

**"A psychoanalytic exploration of the emotional experience of breastfeeding mothers who have experienced difficulties feeding their baby with tongue-tie. An interpretative phenomenological analytic study"**

By Linda Atkinson

A thesis submitted for the degree of Professional Doctorate in Psychoanalytic Child and Adolescent Psychotherapy

Department of Tavistock and Portman NHS Trust

University of Essex

Date of submission for examination – 22<sup>nd</sup> September 2025

## Abstract

**Background:** Infant tongue-tie or ankyloglossia is a relatively minor and easily treated condition associated with breastfeeding complications which have been linked with consequential emotional maternal distress.

**Research Aim:** To gain insight into lived emotional experiences of mothers who have experienced difficulties breastfeeding their tongue-tied baby.

**Method:** This was a qualitative study of four participants who had breastfed a baby with tongue-tie (aged 3-12 months) using a single Free Association Narrative Interview (FANI) - aimed at making available inner-world and unconscious experiences. Data analysis by Interpretative Phenomenological Analysis (IPA) focussed on unique idiographic aspects of individual lived experience leading to identified recurrent group themes. Within the IPA framework, aspects of FANI and Reverie Research methods were included, adopting psychoanalytic concepts, tools and understanding to promote and deepen the unconscious experience made available for understanding within the hermeneutic IPA process.

**Results:** Four main Group Experiential Themes were identified: “The psychological and emotional complexity as a breastfeeding mother”; “The hope of connection and the pain of disconnection”; “Internal relationships with dependency and care in interaction with lived external experiences”; and “Alone and stuck in an unbearable situation – reaching breaking point”.

**Conclusions:** Results suggest breastfeeding is both physical and emotional, with success linked with feelings of maternal confidence and capacity, and difficulties with the reverse. Maternal emotional experiences of infant tongue-tie were inextricably linked with pregnancy and delivery, and past and current lived experiences.

Professional care was profoundly experienced - positively and negatively. If left feeling unsupported, participants reached a state of desperation disrupting their sense of connection with their baby and with the support around them. By contrast, timely, specialist attentive care and emotional containment promoted emotional recovery and a reparative breastfeeding relationship with their baby.

**Keywords:**

ankyloglossia, tongue-tie, breastfeeding, maternal experience, qualitative study, psychoanalytic, containment, maternal wellbeing

## **Acknowledgements**

With the sincerest gratitude to Dr. Lucia Genesoni, my research supervisor, for her warmth, patience, sharp but lightly worn intellect and insight, and her steady encouragement throughout. Her passion in supporting mothers and babies through early childhood has enlivened my project from the outset. I also wish to thank Alison Bruce and Dr. Inge Pretorius for their passion, guidance and support, allowing me the opportunities to find my own interest in this area, and inspiring this project. So too, to Silvina Diaz Bonino and my fellow students in the Tavistock perinatal seminar group for the benefit of their rich thinking and understanding. My tutors, Margaret Lush and Kate Robertson (so sadly missed), and service supervisor, Ivana Ruzic have each been such sources of wisdom, warmth and guidance. The patience of my husband and three sons has been unrelenting. Without their belief in me and steady presence facilitating my preoccupation with it, completion of this study would not have been possible. My deep love and gratitude to them and to my parents, sister, family and friends who have supported me along the way, tolerating my distracted attention. Finally, and most importantly, to the bravery and openness of the four mothers who agreed to participate and share their stories with me.

## Table of Contents

<b>Abstract</b> .....	<b>ii</b>
<b>Acknowledgements</b> .....	<b>iv</b>
<b>Table of Contents</b> .....	<b>v</b>
<b>Introduction</b> .....	<b>1</b>
<i>Tongue-tie/ Ankyloglossia</i> .....	2
<i>Designing the study</i> .....	3
<i>Why is it important?</i> .....	4
<b>Chapter 1 - Literature review</b> .....	<b>5</b>
<i>Search methodology and results</i> .....	5
<i>Review of results</i> .....	9
<i>Psychoanalytic perspectives</i> .....	10
Inter-subjective early infant relationships.....	10
Feeding and breastfeeding .....	14
Containment and support .....	16
<i>The relevance of negative impacts on maternal wellbeing and mental health to infant development</i> .....	17
<i>Linking breastfeeding difficulties (associated with tongue-tie and otherwise) with maternal wellbeing/ mental health</i> .....	18
<i>Linking experiences of healthcare with maternal wellbeing/ mental health.</i> .....	21

<i>The psychological maternal experience of tongue-tie</i> .....	22
<i>Cultural considerations</i> .....	32
<i>Conclusions and rationale</i> .....	33
<b>Chapter 2 - Project design and Methodology</b> .....	<b>34</b>
<i>Introduction</i> .....	34
<i>Aims and Objectives</i> .....	35
<i>Project Design</i> .....	36
Ontology, Epistemology and Methodology .....	36
<i>Method</i> .....	40
Ethics and ethical considerations .....	40
Participants.....	41
Data collection.....	44
Data analysis.....	44
<i>Researcher subjectivity</i> .....	47
<b>Chapter 3 – Results</b> .....	<b>48</b>
<i>Introduction</i> .....	48
<i>Summary of Group Experiential Themes</i> .....	48
<i>Pen Portraits</i> .....	50
Anna and George (7 months) .....	50
Marta and Kaya (7 months).....	52
Eleanor and Ariel (4 months) .....	53
Pippa and Daisy (6 months).....	55
<i>Description of Group Experiential Themes</i> .....	56
<i>Group Experiential Theme 1 – The psychological and emotional complexity as a breastfeeding mother</i> .....	57
1.1 - Breastfeeding and motherhood - a “special business” that goes beyond physical feeding .....	57

1.2 – Managing expectations – the imagined baby and ideas of motherhood during pregnancy .....	59
1.3 - Maternal confidence and worries about capacity – feelings of failure .....	61
<i>Group Experiential Theme 2 - The hope of connection and the pain of disconnection .....</i>	<i>65</i>
2.1 – Trying to make a physical and emotional connection with baby .....	65
2.2 – Trying to connect with support .....	72
<i>Group Experiential Theme 3 – Internal relationships with dependency and care in interaction with lived external experiences.....</i>	<i>73</i>
3.1 – Ideals of care .....	76
3.2 - Disappointments in receiving care .....	80
<i>Group Experiential Theme 4 - Alone and stuck in an unbearable situation – reaching breaking point .....</i>	<i>87</i>
4.1 Not knowing what to do or what is happening .....	87
4.2 Loss of structure and control.....	89
4.3 Feeling trapped .....	90
4.4 Desperation and urgently needing to find a way out .....	94
<i>Group Experiential Theme 5 - Ambivalence – managing feelings of hurt and anger and upset .....</i>	<i>97</i>
<b>Chapter 4 - Discussion .....</b>	<b>102</b>
<i>Aims .....</i>	<i>102</i>
<i>Summary of findings .....</i>	<i>102</i>
<i>Links between results and psychoanalytic concepts .....</i>	<i>105</i>
<i>Reflexivity.....</i>	<i>117</i>
<i>Limitations .....</i>	<i>119</i>
<i>Implications for clinical practice.....</i>	<i>125</i>
<i>Implications for future research.....</i>	<i>127</i>
<i>Conclusion .....</i>	<i>127</i>
<b>References.....</b>	<b>129</b>

<b>Appendices .....</b>	<b>136</b>
<i>Appendix 1 –Table of papers for literature review .....</i>	<i>137</i>
<i>Appendix 2 – Letter of Approval from TREC .....</i>	<i>182</i>
<i>Appendix 3 - Recruitment advertisement.....</i>	<i>183</i>
<i>Appendix 4 – Participant information sheet.....</i>	<i>184</i>
<i>Appendix 5 - Participant consent form .....</i>	<i>190</i>
<i>Appendix 6 – Questionnaire .....</i>	<i>192</i>
<i>Appendix 7 – Interview schedule.....</i>	<i>198</i>
<i>Appendix 8 – Debrief Letter.....</i>	<i>201</i>
<i>Appendix 9 - Extract annotated transcripts showing exploratory notes .....</i>	<i>203</i>
<i>Appendix 10 - Photo showing clustering and re-clustering process .....</i>	<i>209</i>
<i>Appendix 11 - Extract of Table of Personal Experiential Themes.....</i>	<i>212</i>
<i>Table of Personal Experiential Themes (PETs) for Participant 4.....</i>	<i>212</i>
<i>Appendix 12 - Extract of Table of Group Experiential Themes .....</i>	<i>216</i>

#### **List of tables**

<i>Table 1 – Search Strategy.....</i>	<i>6</i>
<i>Table 2 – Search Methodology – PRISMA diagram.....</i>	<i>9</i>
<i>Table 3 – Summary of Papers reviewed.....</i>	<i>10</i>
<i>Table 4 – SPIDER Model for developing research question.....</i>	<i>36</i>
<i>Table 5 - Summary of Group Experiential Themes.....</i>	<i>50</i>

## Introduction

This is an empirical qualitative study of the emotional lived experience of mothers breastfeeding their infant with tongue-tie. My interest comes from my experiences co-facilitating a psychoanalytic mother and baby group offering support to new mothers in the first year of their baby's life and the opportunity to share experiences of delivery, motherhood and their babies. In one particular group it transpired several babies had been diagnosed with tongue-tie. Mothers' descriptions of difficulties breastfeeding through referral, diagnosis and treatment (or not) were emotively told, suggesting a profound impact on their early experience of motherhood. Several still seemed to carry the pain of having abandoned breastfeeding as a result of feeling unable to wait for NHS treatment or afford a private lactation consultant. As a mother with my own previous but more minor experiences struggling to breastfeed (unrelated to tongue-tie) both the physical and emotional pain they described resonated with me, as did recalling the value and impact of helpful and compassionate professional support. Struck by the power of these mothers' narratives, I became interested in understanding more about the maternal experience of infant tongue-tie.

My discipline of child psychotherapy places primary caregiver-infant relationships and earliest infantile experiences centrally within child development (Bion, 1962; Klein, 1946, 1957a, 1959, 1975; Winnicott, 1960). The apparent severity of the emotional impact on mothers of this relatively minor physical condition made me

curious to find out more because of its potential consequential effect on the developing dyadic relationship and possible repercussions for infant development.

