management Approval. I am happy to confirm therefore that Leicestershire Partnership NHS Trust formally approves the study to proceed, subject to the following conditions:

- You abide by the conditions imposed by the REC
- All correspondence with the REC is routed through the Trust Research Office (including the obligatory progress/final report as detailed).
- The agreed protocol is adhered to.
- A summary of any findings is reported to the Trust/Clinical Service/Participants at the conclusion of the study.
- Any changes in the protocol, timescale etc. are notified to the R&D Office
- At the conclusion of the study, a final report form is completed.
- A copy of any subsequent publication is lodged with the Trust.
- That paperwork related to the study may be subject to audit at any time (this requires maintenance of a site file).

This letter also serves as confirmation that as Principal Investigator you are covered by the terms of the Trust's research indemnity for the duration of the project. Please sign and return the attached confirmation sheet without which Trust approval will be rescinded.

With my best wishes on the success of your study.

Regards,

Dr. Dave Clarke  
Associate Director (R&D)
23 May 2005

Dear Ellen

RE: A qualitative analysis of breast-feeding experience in women who have received a diagnosis of postnatal depression.

I am writing to inform you that the Derbyshire Mental Health Trust Clinical Research Committee has reviewed the above research protocol.

As part of the dissemination process within the Trust your protocol has been sent to the Adult Clinical Network. Once you have completed the study we would appreciate a copy of your findings.

If you require any further information please do not hesitate to contact me.

Yours sincerely

Lesley Legg
Research Coordinator

Trust Headquarters, Kingsway Hospital, Derby DE22 3LZ
Tel: (01332) 362221 Fax: (01332) 331254
Chief Executive: Mike Shewan
Chairman: Judith Forrest
Appendices

4.3 Diagram of data collection procedure

Mothers given letters of Introduction and Information Sheet by participating agencies.

Follow-up telephone or mail contact by researcher to mothers who have returned the slip to express interest in participation. Interview date arranged. Consent forms sent to mothers for them to read.

Prior to the interview commencing, participants will be asked to re-read the consent form sent to them and sign it with the researcher.

Interviews conducted and recorded.

Optional 'check-up' telephone calls to participants, 2 weeks after interviews.

Interviews transcribed. Broad themes identified.

Data coding and preliminary analysis.

Themes analysed using an iterative process and written up in narrative form.

Narrative report of findings submitted as thesis.

Agencies approached by researcher to recruit further participants on the basis of theoretical sampling. Selection informed by themes identified in interviews.

Findings disseminated locally and nationally.
Appendices

4.4 Participant invitation letter

DEAR PARTICIPANT,

My name is Ellen Homewood and I am training to become a doctor in clinical psychology at Leicester University. I am carrying out a research project as part of my post-graduate degree training, and am writing to ask if you would take part in this project.

I would like to talk to mothers who have received a diagnosis of postnatal depression. I am interested to find out about their experiences and thoughts about breast-feeding, in order to develop a greater understanding of experiences of mothers with postnatal depression. It does not matter if you do or do not breast-feed; I am interested only in what breast-feeding means to you.

Taking part in the study would involve meeting once with me for about one hour, to discuss your experiences. The interviews would be audio-taped, and can take place at your home, or at a room in a local clinic, at a time convenient to you. The interview and the information you share at interview will remain anonymous. Involvement in the research would not affect any treatment you receive from the National Health Service.

If you would like to be involved, please complete the tear off slip at the end of this letter. You can return this to me in the stamped addressed envelope provided.

If you require further information about the study you can contact me by leaving a message with the university secretary, on this telephone number 0116 223 1648, and I will return your call.

Thank you very much for your time. I look forward to hearing from you.

Tear off slip

My name is:__________________________________________________________

I am happy for Ellen Homewood, Trainee Clinical Psychologist, to contact me at this address/ telephone number to discuss the research project.

Your postal address:__________________________________________________

Your telephone number:______________________________________________

I understand that this does not obligate me to take part in the research and should I wish to withdraw I am free to do so at any time.

Signed ............................................................................................................

PLEASE RETURN SLIPS WITHIN 4 WEEKS OF RECEIVING THIS LETTER
Appendices

4.5 Participant information sheet
Version 2: 23/03/2005

Title of Study:
'A qualitative analysis of postnatally depressed women's experiences of breastfeeding'.