### ***Tongue-tie/ Ankyloglossia***

Tongue-tie (ankyloglossia) is a congenital condition where the piece of skin joining the tongue to the base of the mouth (lingual frenulum) attaches near the tip of tongue or is shortened and thickened, reducing tongue mobility. It presents in approximately 8% of newborns (being more prevalent in boys) (Cordray et al., 2023). Diagnosis and treatment has increased over recent decades (Hill et al., 2020).

Infant symptoms often include difficulties breastfeeding with poor latch; extended feeding length and/or frequency; poor weight-gain; and coughing, choking or clicking whilst feeding - maternal symptoms include sore nipples (with bleeding and cracking) and painful/ swollen breasts (NHS, 2024).

Tongue-tie can be asymptomatic and left untreated, managed through breastfeeding consultation, or treated by manual therapy or correction by a simple surgical procedure cutting the frenulum (sometimes by laser but usually with scissors) - a "frenotomy". This is done without anaesthetic with some minor bleeding afterwards. Longstanding controversy continues over diagnosis and appropriate treatment with non-standardised methods for identifying and grading its presentation (Rodriguez Lara et al., 2025). Tongue-tie, its diagnosis and treatment have been the subject of some discourse over recent decades both as to complaints in the media about patchy public health services, the place of social media in the increase in its

prevalence (Grond et al., 2021; Winkel, 2021; Winkel et al., 2023), the benefits of frenotomy and questions about causality of symptoms (O'Shea et al., 2017).

The National Institute for Health Excellence guidelines endorse frenotomy citing no major safety concerns and sufficient, albeit limited evidence that it can improve breastfeeding, whilst also recognising the complexity of the breastfeeding relationship and the importance of skilled breastfeeding support in managing breastfeeding difficulties (2005). Within the NHS tongue-tie is managed in specialist clinics following referral by midwives, health visitors or GP's, and through a combination of breastfeeding support and frenotomy where necessary. Alongside, diagnosis, management and treatment are available privately through lactation consultants and tongue-tie practitioners (registered with the Association of Tongue-tie Practitioners).

### ***Designing the study***

Having decided on my topic of interest as infant tongue-tie, I narrowed the area of study by identifying my objective as being to gain insight into the emotional experience of mothers of a baby with tongue-tie (White, 2017). Is it in fact an experience loaded with emotional weight? And if so, what is the nature of that emotional experience? This felt important from a child psychotherapy perspective because of its potential impact on the developing infant.

Given I wanted to know about mothers' emotional, lived experiences I designed my project to best promote a depth of material being made available for understanding. I collected data through a single Free Association Narrative Interview ("FANI")

(Hollway, 2013, p. 65) and analysed it using Interpretative Phenomenological Analysis (“IPA”) (Smith et al., 2021). Within the structured framework of IPA, I introduced ideas and concepts from the Reverie Research Method (“RRM”) (Holmes, 2018) and FANI Method at the initial stages of analysis to augment and deepen the level of unconscious material available for analysis and understanding. Some quantitative and qualitative data was collected by questionnaire prior to interview. The constraints of a two-year, part-time unfunded professional doctorate in Child and Adolescent Psychoanalytic Psychotherapy meant a small sample size and single interview point.

### ***Why is it important?***

Early maternal experience and mental health impact outcomes for mother and child (Josefsson & Sydsjö, 2007; McLeish et al., 2020) and mother-infant bonding (Murray et al., 2010). Support and emotional containment for mothers benefits the early mother-infant relationship and a baby’s development (Alvarez, 1996; Winnicott, 1960). The World Health Organisation recommends breastfeeding for the benefit of both mother and baby (2003).

Understanding more about the maternal emotional experience of tongue-tie may offer insight which could inform the care and support made available to mothers, both encouraging mothers to continue breastfeeding through associated difficulties but also providing containment and support to mothers, promoting mental health and confidence and accordingly healthy child development.

## Chapter 1 - Literature review

In order to ground my study in existing research I conducted a narrative review of the existing research literature surrounding the maternal emotional experience of tongue-tie. First, I describe my search methodology. Next, I seek to place my research question within a psychoanalytic theoretical context before moving on to review the literature found and consider the wider context of the relevance of breastfeeding difficulties associated with infant tongue-tie (and otherwise) to maternal/infant mental health. Finally then, considering the literature relating specifically to mothers' psychological experience of their baby's tongue-tie.

### ***Search methodology and results***

Confidence in any literature review depends on a systematic search method and a clear-sighted purpose (Cooke et al., 2012; Cooper, 1998). My purpose was to identify existing research relating to parental lived experiences of infant tongue-tie in seeking a context and justification for my question specifically regarding the emotional experience as seen through a psychoanalytic lens.

As my enquiry was about lived experience, qualitative studies were likely to be most relevant. Accordingly, I chose the "SPIDER" (Sample; Phenomenon of Interest; Design; Evaluation; Research) model to define clear search criteria and a systematic search strategy (Cooke et al., 2012) (recognising the unavoidable limits to objectivity created by my subjective interpretation in defining search terms, reviewing results, and synthesising them into a literature review). I used the search strategy set out in

Table 1 below:

Table 1 – Search Strategy

SPIDER elements	Keywords	Search Terms	N =
Sample	Mother, Parent, Father	“mother*” OR “matern*” OR “parent*” OR “father*”	4666262
Phenomenon of Interest	Tongue-tie; Ankyloglossia	“tongue-tie*” OR “tongue tie*” OR “ankyloglossia*”	3158
Design	Interview; focus group; survey; questionnaire; observation; case study	“interview*” OR “focus group*” OR “survey*” OR “questionnaire*” OR “observ*” OR “case stud*” OR “case-stud*”	14789241
Evaluation	Experience; insight; opinion; perception; perspective; sense; understanding; attitude; belief; feelings	“experien*” OR “insight*” OR “opinion*” OR “perce*”; OR “perspective*” OR “sense” OR “understand*” OR “attitude*” OR “belie*” OR “feel*”	18103430

Research	qualitative; mixed methods	“qualitative” OR “mixed method*”	1957137
“(S and P of I)” AND (“D” OR “E” OR “R”) n = 1532 Hand Search of Titles n = 106			

I conducted a Boolean search on the following databases (via EBSCOhost): APA PsychINFO; Medline; CINAHL; ERIC; Psychology and Behavioural Sciences Collection; and “all databases” (20<sup>th</sup> December 2023) using these search terms and using the search strategy, “(S and P of I)” AND (“D” OR “E” OR “R”). This produced 1532 results, reducing to 1521 in excluding non-English language papers. Handsearching titles for relevance, and excluding for duplicates, left me with 106 papers. A hand-search of abstracts for relevance, excluding those unrelated specifically to parental experience, left 21 papers to retrieve. A citation search of those 21 papers yielded a further 5 papers. Snowballing reference lists and following suggestions offered by online publication repositories produced 2 further results. A search of the Cochrane Library produced one result.

This produced a total of 29 papers which I then read for relevance, excluding those unavailable, providing low quality evidence or not directly relating to the psychological, emotional, or internal experiences of mothers. This left me with 3 papers directly relevant to my research question, although none related directly to emotional experience or from a psychoanalytic perspective. Seven papers were of

contextual interest, relating to non-psychological aspects of maternal experience, wellbeing and mental health in relation to infant tongue-tie.

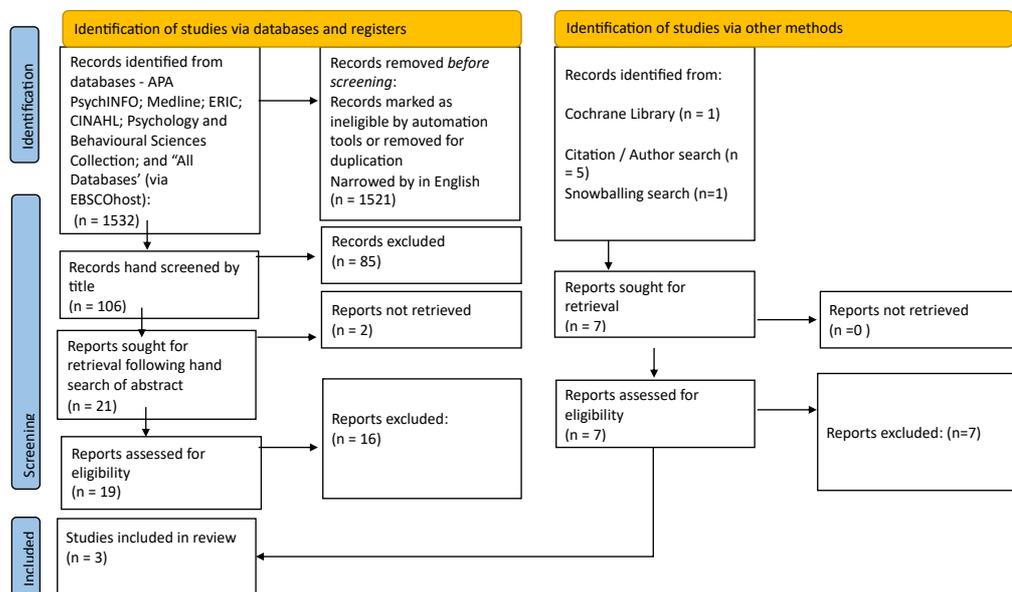
I conducted an additional search (within the same databases) to find psychoanalytically informed empirical literature about maternal experiences of breastfeeding difficulties generally and used the same search terms but replaced the “tongue-tie” search term with (feed\* OR breastfeed OR lactat\*) and adding another (psychoanaly\*). Given the psychoanalytic tradition of infant observation and the centrality of breastfeeding to the Kleinian model I was surprised to find very little literature on the subject even with variations of different search terms. However, removing the search term (psychoanaly\*) yielded 190 results. Searches in relation to maternal experience of minor or routine surgery in infants yielded only one result relevant to parental experience.

Following a hand search of abstract and title of all results I produced a list of a further 16 articles of interest but not directly relevant to my research question being unrelated to tongue-tie. During the course of reading the found materials for this review I used snowballing of reference lists to further explore emerging themes of links between maternal wellbeing and mental health and experiences of healthcare. The overall methodology of my search is summarised in the PRISMA diagram (Page et al., 2021) in Table 2 below and a table of results recording my decision making about inclusion/exclusion is presented in Appendix 1.

Wanting to ground my study within relevant psychoanalytic theoretical thinking I

made an electronic search for non-empirical writing using the search terms (feed\* OR breastfeed OR lactat\*) and (psychoanaly\*) (subsequently using the same terms in Google Scholar), then reviewed course study reading lists for literature relevant to pregnancy, early motherhood and mother-infant relationships, and finally snowballed reference lists of the literature found.

Table 2 – Search Methodology – PRISMA flow diagram



## Review of results

Initially, I will set my study within a psychoanalytic theoretical framework, considering earliest infant development in relationship with care-givers, the psychic upheaval of new motherhood, the feeding relationship and the relevance and importance to infant development of the maternal emotional internal landscape. I then consider child development and empirical literature relevant to these ideas – firstly exploring links between maternal mental health/ wellbeing and infant development; then giving an overview of the papers found linking maternal wellbeing/ mental health with

breastfeeding difficulties generally (16 papers) and specifically in relation to tongue-tie (7 papers). Drawing on themes from these studies I consider briefly literature linking experiences of healthcare with maternal wellbeing/ mental health. This finally leads me to a review of the three studies I found relating to mothers' psychological experiences of their infant's tongue-tie and directly relevant to my question. Finally, I make some observations about the cultural context of the reviewed research and then some conclusions identifying the importance and rationale of this research project.

### ***Psychoanalytic perspectives***

#### *Inter-subjective early infant relationships*

The developing mother-infant relationship has long been central to psychoanalytic thinking about personality development. Klein's ideas of internal phantasy and projection map how the infant puts some order and makes sense of earliest experiences and relationships, starting with those of, and with, the primary caregiver (Klein, 1959). (Whilst this could be any caregiver, the gendered concept of "mother" is the term that has been historically adopted to represent the primary caring role within psychoanalytic literature. I have adopted this terminology with less hesitance than otherwise since my study relates specifically to breastfeeding mothers.)

Although Klein's focus was on the baby's internal state of affairs, she acknowledged the relevance of the external environment (Klein, 1946, 1957a, 1959). However,

Winnicott really brought it to the centre of psychoanalytic thinking about infant development. Through the concepts of maternal preoccupation and holding he described a mother and baby as a unit during earliest infant development with the mother's primary role being to regulate the external environment for the baby so that the baby's experiences remain within tolerable levels of anxiety, allowing the baby to feel held, gradually building a sense of a boundaried and ultimately separate self to the mother (Winnicott, 1956, 1960). A partner and surrounding others themselves have a role in supporting and controlling the environment around mother and baby so as to allow the mother to maintain a sufficiently stable state of mind to allow her to fulfil this role in her preoccupation with her baby (Winnicott, 1960, 1964). Through her careful and attuned attention which Bion described as 'reverie' (1962, p. 36), a mother takes in the communications of her infant's unbearable emotional experiences and through internalising, experiencing and managing, or "containing" them, she is able to give them back in a form that is manageable, allowing the baby to maintain a sense of cohesion and to make sense of the experience, forming the building blocks of being able to learn and develop (1962). However, without sufficient management of the mother's external and internal environment to enable her to keep an available state of mind this process is at risk of disruption.

An infant's initial experiences and development are built on experiences with the primary caregiver. They are in a dance together (Stern, 2002) with the baby attending to the "music and not the lyrics" of the interaction (Stern, 1995, p. 66). A mother's internal experience matters and is inextricably linked with the development of her baby.

Klein describes the development over time of unconscious internal phantasies based on the building blocks of these earliest relationships - imbued with specific emotional experience and meaning (1957b, 1959). These remain at the core of infant experience and relationships with the world. So too, for every adult and every new parent. Psychic experience is an amorphous brew of fragments and constellations of internalised experience and memory; layered; shifting and coalescing and floating to the surface in the present as they are activated by current experience, needing to be processed to create new formulations of emotional experience (Raphael-Leff, 2001a, p. 8).

Quoting Hinde and Stevenson-Hinde, Stern describes a relationship as being “the remembered history of previous interactions” (1976) and himself describes, for each interaction, an internal ‘representation’ for each participant,

*“...determined by how an interaction is perceived and interpreted through the many lenses particular to the participant of the interaction. There are the lenses of fantasies, hopes, fears, family traditions, and myths, important personal experiences, current pressures and many other factors” (1995, p. 12).*

Alongside and associated with conscious remembered experiences and current external experiences lie unconscious representations of emotional content powerfully influencing subjective experiences in the here and now. Within the mix are transgenerational ghosts (Fraiberg et al., 2003) and powerful social and cultural elements.

Looking after a baby is physically demanding and disorienting – pressing and relentless – signalling the loss of the stability and familiarity of routines; time as a couple or to oneself; and being able to plan or “know” what to do. Psychically too, becoming a mother is a time of great upheaval. Monti (2015) describes times of “maternity” (p.110) with pregnancy, delivery and the time after delivery each representing significant psychic events for the mother, the father and those around them; and with a disorganising effect on the ego. Stern (1995) considers the psychological process of becoming a mother a psychic reorganisation, “the motherhood constellation” (p.171) something needing to be worked through just like other significant psychic developmental tasks (e.g. Oedipal). So, new mothers are thrust into a chaotic internal world which they need to make sense of gradually in a parallel process to the new-born making sense of its world (Stern, 1995, 1998). A mother is beset with managing not only her baby’s communicated infantile anxieties but also her own re-evoked ones.

Beginning with pregnancy, the mother will create phantasies and representations based on her own internal world about the baby inside her. Birth heralds the need to begin reconciling the phantasied baby in her womb with that now in arms. Raphael-Leff describes a “triple shadow interaction” in every parent-child couple:

*“the re-evoked child a parent conjures up having been with her or his own parents; the desired or detested child he or she fantasizes this baby to be in relation to their internal constellation; and the real child whom they are beginning to recognize as an individual.”*  
(2001a, p. 130)

A mother needs to work out who the baby is and who she is - the baby that was within and came from her but who is now outside her (Stone, 2014). Motherhood likely stirs important but confusing (and difficult to admit) feelings of ambivalence towards a baby (Parker, 1995). At the same time a mother needs to make a shift from being a daughter of her mother to being a mother to her child (Stern, 1995), at a moment when the combination of the physical trauma of birth (Mosse, 1993) and psychological upheaval likely leave her in need of being 'mothered' - low in resources to 'mother'. Her own experiences of being cared for will inextricably inform what both mean in her mind.

### *Feeding and breastfeeding*

Nourishing a baby in body, by feeding, and mind, through containment is a fundamental parental task. Societal, cultural, and psychological influences pack an emotional punch in whether a mother feeds her baby by breast or formula. For these purposes I shall focus on mothers intending to breastfeed their baby as those most affected by tongue-tie, yet it is worth noting that every mother will have in mind themselves as a breastfeeding mother (Stone, 2014). The breastfeeding couple have long been at the centre of psychoanalytic thinking with Klein placing it at the core of the start of mental organisation through splitting into the "good" and "bad" breast and then the toleration and acceptance of absence and loss through weaning (1946). Yet, notwithstanding its interactive and intersubjective nature the nursing (and postpartum) experiences of the mother remain largely unexplored by psychoanalysis notwithstanding women's ability to speak about the experience

(Friedman, 1996; Mariotti, 2012, p. 2). This has been ascribed to the fact that analytic examination of maternal phantasies in the early weeks historically has often been thought to be precluded by a mother's preoccupation with reality based experiences relating to the needs of the infant and a lack of availability of her own psychic material in her working out of me/not me with the baby (Balsam, 2000).

The process from fusion in both body and mind to differentiation is complicated and intertwined. Raphael-Leff (2001a) describes how both feeding and containment begin with nourishment through the placenta, a precursor to the baby gradually building a sense of having an inside and outside. Breastfeeding can be seen as an extension of this with confusions as to whose milk is whose – is it the baby's or the mother's milk (Stone, 2014)? Who is the giver and who is the receiver – the baby needs the milk but the mother relies on the baby to empty her breasts to avoid engorgement – their comfort is mutually dependent (Friedman, 1996). Stone (2014) interestingly explored these ideas through the book *Beloved* (Morrison, 1987) arguing how the main character, Sethe, is unable to find a space between a sense of herself and her maternal function - equating her milk to her maternal identity. Along with its pleasures, breastfeeding can bring feelings of being trapped or enslaved (Nelson, 2006; Stone, 2014).

Breastfeeding involves a complicated interplay between mother and infant and correct co-ordination of sucking and swallowing by the infant (Schlatter et al., 2019). It is also a complex mutual emotional activity conducted against and within these maternal emotional landscapes. It plays out the earliest opportunities for containment of the infant's extreme emotions by the mother - the quality of the

experience forms the foundations of the baby's relationship to taking something in and its ability to establish a nourishing and intimate experience with the breast or otherwise (Lyon, 2016).

### *Containment and support*

Within this overall mêlée of tumultuous emotional content and psychic reorganisation, the role of containment is no small task, even in the best of circumstances. In order to be able to manage and contain her infant's emotions, the mother needs to have the mental wherewithal to contain her own. In order to help her do this she needs the holding, containment and "supporting matrix" of those around her (Stern, 1995). Without it, primary maternal preoccupation risks becoming "primary maternal persecution" (Raphael-Leff, 2001b, p. 27). She needs to feel "surrounded and supported, accompanied, valued, appreciated, instructed and aided" according to her specific needs (Stern, 1995, p. 177.) Partners, parents, healthcare and social professionals all play their role in creating a "village" around the mother and baby (Diaz Bonino & Ball, 2013, p. 73). Rustin writes of the positive impact for developing mother-infant relationships of institutional and professional practical and psychological containment - meaning an understanding of each mother's inherent anxieties in bearing and caring for a baby and each baby's in arriving into the world and growing up - all the more important when things are difficult or do not go to plan (2017).

Lack of containment for the mother and circumstances threatening her emotional stability and confidence risk compromising her ability to offer containment to her baby.

***The relevance of negative impacts on maternal wellbeing and mental health to infant development***

The Parent-Infant Foundation's "First 1001 Days Movement" (2021), as acknowledged by the UK Government (Department of Health and Social Care, 2021), supports these ideas, highlighting that earliest relationship experiences are pertinent to future development and outcomes for children. There is also recognition that early developing relationships may be hampered by maternal emotional difficulties including mood disturbances (Raes et al., 2014), Postpartum depression ("PPD") and anxiety (Davies et al., 2021; Della Vedova et al., 2023; Glasheen et al., 2009). These can disrupt mother-infant bonding with potential negative effects on infant temperament, attachment patterns, and cognitive, emotional, behavioural, social and physical development of children (Grace et al., 2003; Josefsson & Sydsjö, 2007; Murray et al., 2010).