Chief Investigator:
Ellen Homewood, Trainee clinical psychologist.

Contact details of Chief investigator:
University of Leicester, School of Psychology, Clinical Section, 104, Regent Rd, Leicester, Telephone: 0116 2231648.

Please take time to read the following information carefully, and ask if there is anything that is not clear, or if you would like more information.

1. What is the purpose of the study?
The purpose of the study is to understand how women who have been given a diagnosis of postnatal depression think about breast-feeding. The study is based on women's own accounts of their experiences, rather than the opinions of health professionals.

This information would be useful for health professionals to increase their understanding of postnatal depression, and the related difficulties that these women experience. The results of the study would help health professionals, including psychologists, to meet the needs of women with postnatal depression.

2. What will be involved if I agree to take part in the study?
The investigator will contact you to arrange a convenient time for the interview to take place. The investigator is interested in talking to you about your experiences of postnatal depression and breast-feeding. You will be asked to talk about your views as a mother and about any related difficulties and problems that you have experienced. The interview will be audio-taped to ensure no information is forgotten, and the investigator may take notes throughout the meeting. The meeting would last for approximately one hour. You can bring along a member of your family, or a friend for support, if you feel that would be helpful.

Not everyone who agrees to participate in the study will definitely be approached by the researcher for interview. This is because the researcher may not have the resources to interview all the women who express an interest.

3. Will the information obtained in the study be confidential?
At the beginning of the interview, you will be asked to sign a form consenting to our conversation being audio-taped. All the information you share with me will be kept strictly confidential during the course of the research. When the interview is written up, information that could be used to identify you, such as your name or address, will be taken out. It will be recorded in your medical records that you have been approached to take part in the study. The investigator would have a duty to break confidentiality if she became concerned about a risk of harm to yourself or to others.
Appendices

4. Who is taking part?
All participants will have received a diagnosis of postnatal depression from a Psychiatrist. Between 8 and 10 women will be taking part.

5. What are the possible disadvantages and risks of taking part?
It is possible that talking about some of the experiences may be upsetting. If you become distressed, you can chose to stop the interview. If you have found the interview particularly distressing and feel the need to talk to someone about the issues raised, you will be able to make an appointment for assessment at the Perinatal Screening Clinic.

6. What if I am harmed by the study?
Psychological research is covered for mishaps in the same way as for patients undergoing treatment in the National Health Service (NHS) i.e. compensation is only available if negligence occurs.

7. Who is organising and funding the research?
The study has been organised by Ellen Homewood, a trainee clinical psychologist at the University of Leicester, employed by the Leicestershire Partnership NHS trust, who are funding the research. Clinically relevant research is a requirement of the training for NHS clinical psychologists.

8. What happens after the interview?
The information taken from interviews will be analysed and written up as research document and submitted to the University of Leicester. The interviews will be anonymised, by taking out anything that could be used to identify you, and the content of the interviews will be treated as confidential. The researcher may also share the anonymised findings of this research with the participating organisations. You can request a copy of your interview, either on audio-cassette or a copy of the typed transcript. A summary of the main results will also be made available to participants who request it.

9. Do I have to take part?
You do not have to take part if you do not wish to do so. If you do decide to take part, you will be asked to re-read this information sheet, and you will be asked to sign a consent form. If, at any point, you wish to withdraw from the study, you may do so without justifying your decision and your future treatment will not be affected.

10. How do I get further details?
If you would like to discuss this study further you can leave a message for the investigator, Ellen Homewood, on 0116 2231648, and I will return your call.

Thank you for taking the time to read this information sheet.
Appendices

4.6 Example of interview schedule

Introduction
• Outline of research project and its purpose
• Consent and confidentiality
• Structure of interview

Background information sheet
• Age, nationality, age of infant(s), domestic arrangements, onset of depression, diagnosis of depression, employment status.

Motherhood
• Can you tell me about your experiences of motherhood so far?
• How do your experiences of motherhood fit with your expectations?
• How do you see yourself as a mother?

Breast-feeding
• Can you tell me about how you fed/feed your children?
• What were those experiences like?
• How did you come to breast/bottle feed?