A child's brain, mind and personality develop in intersubjective interchange with its caregiver's (Gerhardt, 2004; Harrison & Tronick, 2025; Lewis & Rosenblum, 1974; Schore, 1994; Stern, 1985, 1995; Trevarthen, 1998) – mother and baby influence and shape each other in dyadic interaction. Each experience is inextricably linked

with the other. Furthermore, motherhood brings a state of psychological flux, making a mother both more available and susceptible to these influences (Lewis & Rosenblum, 1974; Stern, 1995). Her internal situation forms the foundations of her interactions with her baby, fundamentally shaping the baby's sense of its experience and self (Lewis & Rosenblum, 1974; Stern, 1995). So, negative impacts to maternal mental health, wellbeing or confidence as a result of breastfeeding difficulties (tongue-tie related or otherwise) are profoundly relevant to the field of child development.

***Linking breastfeeding difficulties (associated with tongue-tie and otherwise) with maternal wellbeing/ mental health***

The psychological ramifications of breastfeeding difficulties resulting from tongue-tie - including: adjustment to the maternal role; parental confidence; maternal stress; postpartum depression; and mother-infant bonding - remain largely unexplored (Hill, 2019; Tran & Hill, 2022). Hill et al. (2021) conducted a mixed methods cross-sectional study investigating the relationship between tongue-tie, difficulties breast feeding and risks for altered maternal wellbeing by examining maternal stress and mother-infant bonding. The study openly based itself in a context of concerns about missed diagnoses and delayed treatment. Without comparative data it is difficult to learn much from the quantitative results but they found that for mothers of babies with tongue-tie, lack of support at home negatively affected both bonding and parental stress and that complications during birth and pregnancy and number of professionals seen regarding tongue-tie increased maternal stress. The qualitative data found themes that: the breastfeeding relationship improved after frenotomy;

mothers were persistent in seeking answers; and their experience improved after treatment, bringing changes in their perceptions of their baby. The authors' conclusion that their findings suggest increased stress for mothers of babies with tongue-tie particularly when there is a delay in diagnosis is hard to link with the recorded results, but the results remain of interest in themselves.

Using a prospective cohort study, Klatzkow et al. (2023) sought to examine particular risk factors for the development of postpartum depression (PPD) in mothers of babies with a number of otolaryngologic conditions (including tongue-tie). Compared to rates of between 13-20% in the general population (Earls et al., 2010), they found that 18.8% of participants screened positively for PPD with an increased rate of 26.67% for those with tongue-tie/lip-tie.

Devi et al. (2012) explored feeding difficulties relating to infant cleft lip and palate, and highlighted the psychological difficulties the condition may bring to parents - including managing feeding. Cleft lip and palate can result in reduced sucking efficiency, insufficient milk intake, excessive feeding time and failure to gain weight (Devi et al., 2012) - all comparable with difficulties experienced by babies with tongue-tie. The authors note how feeding an infant is not only an opportunity for nutrition but is also the time when the baby is most alert and available for social interaction (Nassar et al., 2006), perhaps meaning a situation primed for interference with social and emotional development resulting from feeding difficulties. Furthermore, inability to feed infants with cleft lip or palate can result in maternal stress and anxiety and affect mother-infant bonding (Saunders et al., 1989).

Turning to consider research exploring links between breastfeeding difficulties more generally and negative impacts on maternal mental health and wellbeing, there is generally consensus that mothers and their infants are a vulnerable population (Messner et al., 2020) and that breastfeeding is an “emotional journey” requiring determination and persistence to continue (Nelson, 2006). Studies have shown links between: nipple pain and emotional distress; multiple maternal physical difficulties (e.g. nipple pain, mastitis, and concerns about milk supply) and depressive symptoms (Cooklin et al., 2018); and pain and depression (Kroenke et al., 2011). Concerns about milk supply have been shown to be linked to low levels of maternal confidence (McCarter-Spaulding & Kearney, 2001) and the likelihood of difficulties (Feenstra et al., 2018). Worries about infant weight-gain lead to maternal anxiety about the infant (Brown et al., 2011). All of these symptoms and concerns are associated with tongue-tie.

Breastfeeding difficulties can impact a mother’s self-esteem, wellbeing, and experiences of early motherhood (Henshaw et al., 2015; Redshaw & Henderson, 2012); bringing guilt, emotional stress, anxiety, and altered family dynamics (Pados & Hill, 2019; Shakespeare et al., 2004). PPD is associated with problems breastfeeding (Shakespeare et al., 2004; Watkins et al., 2011) as are unmet hopes and expectations of successful breastfeeding (Borra et al., 2015). That the nature of experience rather than duration is a predictor of depressive symptoms (Brown et al., 2016) seems relevant to tongue-tie with the potentially short but intense period of difficulty. Ceasing breastfeeding can lead to feelings of dissatisfaction isolation, despair, frustration, guilt and shame (Fallon et al., 2017; Labbok, 2008; Nelson,

2006); with feelings of guilt and shame more likely to be associated with a change of intention rather than whether a mother is breastfeeding or formula-feeding (Fallon et al., 2017). Guilt and shame are predictors of PPD and anxiety (Jackson et al., 2024).

Overall, there seems compelling evidence that difficulty breastfeeding both related to tongue-tie and otherwise can adversely affect maternal confidence, wellbeing and mental health.

### ***Linking experiences of healthcare with maternal wellbeing/ mental health.***

Relevant to this literature were themes of frustrations at a healthcare system perceived to be inconsistent, unsupportive, and unintegrated. The literature regarding breastfeeding difficulties more generally echoes experiences of difficulties in interactions with professionals (Jackson et al., 2024; Nelson, 2006; Shakespeare et al., 2004). Yet the support of healthcare providers is significant (Pados & Hill, 2019) with postnatal care playing an important part in a safe and successful transition to parenthood (Dermott, 2006). McLeish et al. (2020) found that for mothers with high levels of need, low levels of postnatal support undermined maternal confidence and wellbeing. They cite the particularly negative consequences of failures in postnatal care for first-time mothers and the socially disadvantaged but also the converse positive effects of timely support which is inversely associated with stress, PPD and anxiety (Kurtz Landy et al., 2009; Leahy-Warren & McCarthy, 2011). Jackson et al. (2024) found increased anxiety and

depression was associated with poor healthcare professional support and high pressure to breastfeed

### ***The psychological maternal experience of tongue-tie***

Having reviewed the wider context I now review the three studies directly relevant to my research question - those relating to mothers' psychological experiences of their infant's tongue-tie and summarised in Table 3 below.

*Table 3 Summary of papers reviewed*

<b>Author, Year</b>	<b>Study Type and description</b>	<b>Participants</b>	<b>Method of data analysis</b>
Edmunds et al., 2013	Qualitative study based on description and interpretation - two focussed interviews	10	Hermeneutic phenomenological (Van Manen, 2016)
Wong et al., 2017	Qualitative analysis of multiple online discussion	501 posts contained within 76 forum 'threads'	Ethnographic content analysis

	forums with a post/ respond format		
Waterman et al., 2021	Qualitative descriptive study - two semi- structured focus groups	16 – participants of whom only 9 participated in focus groups (3 in one, 6 in the other)	Conventional content analysis (Hsieh & Shannon, 2005)

**Edmunds et al. (2013)** studied Australian breastfeeding mothers' experiences of infant tongue-tie with the aim of trying to understand, capture and describe them with a broader aim of informing clinical healthcare practice and was made within a context of existing research evidencing links between tongue-tie and breastfeeding difficulties (including maternal nipple pain and damage) but a lack of qualitative research into the nature of mothers' experiences.

Participation was by invitation during the initial visit to a public-health breastfeeding clinic at the point of tongue-tie diagnosis, with interviews about breastfeeding experiences since birth conducted at that visit. Without details of the rationale or nature of the purposive participant selection, exclusion or inclusion criteria or demographic data it is difficult to assess for bias within the selection process. A

further interview took place a fortnight later exploring mothers' experiences of advice. Seven of the ten babies had undergone a frenotomy at this point.

Using open-ended questions within the interviews was a suitable way of exploring participant experiences as was the use of a hermeneutic phenomenology aimed at exploring the meaning, examination and description of human experience. Data analysis is sparsely described, detailing only the broad phenomenological approach and that there were three researchers who immersed themselves in data to produce themes. Without a clearly described structured analytic method, or any statement about managing inter-rater reliability and disagreement, it is difficult to assess the reliability of the resultant themes. Additionally, lack of information about the researchers' identities precludes assessment of possible inherent biases in interviews, analysis and theme production. These factors limit the validity of the results. As a small sample study in a single location, the results are not generalisable.

Results showed 6 phases of experience categorised by the themes: "Expectations"; "Something is wrong"; "Questioning, seeking advice, no real answers"; "Symptoms and perseverance"; "Approaching the wall – it's all too much"; and "Relief". Within the theme of "Expectations" the authors described how all participants had no expectations of difficulties preventing breastfeeding. The theme "Something is wrong" detailed how as problems emerged, mothers' breastfeeding experiences unravelled, leaving them struggling to understand why. Many mothers described "anticipatory dread" of breastfeeding due to pain. Spurred by the desire to have their

imagined breastfeeding relationship with their babies, mothers sought to understand the cause of the problems and how to resolve them, bringing the theme, “Questioning, seeking advice, no real answers”. However, they were confused by differing advice from professionals. The theme, “Symptoms and Perseverance” captured how mothers persevered with breastfeeding despite increasing difficulties and intense pain. The next theme, “Approaching the Wall – It’s all too much” described mothers’ reaching a breaking point - feeling unable to continue breastfeeding, inadequate and worried about the relationship with their baby. The final theme, “Relief” for the most part related to mothers whose baby had been given a frenotomy, with relief expressed at an identifiable and treatable cause for the difficulties, and an anticipated improvement - with reports of release from pain following frenotomy.

Despite its limitations this study provides evocative themes and evidence offering a credible picture of mothers’ real and lived experiences of trying to breastfeed a baby with tongue-tie. The authors draw a convincing conclusion of a “harrowing journey” in sharp contrast to mothers’ expectations and of difficulties in getting consistent advice. However, the conclusions that the authors draw about improvements in pain after frenotomy are unclear with it being described variably as being the case for ‘some’ and then ‘most’ women. Further specificity of results would have lent further credibility to this conclusion.