Postnatal depression
• How did you come to be diagnosed with postnatal depression?
• How were you feeling at that time?
• What happened after the diagnosis?
• How did you understand how you were feeling at the time?
• Did depression affect what you did and what you didn’t do? How?
• Did the depression affect the people around you?
• How did you cope with the feelings?

Breast-feeding and postnatal depression
• How did the depression affect your experiences of being with your baby?
• How did the depression affect your experiences of feeding?
• How did feeding affect your experiences of depression?

General Probes
• Could you tell me some more about that?
• How does that make you feel?
• What does that mean to you?
• How do you make sense of that?

Ending
• Review consent and state will send copy of consent form to them.
• Provide de-brief, including information on access to support if necessary, procedure for analysis, future contact.
• Offer two-week follow-up telephone call to participants.
Appendices

4.7 Sample of open coding procedure

76 E: Right, as a mother?

77 D: As a mother, as anything.

78 E: And your thoughts about breast-feeding, you said you'd decided before your first one. What were your thoughts going into your second pregnancy?

80 D: That I wanted to try again. I was, I was much better and / hadn't had to go on medication this time and I was really wanting to avoid that because I thought, well / if it's the medication then it'll be alright if I'm not on the medication.

82 But, I / was sort of, open-minded. I wanted, I still wanted to breast-feed him / I wanted to have a different experience. It wasn't a different sort of like, I mean, I changed hospitals partly because the memory of the other hospital took over although I stayed under the same Mother and Baby Unit. That should make life difficult! ((Dina laughs))

87 Um, and J was born and he was also losing a lot of weight / I'm not entirely sure how I did it / but he was feeding the whole time. People think I exaggerate but he wasn't off for more than twenty minutes at a time for two weeks and I was getting so frustrated because I had tried everybody and anybody to help and they all said, well check the fix. It's not the fix. He was feeding for so long that if it had been the fix I would have been in agony. Because it was my second. I knew a bit more about that and I'd found out that, eventually, after a lot of to-ing and fro-ing / I was still trying to exclusively breast-feed / but ( ) just so I could have an hour or two to sleep I saw a breast-feeding advisor at / and said he got a dis-coordinated suck, he can't actually suck well enough to do it / It runs in families, especially with boys.
So what was that like, having that piece of information?

That piece of information changed everything. It brought me out of the depression that I was in. Mean it was mild, but it was still there, because it was suddenly not my fault. It was suddenly not my fault that I couldn't breastfeed and it was suddenly not my fault that I couldn't breastfeed D either because the pattern was the same there. She said she usually sees it when they are not gaining weight at all. Mine did a little bit but that's because they were being fed for so long, which really wasn't fair on my elder boy, which is why I'd been so desperate to find an answer because, I mean, he'd been brilliant to be quite honest. He was ever so good, but it can't have been any fun for him.

What were the concerns about it not being fair for him? Well the fact that I was sitting there with plugged in so much of the time I mean I had caesareans both times and I mean a couple of weeks after the second one, I was in a park in [ ] I'd got J plugged in, I was lifting D onto the swing with my other hand I was thinking, I'm sure I'm not supposed to be doing this. ([Dina speaks to J]) Yes, we weren't we?

Going back to when you were thinking about breast-feeding, what did other kind of significant people in your life think about that decision that you made?

Um, my husband, R, he was supportive and except when he saw the effect it was having on me being so miserable and so, but he understood, but it was hard for him because he couldn't do anything you know, he couldn't suddenly go and feed them or anything. No one else really expressed too much um, interest, knowledge or anything. I'm not sure that they particularly knew if I never told any of my family I was suffering from depression. Point of change & escape? Mood lift Being relieved of responsibility, blame? Idea of responsibility to BF difficult re-interpreting post difficulties Cost/sacrifice of continuous BF = unfair Sharing self as mother// deep sense for explanation Suffering of older child Physical unavailability // hearing multiple needs Questioning (Scientific) behaviour?
4.8 Example of memo-writing

**CARD 45**

**Concept title Possessing infant**

**Reference/s**

<table>
<thead>
<tr>
<th>Reference</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>LB.P4</td>
<td>I couldn’t let her out of my sight.</td>
</tr>
<tr>
<td>LB.P13</td>
<td>...husband was being pushed out and I wasn’t allowing him to do anything.</td>
</tr>
<tr>
<td>LB.P31</td>
<td>I miss it dreadfully when I stop BF and I felt as if I’d had something taken away from me, like there was a very unique bond that nobody could have. I felt very much like he’s my baby and only I can look after him, I can feed him and we’d got this incredible connection and I think that’s what bonds you together. When you know anyone can feed him its like well…whatever.</td>
</tr>
<tr>
<td>LB.P52.</td>
<td>The end of time with baby when stopped BF, he wasn’t mine anymore</td>
</tr>
<tr>
<td>LB.P53</td>
<td>I don’t think there’s anything wrong with that feeling of the baby being all yours. You’re the one that’s done all the hard work for it. There should be a time when you feel that the baby is yours.</td>
</tr>
<tr>
<td>LB.P52.</td>
<td>It was the end of my time with my baby, he wasn’t mine anymore</td>
</tr>
<tr>
<td>CM.P7</td>
<td>He never went anywhere without me it was we would just be together because as I say, he’s mine.</td>
</tr>
<tr>
<td>NP.P15</td>
<td>I can close the door when I put her to bed, and it is as if I didn’t even have her.</td>
</tr>
<tr>
<td>VJ.P7</td>
<td>I was quite worried (about returning to work) thinking I hope I’m OK to got back. Worried about not wanting to leave him and just want to be at home with him and wouldn’t feel like I wanted anyone else to look after him</td>
</tr>
<tr>
<td>JN.P3</td>
<td>The birth, I don’t think was that bad really but it was afterwards that I just felt so ill and that he wasn’t mine.</td>
</tr>
</tbody>
</table>

**Memo:**

There is great diversity within this category. LB in particular describes her powerful feelings of needing the infant to be close to her. This ‘possessiveness’ is reflected by CM and VJ. Even their husbands were excluded from the relationship. This may indicate a concern or anxiety about harm coming to the infant and the sense that the mother needs to protect it. These participants certainly describe other experiences of anxiety in relation to care-giving. It could also be understood as an ‘obsessive’ aspect of depression that has been described elsewhere. In both cases, it may reflect mothers’ attempts to regain control over a world that feels dangerous. A dichotomous point of view, perhaps reflecting a different form of depression is voiced by NP and JN, who both describe feeling that their infants did not belong to them. These comments reflect a much more detached experience of the infant, quite different from that of the other women.

The difference between these experiences needs flushing out in greater detail and may need separating into different categories representing different aspects of attachment to the infants and could be explored in terms of wider anxieties about harm too. It would be useful to explore how feelings of possession to the infant changed over the course of the depression.

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Appendices

4.9 Quality criteria

Unlike scientific research based on positivist paradigms, criteria for assessing qualitative research are not 'objective' but depend on the researcher's particular adaptation of the methodology. However, growing use of qualitative methods in psychology (O'Neill, 1999; Rennie, Watson & Monterio, 1999) has been paralleled by concerns about the rigour with which studies are conducted (Elliot et al. 1999). This points to the need for quality standards that validate findings independently of the researcher. The quality criteria used in the design of this study were based on 'evolving guidelines' of Elliot and colleagues (1999). Yardley's (2000) framework was also drawn upon.

1 Owning one's perspective

The first measure refers to the assumption that the qualitative researcher cannot speak from a position of objectivity (Dey, 1993; Silverman, 1993) and that findings are influenced, at least in part, by the researcher's values and preconceived ideas. Therefore, the researcher's position must be owned as part of the fabric that constitutes the understanding of the data. The researcher of this study attempted to ' bracket' (Elliot et al. 1999) preconceived influences in order to achieve an uncontaminated understanding of the data. This was done by using a reflexive journal (Lincoln & Guba, 1985) to document the research process, and explicate implicit assumptions. Box 1 contains an extract of the researcher's journal. The researcher also completed a reflective set of questions after each interview.
Thoughts from interview number X:

She talked a great deal about physical complications... was this causal? It certainly
seems to fit with other mothers’ narratives... or is it a psychosomatic tendency... i.e.
emotional difficulties are manifest in physical ones. Noticeably she talked very little
of emotional connection with her children. This may be a theme to test out further.
Breast-feeding was a duty. Perhaps depression got in the way of feeling emotional
about it. She also alluded to the relationship with her mother and I wonder if this is
significant, as many participants have mentioned whether their mother breast-fed or
not. Lots of self-esteem issues and again, the role of father was mentioned in (lack of)
understanding and being supportive.