The second study addressing mothers’ experiences was conducted in the USA by **Wong et al. (2017)**. This study of online forums aimed at better understanding the experiences, thoughts and perspectives of mothers breastfeeding a baby with

tongue-tie. Its context recognised the pressures mothers might feel to breastfeed and the potential psychological and emotional distress that might be caused if unable to (Borra et al., 2015) but no clear statement of the aims and objectives of the study is given. Analysing online data - aimed at making use of a source of information proliferated over time and offering a platform for individuals to share experiences, difficulties, and concerns anonymously in an uninhibited way - seemed an interesting and appropriate method of investigation. However, by its nature, no biographic, demographic, or geographic data could be collected and participants were self-selecting with no visibility as to their motivations for posting. Possibly, only those with extreme experiences either way would have posted, limiting the generalisability of the study.

Relevant websites were identified by selecting the top 50 hits of Google searches made using a variety of search terms in English. Inclusion and exclusion criteria were applied and threads were randomly selected for analysis. Selecting in this way accounts well for reducing researcher bias but precludes ensuring a breadth and range of experiences.

In accordance with the ethnographic content analysis method used, the authors used a combination of their experience and the themes produced from the research by Edmunds et al. (2013) to create six discussion domains: “mothers’ initial expectations; breastfeeding complications; questions; diagnosis; treatment options; and treatment outcomes”. These were subdivided into 22 codable discussion topics, with their presence or otherwise then noted in reviewing the posts. The authors assessed inter-rater agreement, lending confidence to the process of

analysis. Without information about researchers' respective places within the field of study it is hard to make an informed assessment of inherent bias.

Results showed 94.7% of threads and 53% of posts mentioned at least one of the domains. Breastfeeding complications were the most frequently discussed topic and within that (and of direct relevance to my research study) expressions of emotion were a common sub-topic with expressions of frustration, dread, sadness, and dismay.

Another common thread topic was tongue-tie diagnosis with expressions of frustration and anger, and with about one-fifth mentioning delayed or missed tongue-tie diagnoses. Most threads included a question about treatment (most frequently scissor frenotomy). Many mothers described both subjective and physical improvements after the frenotomy had been performed.

The authors signpost mothers' initial thwarted expectations to breastfeed and the complications of failures in healthcare support combining to make an emotionally challenging time. Expanding on and providing more specificity to claimed causality links between these ideas and the results reported would have lent further credibility to them. However, overall, the authors' conclusions that mothers do use online forums for support with breastfeeding difficulties associated with tongue-tie and that they experience both "physical and emotional hardships", seemed convincing. Their identification of the need for empathic care and support by healthcare providers to

encourage mothers to seek support from them rather than trying to manage in alienation and isolation, turning to online forums instead, also seems reasonable.

The last study I found relating specifically to maternal lived experiences of tongue-tie was by **Waterman et al. (2021)**, a Canadian study set within a background promoting, supporting, and protecting breastfeeding. Its aims were to explore breastfeeding mothers' experiences of infant tongue-tie so as to describe the experiences and the meanings that the mothers ascribed to them. Included within this aim was to explore experiences of healthcare provision.

Participants were purposively selected to find participants who could "contribute detailed information to enhance our understanding" (p. 2). Unsure what this meant, this raised questions for me of unstated potential researcher cultural or social bias in sample selection. Demographic data showed a homogenous sample of educated, partnered and financially secure participants with no details of ethnicity recorded.

Recruitment was through an advertisement on two social media groups. Participants needed to have breastfed a baby with tongue-tie for any duration in the previous 3 years. Of the 16 participants initially selected, 9 attended the focus groups - divided into 3 and 6 between the two groups. No account is given of the rationale for allocation to each focus group which precludes assessment of potential bias.

The choice of focus groups by semi-structured interview seemed an appropriate method to provide rich data - encouraging opportunities for open discussion and

sharing of experiences between participants and making group dynamics available for investigation. The study's design sought to limit researcher input but some biographic information would have been helpful to assess the relevance of their perspectives. Groups were led by one of the authors with a qualified and experienced qualitative investigator and a third researcher. Focus groups were recorded and researchers took individual notes, including one's reflections - used to identify emotional responses and group interactions and dynamics.

The paper offers a comprehensive account of the method of content data analysis with a clear description of its rationale and motivations. The process of data coding is clearly described and seems robust with researchers refining themes together and resolving discrepancies by consensus.

Results from both focus groups showed a mismatch between expectations and experiences of breastfeeding and three themes: "mothers' wellbeing"; "strained interpersonal relationships" and "frustration with the healthcare system". Within the theme, "mothers' wellbeing" there were sub-themes of: physical pain, feelings of desperation, guilt and disappointment and resilience. Intense physical pain, impacting mothers' emotional wellbeing was described. As were feelings of desperation to find out what was wrong and feelings of isolation. Mothers reported guilt for their baby's experience, blaming themselves for not being able to breastfeed and dreading it each time. Many expressed feelings of disappointment at their breastfeeding experience and the unanticipated difficulties. However, they also

showed resilience in self-advocacy, persevering in getting the support and help they needed and in continuing breastfeeding.

The second sub-theme of strained relationships with partners, parents and other children, with family members not understanding mothers' determination to continue breastfeeding or mothers being preoccupied with their tongue-tied baby to the exclusion of their other children. Yet, in some cases these relationships were noted to be an essential resource for managing.

The final theme described frustrations with the healthcare system with mothers feeling dismissed and unheard, leaving them feeling isolated and affecting their emotional wellbeing. There was also a sense that appropriate priority was not afforded to the breastfeeding relationship and there was a lack of systemic support. A sense of distrust and doubt was fuelled by professional inconsistency, disregard to tongue-tie as a complicating factor in breastfeeding, and lack of knowledge about it. Participants advocated for clear processes for referral, assessment and management of tongue-tie and further training.

The results show an evocative and rich authenticity, particularly in the quotes provided. Yet, the self-selection for participation combined with the undocumented purposive sampling leave questions about transferability. Would only mothers with particular experiences or motivations to persevere with breastfeeding have been on the social media platforms used to advertise the study and then have responded? All participants had persisted with breastfeeding and their babies given a frenotomy.

Furthermore, the homogenous sample comprised more privileged mothers likely to be able to afford a private frenotomy, with partner support and with an education empowering them to advocate for themselves. I would also have been interested to hear more about the effect of group dynamics on the results. Nonetheless the authors' conclusions of a significant impact on mothers' physical and emotional wellbeing and on their relationships, and of frustration and distrust with the healthcare system, felt credible. The authors acknowledge the need for research with more diverse populations. Their stated implications of the study's findings as being to inform clinical practice of the challenges faced by breastfeeding mothers of babies with tongue-tie and of providing appropriate and co-ordinated, evidence-based care seem reasonable.

Overall, taken together these three studies provide a convincing picture of the emotional significance for participants of experiences breastfeeding their baby with tongue-tie, with themes of physical and maternal emotional distress and frustrations with diagnosis, care and healthcare support.

Other studies I read (of "low-quality" evidence as individual case studies or with aims not directly relevant to this study) echoed themes of distress, pain and frustrations with the healthcare system (Kam, 2021; Ray et al., 2020; South, 2016; Tran & Hill, 2022; Wakelin et al., 2017). A US qualitative analysis of social media posts relating to tongue-tie found that 21.7% of parental posts included themes of anxiety or emotion (Grond et al., 2021)

### ***Cultural considerations***

As well as acknowledging the Western context within which psychoanalytic thinking has developed, the lack of diversity in these research studies is notable - what demographic data was recorded suggesting a strong preponderance of white, educated, middle to high income and partnered participants with the financial means to access a private frenotomy.

The design of most of the studies involved self-selection by participants, meaning their results can only represent the experiences of those with the motivation or ability to respond – likely to be dependent on language, geographic, financial, social, and cultural factors. In particular, the described themes of resilience, self-advocacy, determination to continue and seek care and treatment may be mediated by education, social status, surrounding support networks and access to financial means. Social and cultural norms around maternal identity, breastfeeding, childcare, and care and support of postpartum mothers vary widely and yet are likely to be powerful influences on mothers and key to fully understanding their experiences. Globally, health and social care systems have varying resources, priorities, care management protocols, structures, and relationships between private and public care – all of which will have a bearing on the maternal experience.

### ***Conclusions and rationale***

In summary, the evidence in this review gives a compelling picture of maternal emotional upheaval and distress associated with breastfeeding difficulties associated with tongue-tie alongside perceptions of an unreliable, inconsistent and unsupportive healthcare network. Within the wider context there is well-accepted evidence of the relevance of maternal emotional wellbeing and internal stability to developing parent-infant relationships and infant development within psychoanalytic, child development and empirical literature. Therefore, better understanding a mother's internal emotional world in relation to her breastfeeding experiences associated with tongue-tie seems both pressing and highly relevant - not only to mothers' wellbeing but also infant development. This psychoanalytic study into the maternal emotional experience of breastfeeding difficulties associated with tongue-tie offers a previously unexplored and particular opportunity to find out more about mothers' experiences in all their complexity and depth - carrying the potential to expand insight and promote the possibility of helpful containment for both baby and mother.

## Chapter 2 - Project design and Methodology

### *Introduction*

This research project explores the emotional experience for mothers who have experienced difficulties breastfeeding their baby with tongue-tie through inquiring about their lived experiences of those difficulties. It used an in-depth Free Association Narrative Interview (“FANI”) (Hollway, 2013) to gather life narratives of four mothers with the aim of making available their inner worlds and unconscious experiences. It then used Interpretative Phenomenological Analysis (“IPA”) (Smith et al., 2021) as a robust qualitative method of data analysis aimed at understanding individual participant lived experiences, focussing on the unique idiographic aspects of each individual experience whilst also allowing identification of recurrent themes between participants as a group. Within the IPA framework of data analysis, aspects of FANI and RRM (Holmes, 2018) were used to promote and deepen the availability and understanding of participants’ unconscious experience, so being made available for the hermeneutic analytic process.

### ***Aims and Objectives***

I used the SPIDER model (Cooke et al., 2012) to develop my main research question:

*Table 4 - SPIDER Model for developing research question*

<b>Sample</b>	Mothers of infants
<b>Phenomenon of Interest</b>	Emotional experience of tongue-tie in their baby
<b>Design</b>	Interview
<b>Evaluation</b>	Interpretative Phenomenological Analysis of interview transcripts within a psychoanalytic framework
<b>Research type</b>	Qualitative with some quantitative elements.

This produced the question: “What is the maternal emotional experience of infant tongue-tie?”. During the course of the project, a change in recruitment method meant that my sample was limited to breastfeeding mothers, so I amended this to, “What is the emotional experience of breastfeeding mothers who have experienced difficulties feeding their baby with tongue-tie?”.

Given its nature, I wanted to approach the question openly but had questions in my mind about maternal expectations about motherhood, their baby and feeding, the

sense mothers made of the process of tongue-tie diagnosis through to treatment and of their sense of their baby's experience.

### ***Project Design***

This research project adopts a qualitative design using a single interview adopting FANI method interview techniques and principles (Hollway, 2013). Data was analysed using IPA. Wanting to reach a certain level of depth of understanding of unconscious material in my making sense of each participant's experience (Smith et al., 2021), I chose to adopt aspects of the FANI (Hollway, 2013) and RRM methods (Holmes, 2018) within the initial stages of data analysis within the IPA framework.

### ***Ontology, Epistemology and Methodology***

The study's purpose was to gain understanding about the nature of the individual maternal subjective experience of tongue-tie and in particular its emotional content. It was designed within the ontology that human experience is both conscious and unconscious and that the unconscious operates dynamically to protect against anxiety and informs our lived experience and behaviours (Hollway, 2013).

Psychoanalysis offers an epistemology (through concepts including free association, transference, reverie, defences and containment) for bringing unconscious emotional material into consciousness, so making it available to be thought about and understood.

To do justice and be sensitive to any study of individual experience it must be interpretative (Hollway, 2013) but still can only ever say something of the experiences. Words do not necessarily have shared meanings. Describing in words a patch of yellow sunlight loses something of its “warmth, shape, brightness, pleasure and amodal aspects” (Stern, 1985, p. 176). Seeking to understand the individual experience my study suited an interpretative and idiographic approach like IPA (Smith et al., 2021). IPA is a specific and well-recognised method for exploring lived participant experience and for reaching understanding of how the participant makes sense of it (Pietkiewicz & Smith, 2014). It is “doubly hermeneutic” in that it involves the researcher making sense of how each participant makes sense of their experience (Smith et al., 2021). IPA acknowledges the researcher’s active influence in gaining access to participant experience and then making sense of it by interpretative activity. Not being a “recipe”, it offers flexibility involving the researcher’s creative activity in seeking the greatest understanding of each participant’s experience.

I considered what mode of investigation best suited the study. A focus group might facilitate discussion of shared experience and get the discussion going, with group dynamics offering insight into unconscious material. However, it would not be suited to reaching in-depth individual experiences. Similarly, an observation of mother and baby might have offered insight into dyadic dynamics but not individual experience, and without an interview it would not be possible to link directly with tongue-tie.

I decided individual interviews would be most suitable to reach the information being sought and that rather than semi-structured interviews, a FANI interview (Hollway, 2013) would allow the richest and most fruitful opportunities to find out about the maternal emotional experience of infant tongue-tie. FANI is rooted in the idea that humans make sense of experience through narrative. By asking questions such as “Can you tell me about ...” specific remembered experiences, participants are encouraged to tell their stories so that using psychoanalytic, epistemological concepts latent material is brought into consciousness - made available to be thought about and understood.

The FANI methodology challenges the idea that:

*“participants are ‘telling it like it is’, that participants know who they are and what makes them tick... and are willing and able to “tell” this to a stranger interviewer.” (Hollway, 2013, p. 3)*

It uses the concepts of the defended and psychosocial subject and free association to make available for research study the unconscious and otherwise inaccessible parts of the participant’s experience. Giving birth and new parenthood, combined with discovering a medical condition (albeit minor) in one’s baby are experiences likely to stir up anxieties and so defences, making the FANI methodology appropriate to reach latent and defended-against material, centred around Bion’s concept of reverie (Bion, 1962). FANI acknowledges the interview space as a shared intersubjective experience comprising participant, researcher and interview

experience in interplay. It was important to me that findings were “of” mothers and not “about” them. Time and resource constraints meant I was unable to conduct two interviews as anticipated by the FANI method. However, I felt that a single interview still offered the best opportunity to reach the information sought.

I considered using the RRM method within the interview but decided against it as a novice researcher. The RRM method (Holmes, 2018) uses concepts of relational reverie, reflexivity, negative capability and the idea of “waking dreaming” to reach countertransference responses founded in intersubjective exchange with the participant (Holmes, 2018, p. 29; Ogden, 1996). Given that my hope was to reach in-depth understanding of mothers’ experiences, this method held much attraction for me. In the spirit of IPA as a creative hermeneutic process, I concluded that adopting FANI and RRM concepts within my analysis would provide opportunities to deepen both the material made available and my understanding of it. Constraints of time and resources precluded using the teaching groups anticipated by RRM (Holmes, 2018, pp. 108-132). However, I felt my skills as a child and adolescent psychotherapist equipped me as a single researcher to use the method by seeking an ‘evenly suspended’ state of mind (Freud, 1912, p. 111) allowing me to consciously engage with dream thoughts evoked by the material (Holmes, 2018).

The timing of interviews was considered, seeking to find a balance between capturing the raw emotional experience of mothers, the practical and ethical considerations of seeking mothers’ participation soon after delivery, and allowing time for mothers to have processed their experience. I decided that interviewing

when babies were 3-12 months would mean care and treatment pathways would have taken place, things would likely be more settled practically and emotionally and would allow mothers to have made some sense of their experience whilst remaining within relatively recent recall. With weaning recommended at 6 months, it might also allow for investigation into thoughts and expectations about future feeding plans. As a retrospective study, recall bias was acknowledged but felt to be outweighed by the benefits. So too with potential bias created by delaying until after treatment with participation possibly dependent on the care or treatment mothers felt they received.

## **Method**

### *Ethics and ethical considerations*

Being educational in nature, small in size and scope and unlikely to produce generalisable or transferable findings this study did not require approval through the National Office for Research Ethics Committee. The Tavistock Review Ethics Committee (“TREC”) conducted its ethical review, approving it (subject to ratification) on 22 January 2024 (see Appendix 2). Written consent to circulate a recruitment advertisement (Appendix 3) was obtained from the respective founders of the social media and baby groups and one other professional offering postpartum services. The Tavistock and Portman NHS Foundation Trust sponsored the project and provided indemnity for its design and practice. The study was made within legal requirements of data handling and protection and health and safety regulations, in accordance with the relevant Tavistock and Portman NHS Foundation policies and in compliance with the Code of Ethics of the Association of Child Psychotherapists (of which I am a member). Consideration was given to the possibility that speaking about experiences relating to the early postnatal period could be emotionally

arousing and was mitigated for in the project design.

### *Participants*

#### *Inclusion and exclusion criteria*

Preliminary inclusion criteria were as follows:

- Participant is over 18 years of age and is the biological mother of baby with tongue-tie
- Participant's baby has been diagnosed with tongue-tie by a medical professional or member of the Association of Tongue-tie Practitioners ("ATP")
- Participant's baby is 3-12 months at the time of interview
- Participant is sufficiently proficient in speaking English to be able to consent and participate meaningfully in interviews

Preliminary exclusion criteria were:

- Diagnosis of any other physical oral anomaly or medical condition affecting feeding (e.g. cleft lip/ palate)
- Pre-existing psychiatric condition in participant

Diagnosis of tongue-tie by a medical professional or member of the ATP represented an identifiable way of determining whether a baby has tongue-tie. The requirement that participants be over 18 and proficient in English ensured full participation and that informed consent could be given. Exclusion of participants with pre-existing psychiatric conditions or babies with other oral anomaly or medical condition

affecting feeding kept focus specific to the maternal experience of tongue-tie. The age-range of babies at interview has been discussed in the Project Design section.

#### *Recruitment process*

Aiming to reach a wider demographic and range of experience, the project design initially anticipated recruiting through a local community NHS midwifery service, asking midwives to seek consent from mothers to be contacted later about the study at the point of referral for tongue-tie. However, due to delays and complications obtaining consent which could not be accommodated within the study's time constraints, the recruitment method was changed. Under the new method, participants were recruited through an advertisement (Appendix 3) posted on a breastfeeding social media group and circulated to professionals providing postpartum services to mothers and babies. One of these included the baby group which I had previously facilitated but with the proviso that participants could not have been in the group when I was there.

Within a few days of the advertisement being posted on the social media site I received 12 initial responses expressing interest in participating. I applied the selection criteria, seeking further information where necessary. If the baby was younger than 3 months, I sought consent to contact respondents again when they were. Many respondents had older children born with tongue-tie (up to 7 years) and were therefore excluded. I kept a record of the order of responses as a method of selection should I have more eligible volunteers than I could interview. Two members of the baby group responded, one of whom was excluded as I knew her

from my previous involvement. Still needing participants, I readvertised a few months' later, receiving 6 responses, 3 of whom were excluded due to their child's age. I applied the selection criteria in the same way.

On receiving expressions of interest from eligible potential participants I made contact by telephone, further exploring their interest in participating. If they remained interested, I requested their email to send them the participant information sheet (Appendix 4) and consent form (Appendix 5). During this call, I also explained how to complete a short questionnaire (Appendix 6) which I sent on receipt of the signed consent form. The questionnaire sought practical information about the participant, the baby's tongue-tie and treatment to ensure sufficient time within the interview to focus on exploring the emotional experience. At this time, I also arranged a time and location for the interview. I let mothers know that they could choose whether their baby was with them at interview but explained that in being there they would be included within data collected. All participants agreed to this. I kept a reflective research log of these interactions.

#### *Final Sample*

The final sample comprised four mothers, one aged between 26-30, one 31-35 and two over 35. Their infants ranged in age between 4 and 7 months at the time of interview. All participants were university educated (two to post-graduate level). All were white with two native to the United Kingdom. Three of the four mothers were living with their baby's father. To protect anonymity, I use the following pseudonyms

for each dyad within this paper: Anna and George; Marta and Kaya; Eleanor and Ariel; and Pippa and Daisy.