Box 1. Excerpt from reflexive journal

To facilitate sensitivity to context (Yardley, 2000) the influence of participants’
socio-cultural contexts on their accounts were considered through supervisory
discussions with the field supervisor, who was clinically familiar with the population.
The possible influence of the researcher’s personal, theoretical and epistemological
orientations were also discussed in supervision (see Appendix 4.10).

2 Situating the sample

This measure refers to the importance of providing sufficient information about
the participants in order that readers can understand the contextual parameters of the
data and consider who else the findings may be relevant to. Demographics are shown
in Table 1.

3 Grounding in examples

Elliot et al. (1999) emphasised the need for researchers to offer examples of ‘raw’
data to illustrate the analytic process and to facilitate understanding of the analysis. It
also allows readers to assess the goodness of ‘fit’ between data and theory, which is
considered a central aspect of grounded theory. In the interests of transparency, the
researcher documented each phase of analysis so that decisions around coding and
interpretation were open to scrutiny, adding to the intellectual integrity of the
research. Copies of transcripts are available for perusal in addition to an example of open coding (Appendix 4.7) Finally, excerpts from transcripts are referenced in the analysis section and Appendix 4.11, to illustrate the process model.

4 Providing credibility checks

A fourth element of evaluation is assessing the credibility of the analytic process. Elliot et al. (1999) recommend procedures including 'respondant validation' in which the researcher verifies their interpretation of the data with participants. This was not employed for two reasons. Firstly, further contact with participants to re-visit the difficult experiences they had described was considered potentially distressing. Secondly, the researcher did not anticipate that their 'psychological' interpretation of the data would necessarily fit with each participant's experiences (Barbour, 2000). Instead, the researcher sought the views of clinical and academic supervisors who offered confirmation that the researcher's understanding fitted with the data.

Other checks of credibility are integral to the methodology. An inclusive approach to data was employed in that all data considered relevant to the research question was incorporated into the analysis. In addition, constant comparison was used to check the developing conceptualisation of data with each other piece of data so that emerging categories and themes related closely to the original accounts.

5 Coherence

Producing a meaningful and integrated account of the data is the aim of grounded theory methodology. This is achieved by developing a hierarchy of increasingly abstracted themes that pivot around a core category (Strauss & Corbin, 1998) and are represented in a process model. The purpose of this study was to create a conceptualisation of participants’ experiences that was coherent and meaningful. The
researcher described a ‘fit’ between the phenomenon under scrutiny and the approach used to investigate it.

6 Accomplishing general versus specific tasks

Findings should be able to answer questions about participants’ specific experiences and, at the same time, explain how far the findings can be generalised. The highest possible level of saturation was reached in all main categories (except re-emergence, for reasons explained in the main text), confirming the rigour of the findings.

7 Resonating with readers

The final quality measure refers to the extent to which the findings make sense to its audience and offers something useful (Yardley, 2000). Since this study investigated experiences of a clinical population, it potentially offers useful links to clinical practice. The implications of the study are explored in the discussion chapter.
4.10 Theoretical and professional orientation of the researcher

The researcher was a female trainee clinical psychologist in the final year of doctoral training. The researcher held a longstanding interest in mother-infant relationships and explored this initially in her undergraduate master’s dissertation in the ‘communicative musicality’ of mother-infant interaction at the University of Edinburgh. The researcher’s developing interest in the psychodynamic theory led to a curiosity about the importance of early communication and the mother-infant relationship on the infant’s developing psychological well-being. The researcher was particularly interested in exploring the meaning of early relationships and why they might be distressing to both mother and infant. Breast-feeding represented an important exchange between mother and infant, but one that is imbued with social as well as personal meaning for women. On realising the dearth of psychological research in the relationship between postnatal depression and breast-feeding, the researcher felt it important to explore this area in order to facilitate understanding of the psychological meaning of these experiences. At the time of the study, the researcher had little experience of conducting qualitative research, and had no children of her own.
4.11 Transcript excerpts

For brevity, lower-order categories are described as facets of the intermediate-level categories in the analysis section. Data given here are mainly examples of lower-level categories referred to, but not illustrated, in the main analysis. Some examples given here are in addition to those in the main text.

Main category: Anticipating
Intermediate category: Being decided
Lower-level category: Doing what’s best

*I looked at the books, I thought, right, I’m going to try it, I thought, I’ve waited this long to have children, I want to do my utmost best... for them.* (JW, p206, L28-30)

Lower-level category: Romanticising

*I was gonna be like an earth mother, you know, I was gonna have my breasts out everywhere... I was gonna be hanging out there...carrying my baby on my hips and feeding continually and all this kind of [thing].* (LB, p12, L151-154)

Intermediate category: Being uncertain
Lower-level category: Experiential learning

*My mum breast-fed, not completely successfully...she only managed to breast-feed me, but she had managed so I thought, if she can do it, I can do it. So I’d wanted to breast-feed.* (SH, p144, L46-49)

Lower-level category: Fear of failure

*I’d already bought bottles. Perhaps I shouldn’t have done or it might predispose, I had a feeling that I might have to.* (SM, p248, L567-568)
Main category: Overwhelming Responsibility

Intermediate category: Experiencing social intrusion

Lower-level category: Being judged

I didn't think that I'd like a baby attached to part of my body and I felt embarrassed about it. I think in today's society it's not seen as a normal thing. I'd never really seen anybody breast-feeding in public...I have done it, but I wasn't comfortable doing it. I'm not comfortable about exposing myself. I find that very, very, very difficult. (SH, p146, L64-84)

You are made to feel as though you're...completely odd because you're bottle-feeding. (CM. p62, L39-41)

Lower-level category: Pressure to Perform

There's so much pressure on you to breast-feed...you're told that breast is best and you should do it and so when you don't, you think you are a failure and it's what you should be doing. They were saying you've got to breast-feed, you shouldn't bottle feed but then they were saying, but if for some reason you can't, it's OK to bottle-feed, but it's only OK if you can't, not because you choose not to. (JN, p185, L337-347)

Intermediate category: Confronting absolute dependency

There's this bond between a mum and child and half of me didn't want that. I thought it would be nice if the child equally went to mum or dad, but it seems as though they do tend to go to their mum for whatever they need. (VJ, p119, L40-43)

Lower level category: Fearing capacity to harm
You don't realise before you have children that decisions you make now affect them as they get older... There's such a huge responsibility... It's constant. (VJ, p134, L406-411)

He was just losing so much weight and it was so stressful I ended up mix-feeding him. (DE, p253, L36-37)

**Lower-level category:** Needing to succeed

*It doesn't matter how ill I am, I should be able to breast-feed and it is the best thing for him, you know, it's the best thing.* (SH, p165, L569-570)

**Intermediate category:** Experiencing infant intrusion

**Lower-level category:** Encountering complications

*I tried to breast-feed but I was so tired from the birth and I wasn't producing any milk, and then I felt really uncomfortable.* (JN, p183, L278-280)

**Main Category:** Being fractured

**Intermediate category:** Suffering

**Lower-level category:** Becoming trapped

*I think I just wanted time out... to be able to go about and do stuff on your own before I had him, to go to the point where I suppose you had to adjust drastically and to not even be able to have a bath.* (CM, p66, L135-138)

**Lower-level category:** Collapsing

*I thought, I can't do this anymore. I can't feel this way in my head anymore... I just wanted to top myself.* (JW, p216, L283-287)

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Intermediate level category: Splitting off
Lower-level category: Disconnecting

I was withdrawing so I didn’t dare say anything in case it upset him [husband]. (CM, p65, L113-114)

Intermediate level category: Satisfying

Because it [breast-feeding] had been so stressful to start with... it was so much more relaxing to be able to sit there and see him drinking a bottle. He’d be looking into my eyes and I could see him and I could see that he was feeding and then I could put him down afterwards and he’d not start screaming again straight away. (DE, p257, L127-131)

Main category: Self-evaluating

Intermediate category: Defending self
Lower-level category: Ranking

I think she’s trying to make a statement; oh I’m breast-feeding. (CM, p85, L595-597)

Intermediate category: Blaming self
Lower-level category: Feeling inadequate

I thought perhaps I wasn’t good enough. (VJ, p134, L415)