### *Data collection*

All participants requested that interviews be conducted in their home. Prior to each interview, I reviewed the participant's response to the questionnaire so that I had in mind the external circumstances of their experience. Each interview began with a brief explanation of the project and how the interview would proceed. Interviews were by FANI with a view to encouraging participants to tell narratives of their specific experiences and were therefore unstructured. However, I had an interview schedule with some prompts should they be needed (Appendix 7). In each case I asked participants if they could tell me about times they had felt supported and unsupported and about feeding plans. At the end of the interview, I gave participants a debrief letter (Appendix 8) including details about me, the project and signposting sources of support.

Interviews were digitally recorded in duplicate. Immediately after each interview, I made field notes to ensure congruence between verbal and non-verbal data and capture my own reflections and recollection of the encounter. The digital recordings were transcribed using suitable transcript software and then reviewed taking out any identifying information.

### *Data analysis*

The interviews were analysed using IPA (Smith et al., 2021) as a robust structure for

analysis. Concepts central to FANI (Hollway, 2013) and RRM (Holmes, 2018) methods were also used in the process of data analysis as part of the IPA iterative hermeneutic process to further promote latent material being made available for understanding and analysis. These methods make use of psychoanalytic concepts such as intersubjectivity, containment, transference, defences and reverie to elucidate and make sense of material related to unconscious lived experiences. This initial stage of analysis informed and enhanced the interpretative process through IPA of trying to understand how each participant made sense of their lived experience.

The following steps were undertaken:

1. Before analysing the data itself, I wrote a “pen-portrait” about myself, to heighten my awareness of my part in data collection and analysis. I re-read my field notes and research log.
2. I listened to digital recordings and read transcripts, immersing myself in the data to get a sense of each participant’s experience in accordance with the principles of IPA. Transcripts were annotated accordingly.
3. Transcripts and recordings were further examined using RRM methodology - opening myself to reverie in establishing within myself an inner containing space and capturing “pit of the stomach feelings”, thoughts, images, or pictures that came to my mind (Holmes, 2018, pp. 65 and 91-93). This included listening to recordings once each at low volume so that the words were indistinct but leaving available the emotional timbre. Transcripts were

annotated accordingly.

4. I re-examined and annotated transcripts and recordings using the FANI methodology, specifically using the psychoanalytic concepts of intersubjectivity, containment, transference and defences and wrote a “pen-portrait” for the participant with the aim of bringing them “alive”.
5. Pen portraits and field notes from the interview were reviewed and analysed using the same psychoanalytic concepts.
6. In accordance with IPA, I then reviewed a separate copy of the transcripts making categorised exploratory notes. I then incorporated into that copy of the transcript my notes from steps 3 and 4 (example extract at Appendix 9). From this, I established personal experiential statements triangulating between the exploratory notes and my additional notes produced using RRM to capture something of the participant’s experience as understood by me whilst remaining focussed on the participant’s experience. Next, I manually cut up, clustered and re-clustered these statements (photo at Appendix 10) looking for connections to establish individual emergent personal experiential themes (“PETs”) which I named and consolidated and organised into a table, linking personal experiential statements with relevant extracts from the transcript (example extract at Appendix 11).
7. I repeated this process for each participant and then re-examined the PETs of all participants together, seeking connections between them and noting areas

of similarity and difference, creating a set of Group Experiential Themes (“GETs”) which I organised into a consolidated table across participants (example extract at Appendix 12).

8. The limited size and scope of the study meant that I could not develop all GETs within my findings but selected those that connected best with each other.

### ***Researcher subjectivity***

In FANI and RRM the psychoanalytic concepts of intersubjectivity, containment, transference, defences and reverie are acknowledged as part of data production and are key in data analysis (Hollway, 2013; Holmes, 2018). Recognition is needed in both of my part as a participant. A different researcher would collect different data and make different sense of it. My unconscious world, that of each participant, their baby and all three of us together will all have been in interaction. Dynamics of sameness and difference arising from my gender (female), age (middle-aged), ethnicity (white) and profession together with possible dynamics of maternal transference are all recognised as having carried significance. So too, my position as a mother who experienced breastfeeding difficulties (but unrelated to tongue-tie) is relevant.

## Chapter 3 – Results

### *Introduction*

The narrative nature of interviews (FANI) encouraged participants to tell their stories in an open, non-structured way, making available unconscious material for analysis. Participant experiences of their baby's tongue-tie were inevitably and inextricably linked with their experiences of pregnancy, delivery and post-partum weeks - each significant and highly emotive events in themselves. Each participant also brought their own personal life history and experience and was meeting me for the first time - making their own sense of me and of being interviewed by me. Findings are in this overall context.

### *Summary of Group Experiential Themes*

Amidst an incredibly complex and individual emotional landscape, IPA data analysis revealed five main group experiential themes (GETs) and within those, several sub-themes (set out in Table 5 below).

Table 5 – Summary of Group Experiential Themes

	Group Experiential Theme	Sub-theme
1.	The psychological and emotional complexity as a breastfeeding mother	Breastfeeding and motherhood - a “special business” that goes beyond physical feeding
		Managing expectations – the imagined baby and ideas of motherhood during pregnancy
		Maternal confidence and worries about capacity – feelings of failure
2.	The hope of connection and the pain of disconnection	Trying to make a physical and emotional connection with baby
		Trying to connect with support
3.	Internal relationships with dependency and care in interaction with lived external experiences	There are ideals of care
		Individual experiences of disappointments in care
4.	Alone and stuck in an unbearable situation – reaching breaking point	Not knowing what to do or what is happening
		Loss of structure and control

		Feeling trapped
		Desperation and urgently needing to find a way out
5.	Ambivalence – managing feelings of hurt, anger and upset	

Before detailing each of the GETs I set out an abbreviated version of each participant's pen-portrait (incorporating information from the questionnaire).

***Pen Portraits*** (Names changed throughout to protect anonymity)

*Anna and George (7 months)*

Anna (White/European) is in her late thirties and highly educated. Although her accent suggested she was not native to this country, she did not mention her birth country or family. A solo parent by choice she planned accordingly during pregnancy, anticipating needing babysitters and combining breast/ formula-feeding - seeing herself and baby George as very much a 'team'. George's birth by emergency Caesarean followed a failed induction and long labour. Immediately afterwards Anna was put under general anaesthetic with the local one no longer effective. A doula present throughout labour and delivery had already gone when she woke from the anaesthetic. She was alone and disoriented with George in the

cot next to her. Anna found her first encounter with healthcare staff - a maternity nurse - immensely upsetting, feeling criticised for not having already dressed George.

Although George's tongue-tie was identified in the hospital, he appeared to be feeding well so Anna thought no more of it. Initially, once home, all seemed well. Whilst grateful for midwives' visits, Anna often felt judged as a single parent, sensing they doubted her capacity to care for George alone. George constantly fed and cried but his steady weight-gain meant nobody other than Anna was concerned. With painful feeding and post-operative pain exacerbating things Anna became desperate. She researched online what the difficulties might be and became quite isolated, struggling to get out of the house and feeling able only to communicate by email or online when George was asleep or feeding. The breastfeeding social media-group she joined felt invaluable. Remembering the tongue-tie diagnosis in hospital, she tried to contact the tongue-tie clinic but received no reply to her emails.

At 5 weeks she consulted a lactation consultant privately who referred her to the NHS tongue-tie clinic but the several weeks' wait felt too long. So, she arranged for a tongue-tie practitioner to perform a frenotomy. Anna said little about the procedure itself. The practitioner also examined George's latch and noticed that despite his lengthy feeds, George was not taking in much milk - Anna's milk supply had become very depleted. It was several weeks after the frenotomy before Anna felt things improve and saw her milk supply recover – but never sufficiently to feel enough.

*Marta and Kaya (7 months)*

Marta (White/European) is in her late twenties and university educated. She lives with her baby, Kaya and her partner. She spoke of her birth country and of being away from home but spoke only of her partner's family – not her own. Her partner's work patterns meant Marta was mostly alone with Kaya and often at night.

Kaya was born vaginally in a birth-centre following induction. She suffered a mild physical trauma during birth but otherwise all went well. For the two days they remained in the birth-centre, midwives supported breastfeeding, something Marta had always assumed she would do. Marta put pain and difficulty feeding down to being part and parcel of establishing breastfeeding. Professionals did not seem concerned. A specialist tongue-tie team at the hospital did not serve the birth-centre.

Once home, things really deteriorated. Kaya constantly fed, never seeming satisfied or sleeping - only a few hours in total over the first 36 hours. Feeling very much alone, Marta desperately sought help from the healthcare system, being particularly grateful for the 24-hour helplines. Everyone reassured her that as a big baby Kaya probably just had a large appetite. However, several days later a breastfeeding support worker visited and identified a significant tongue-tie, recommending supplementing feeding with formula. Marta struggled, feeling completely unprepared for bottle-feeding. Finally, Kaya slept. Near physical and emotional collapse, Marta

called a helpline who checked Kaya's safety and then advised Marta to take some time for herself whilst Kaya slept, allowing Marta some recovery.

On Kaya's referral to the tongue-tie clinic, the month's wait felt too long to bear. Determined to breastfeed Kaya, Marta switched the formula for expressed breast milk but found combining expressing, bottle-feeding and breastfeeding complicated and difficult. Just as she was considering a private frenotomy in desperation, the NHS appointment came through at 12 days postpartum. Marta said there was little to say about the procedure itself. Afterwards, Marta worried the tongue-tie might grow back – terrified of finding herself back in the same situation. Subsequently she exclusively breastfed but it was several weeks until the breastfeeding relationship felt settled.

#### *Eleanor and Ariel (4 months)*

Eleanor (White/British), a highly educated care professional in her thirties, lives with her partner and baby, Ariel. Ariel's birth coincided with the serious illness and subsequent death by euthanasia of the couple's dog. Eleanor's family live some way away and although she spoke about them, she gave the impression she found their support a mixed blessing.

Ariel's conception was assisted due to a genetic condition and pregnancy brought some concerns about her development. Eleanor had meticulously researched, pregnancy, early motherhood and infant development, keen to ensure the best

possible start for Ariel, hoping and planning for a homebirth - discussed with their assigned one-to-one midwife. However, at term, concerns around foetal movement meant the hospital were keen to induce birth. Eleanor and her partner resisted this, instead being regularly monitored but feeling doubted and judged for their decision. After three tense weeks (with their dog simultaneously very unwell), they decided to request an elective caesarean. Yet this decision was taken out of their hands with sudden concern about Ariel's heart rate meaning an emergency caesarean.