I’d hold him and he’d fall asleep on me and things, but if he cried, I couldn’t bear it because I knew there was something I’d have to do and I’d probably wouldn’t be able to do it. (JN, p181, L240-242)

Lower-level category: Regretting

... but I know I did look back when he was a few months old and think, perhaps I should’ve tried harder [to breast-feed]. (VJ p141, L596-597)
I miss it dreadfully when I stop breast-feeding and I miss, I felt as if um I'd had something taken away from me, like there was a very unique bond that nobody could have, I mean it's, it, le-, it's, you know, and I felt very much like he's my baby and only I can look after him I can feed him and um, and we'd got this incredible connection and I think that's what bonds, bonds you together um and then when you, when you know, anybody can feed him it's like, well... you feel as if you've been rejected.

(LB, p35, L717-732)

Intermediate category: Seeking affirmation
Lower-level category: Feeling successful

I think there are times when I get, it's almost like job satisfaction, you know, when I feed her and she eats for um, you know, er, I take her nappy off and she kicks around happily for a while, you know, it's almost like um, I'm being praised for something that I've done. (NP, p110, L481-484)

Main category: Re-emergence
Intermediate category: Separating out
Lower-level category: Reprioritising

Things like that I try not to worry about now. I really think they are so minor. What is important is that he's happy and healthy and that seems to be working so far, just try and have fun (VJ, p135, L441-444)

Intermediate category: Recognition
Lower-level category: Partner

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I suppose because he knows me so well and I felt that if ever I was worried about things, which was constantly, I would talk to him. I wasn’t embarrassed or worried in front of him. I don’t think I’d have got through as well if he wasn’t around. He was like a walking stick, many, many times. (SM p241, L367-376)

**Lower-level category:** Professionals

*She helped me to look at other things in my life that I needed to address, to think about, that I am a person as well, that I’m not just this mum and to try and think of the future.* (JW, p317, L322-325)

**Lower-level category:** Peers

*I was feeling guilty about everything, I didn’t play with M enough, perhaps he didn’t eat the right things that day, did I give him enough attention, should I have taken him outside. I felt I wasn’t good enough... Talking to other mums I realised that they all feel like that. So my worries weren’t specifically all related to being depressed anymore than related to just being a parent.* (VJ, p133, L389-402)
4.12 Details of participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>1 LB</th>
<th>2 CM</th>
<th>3 NP</th>
<th>4 VJ</th>
<th>5 SH</th>
<th>6 JN</th>
<th>7 JW</th>
<th>8 SM</th>
<th>9DE</th>
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<td>Number of children</td>
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<td>Age of children</td>
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<td>4 wks and 3 years</td>
<td>8 months</td>
<td>18 months</td>
<td>6 yrs, 3 yrs, 4 months</td>
<td>3 months and 2 yrs</td>
<td>2 and 3 years</td>
<td>7 yrs and 17 months</td>
<td>3 yrs and 6 months</td>
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<td>Marital status</td>
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<td>Living with partner</td>
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<td>Occupation</td>
<td>Bookkeeper</td>
<td>Home care manager</td>
<td>Teacher</td>
<td>Civil servant</td>
<td>Clerk/typist</td>
<td>Nursery nurse</td>
<td>Hotel receptionist</td>
<td>Post/stationery manager</td>
<td>Teacher</td>
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<tr>
<td>Time of diagnosis</td>
<td>Second child postnatally</td>
<td>15 months postnatally with first child</td>
<td>4 months postnatally</td>
<td>9 months postnatally</td>
<td>First child postnatally</td>
<td>Antenatal during both pregnancies</td>
<td>Antenatal during both pregnancies</td>
<td>5 months antenatal</td>
<td>Antenatal</td>
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<td>Psychological input?</td>
<td>Psychologist</td>
<td>Counsellor and psychiatrist</td>
<td>Psychiatrist and community nurses</td>
<td>Community nurses</td>
<td>Psychiatrist and midwives</td>
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<td>Counselling/cognitive therapy</td>
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<td>History of mental health problems?</td>
<td>Depression since childhood</td>
<td>N</td>
<td>N</td>
<td>Mild depression in early adulthood</td>
<td>N</td>
<td>Depression during adolescence</td>
<td>Depression since adolescence</td>
<td>N</td>
<td>Mild depression in adulthood</td>
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<td>Did you breast-feed your children?</td>
<td>All three children</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>All three children</td>
<td>N</td>
<td>Tried with both, succeeded with second</td>
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<td>Duration of breast-feeding</td>
<td>Between 3 wks and 6 months</td>
<td>First few days</td>
<td>Ongoing</td>
<td>2 wks, 7 months, 4 wks</td>
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<td>3 months</td>
<td>6 months, ongoing</td>
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<td>Did you receive support or information on breast-feeding?</td>
<td>Midwives</td>
<td>Y</td>
<td>Health visitor and midwives</td>
<td>Yes</td>
<td>Midwives and breast-feeding counsellor</td>
<td>Parentcraft and leaflets from midwives</td>
<td>Midwives</td>
<td>Midwives</td>
<td>Midwives and specialist advice after discharge</td>
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NB. All information was self-reported and gathered from an information questionnaire carried out prior to interview.
### 4.13 Details of reviewed papers relating to postnatal depression and breastfeeding

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<th>Title</th>
<th>Date</th>
<th>Journal</th>
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<td>1</td>
<td>Alder, E. and Bancroft, J.</td>
<td>The relationship between breastfeeding persistence, sexuality and mood in postpartum women.</td>
<td>1988</td>
<td>Psychological Medicine, 18, 389-396.</td>
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<td>2</td>
<td>Alder, E. and Cox, J.</td>
<td>Breast-feeding and post-natal depression.</td>
<td>1983</td>
<td>Journal of Psychosomatic Research, 27 (2), 139-144.</td>
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<td>21</td>
<td>Tamminen, T.</td>
<td>The impact of mother’s depression on her nursing experiences and attitudes during breastfeeding.</td>
<td>1990</td>
<td>Acta Paediatrica Scandanavia, 72, 9-12.</td>
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<td>22</td>
<td>Thome, M. and Alder, B.</td>
<td>A telephone intervention to reduce fatigue and symptom distress in mothers with difficult infants in the community.</td>
<td>1999</td>
<td>Journal of Advanced Nursing, 29 (1), 128-137.</td>
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<td>25</td>
<td>Uvnas-Moberg, K.</td>
<td>Oxytocin may mediate the benefits of positive social interaction and emotions</td>
<td>1998</td>
<td>Psychoneuroendocrinology, 23 (8), 819-835.</td>
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Appendices

Appendix 4.14. Participant consent form

CONSENT FORM

Title of study: 'A qualitative analysis of postnatally depressed women's experiences of breast-feeding.'

Chief Investigator: Ellen Homewood, Trainee Clinical Psychologist.

Please read this form in conjunction with the Participant Information Sheet, Version 2: 23/03/2005.

Please indicate your response by putting an X in the appropriate box for each statement.

• I agree to take part in the above study as described in the Participant Information Sheet.
  
  YES □
  
  NO □

• I have read and understood the Participant Information Sheet and have had the opportunity to ask questions and discuss the details with Ellen Homewood. The nature and purpose of the interview to be conducted, and my involvement in it have been explained to me, and I understand what will be required if I take part in the study.
  
  YES □
  
  NO □

• I understand that I am free to withdraw from the study at any time, without justifying my decision, and without it affecting any provision available to be from the National Health Service.
  
  YES □
  
  NO □

• I understand that the information I share will be treated as confidential. I understand that no information that may identify me such as my name, and address, will be contained in the report of this project.
  
  YES □
  
  NO □
• I understand the reasons why the research interview will be audio-taped. I understand that the information recorded during the interview will be treated as confidential and will only be used for this study.

YES ☐

NO ☐

• I understand that the audio-cassettes will be destroyed on the first of the following two events, i) if I withdraw my consent to participate in the study, or ii) on satisfactory completion of the project.

YES ☐

NO ☐

• I understand that compensation for any harm that arises from the project will only be available in a case of negligence.

YES ☐

NO ☐

Signature of Participant.................................................................Date......................

Name (In block capitals).................................................................

I have explained the study to the above patient and she has indicated her willingness to take part.

Signature of Researcher.................................................................Date......................

Name (In block capitals).................................................................