Initially, Eleanor was on rather a high having safely delivered Ariel. Breastfeeding seemed to be working but soon she started having concerns about Ariel's latch. Professionals mentioned tongue-tie specialists but seemed unconcerned and they were discharged. Eleanor's assigned midwife was not working for the days around Ariel's birth and was sorely missed.

Things deteriorated once home, with Ariel unable to latch at all, distressed and hungry with the emotional turmoil amplified by their dog's death. Reserves of colostrum harvested in late pregnancy were fed to Ariel by syringe but quickly used up. At four days, their midwife identified a moderate tongue-tie but suggested they persevere to see if the difficulties would resolve. Distressed and low in mood, Eleanor struggled facing trying to latch consistently. At their midwife's suggestion, they introduced nipple shields (which proved to be the wrong size, causing nipple damage and pain) and then a 'finger-feeding' system (introduced in the midwife's absence as she was on leave). Eleanor's partner took up the primary role in finger-feeding.

At two weeks, the midwife (a tongue-tie practitioner) performed a frenotomy. Eleanor reported it as going smoothly, with few apparent side effects or disturbance. However, without an immediate improvement in breastfeeding their midwife recommended they seek extra help when she discharged them (somewhat earlier than usual).

Eleanor then contacted a lactation consultant who offered advice about latch and positioning and identified they were using the wrong size nipple shields. A week later, things finally seemed to be improving. After a further visit by the lactation consultant, Eleanor felt able to manage without further support. Gradually they moved to exclusive breastfeeding, although Eleanor has continued to use the nipple shields.

### *Pippa and Daisy (6 months)*

Pippa (White/British), university educated, is in her mid-forties and has a successful career. She lives with her partner, and two children, baby Daisy and her three-year-old son (also born with tongue-tie). At the time of the interview, an international house move associated with her partner's work was imminent. Pippa described her medical childhood family as no-nonsense and practical. Her mother died when she was in late adolescence. Her father lives with his second wife some distance away but visits regularly. His support is kindly but can seem a bit removed. Pippa's partner works long hours and is often unavailable.

Daisy's conception was assisted following an earlier miscarriage. Profound breastfeeding difficulties with her tongue-tied firstborn (following a traumatic birth during Covid) led Pippa to seek a private lactation consultant prior to Daisy's birth just in case. Pippa first contacted me around this time about participation in the project regarding her firstborn. Concerns about foetal movement meant the planned caesarean was suddenly brought forward.

Unlike her brother who had been unable to feed at all, Daisy latched but extremely painfully for Pippa. Daisy suffered from both wind and reflux resulting in explosive spit-ups. The lactation consultant visited and offered helpful advice and explanations around positioning. She also identified that Daisy had a slight tongue-tie. Pippa persevered breastfeeding Daisy, hoping things would resolve over time, but aware her mood had dipped and with a return of the intrusive thoughts of harm she had experienced with her firstborn, she arranged for a frenotomy when Daisy was six weeks. She described Daisy's frenotomy as straightforward - but having been less so for her firstborn.

### ***Description of Group Experiential Themes***

Overall, the GETs show that the way participants made sense of their experiences of tongue-tie went to the core of their experiences of motherhood, their baby, their relationship with their baby and their sense of the support available to and within them. The experience had been profound, painful and desperate. However, these were inextricably linked with their overall experience of delivery and the first

postpartum weeks. I approach each GET accordingly in the sections below and in the discussion.

***Group Experiential Theme 1 – The psychological and emotional complexity as a breastfeeding mother***

This theme illustrates how each participant account brought a sense of the psychological and emotional significance of becoming a mother - with the decision to breastfeed being an integral part of that. The complexity of their experiences was articulated in three main ways, as represented in the following sub-themes.

***1.1 - Breastfeeding and motherhood - a “special business” that goes beyond physical feeding***

For each participant, breastfeeding represented something both physical and psychological – a special, almost magical phenomenon relating to maternal capacity and linking them with their baby.

Anna’s description made clear her sense of its link with maternal potency and capability. When she spoke, I felt a glow at seeing a sense of her own resources.

*“...we've got this superpower (motioning towards her breast where George feeds) of... yes.... when he's... he's fallen asleep now (says softly and affectionately)...” p.63*

More matter of fact, Pippa's description makes clear her sense of its power in meeting her baby's needs.

*“...like the absolute... solves every problem.” p.61*

Marta's sense is of something almost spiritual, mysterious and wonderful – combining the tangible and intangible – linking mother and baby and rooted in what her body can provide:

*“it's such a special...um... thing you can do for your baby like, you know, like ...just like... literally like give them your energy. I don't know, like sustain them, but you're... your body, right?” p.59*

Eleanor's pleasure and sense of wonder and pride at being able to meet her baby's needs through breastfeeding felt palpable.

*“... just so pleasant that your baby can have a need and cry and that you can just meet that with your own body. Like it's quite miraculous in my view. So yeah, it's ...now... now it feels good.” p. 87*

Participants shared a sense of the emotional significance for their babies too, with feeding going beyond physical nutrition and being linked to feelings of comfort and reassurance that they could provide. Anna describes:

*“It might not be hunger. It might just be that he wants to be on the boob for comfort” p.21*

Marta recognized too that Kaya might be seeking emotional comfort rather than nutrition at the breast.

*“I think she might have been using me [as a] dummy because oftentimes I would just put her...erm... on breast again.” p.42*

Her use of the word ‘dummy’ also perhaps suggests complex, ambivalent feelings within her, perhaps of feeling misused or of powerlessness at not knowing what else to offer.

Anna articulated a growing awareness of links between the emotional and physical experiences of breastfeeding, describing how she has come to notice George’s distraction whilst feeding and her lack of milk let-down when she herself is distracted by other things rather than focused on him – a powerful example of the dyadic connection, with the physical and the emotional cyclically interlinked and interdependent.

### *1.2 – Managing expectations – the imagined baby and ideas of motherhood during pregnancy*

All of the mothers spoke in different ways of their expectations (or otherwise) during pregnancy about feeding/ mothering their baby. When careful plans and expectations of pregnancy did not materialise, Eleanor was left with a sense of irreparable damage:

*“...I just had it kind of certain in my mind that ... there was some kind of seismic things happening in those first two weeks that I’d kind of... couldn’t undo.” p.60*

In contrast, Marta, Pippa and Anna each spoke in different ways of specifically not having any expectations. Aware of the potentially unrelenting demands associated with parenting alone, Anna spoke of ridding herself of them as a way of preparing herself emotionally for motherhood. Perhaps by imagining only successful breastfeeding, Marta kept doubts far away but then felt utterly unprepared emotionally and practically when she needed to supplement with formula.

*“...so I always plan on breastfeeding, like, I’ve never even considered formula ... like to get back-up formula or anything like that. I just, I was like, “I’m gonna breastfeed. I’ll be breastfeeding. Like, I don’t think any of that” p.6-7*

For Pippa, avoiding expectation was fuelled by doubts about safe delivery given her older age, difficulties conceiving and recent miscarriage - but made it hard to enjoy her pregnancy or to make space in her mind to imagine Daisy.

*“...but yeah, and I think a bit like with [firstborn’s name] because I was anxious about ...just because of my age... I didn’t... um...er... dare imagine what she’d be like, if you know what I mean... in case of problems.” p.112*

It seems that for these mothers, rather than not having any expectations they perhaps had frightening ones to be avoided or actively kept out of mind.

### 1.3 - Maternal confidence and worries about capacity – feelings of failure

The mothers expressed doubts in different ways about the maternal capacity of their bodies. Pippa's struggles to conceive and earlier miscarriage had left her doubtful of her ability to grow and deliver a healthy baby. She described being "an anxious mess" throughout the pregnancy. For Eleanor the worries were about producing milk and how it might be limited by the small size of her breasts. Although not explicitly stated, Anna's doubts are manifest in her physical relief at George's safe delivery.

*"... the moment he was out that was the... my...you know... my main thing was is he... is he healthy? And soon after they told me...erm... yes, he's healthy... I... pfff (exhales) I kind of almost like decompressed." p.14*

Eleanor's similar relief was quickly shattered by her difficulties feeding Ariel.

*"So, to have this healthy baby which is miraculous. Like ...I'm like, "Oh my God, we've actually done it". So, I kind of went from that like high ...and of course hormonal as well... that high um...to this...just this feeling of like "Oh my God, I can't do this. I'm completely stuck, and I can't feed my baby" (struggling to speak and taking a deep breath)." p.34*

Difficulties breastfeeding appeared to find root in these pre-existing anxieties - affecting the participants' sense of maternal identity in different undermining ways.

In the following extract Marta describes the relief at seeing the physical evidence of her milk production when she first expressed milk but then the rejection and defeat when Kaya posseted it back up:

*“Like she was just so excited. Erm... and she spat out like most of it. I felt like... I felt so defeated too because...erm ... well first of all, when you like start pumping, expressing like y... you...you're not getting as much milk in the beginning. Erm...and I was just sooo happy like when I did the...had my first pumping session, I think I got 60 erm... millilitres... that's two ounces. I was like, “Oh my god, this is so great. Like this is so much milk!” I just felt so excited. I took a picture ... I still have the picture on my phone, because ...er...yeah, it was like such a sense of achievement...She... she... she gobbled it down. But yeah... um...she had a massive spit up. And I yeah...I... that, that, that...felt... felt awf...felt awful... ‘Cos...Yeah! (laughing but then quiet, becoming emotional)...p.43*

She commented that she thought Kaya had a tummy ache afterwards as well suggesting a sense that her milk had somehow been harmful, but possibly too, a projection of her aggression at the hurt of feeling rejected - also perhaps mirrored in the terms “spat-out” and “gobbled”.

Both Anna - in feeling she could not produce enough milk to sustain George - and Eleanor - in her continued use of nipple shields - seemed to have lingering worries about their capacity to breastfeed. Ongoing anxieties beneath Anna’s apparent self-

assurance were also perhaps suggested in her expectations that others would think her incapable of looking after George alone. For Eleanor it was felt more directly:

*“I was feeling... completely lost and kind of... I think devastated and kind of (baby unsettled at breast) just completely inadequate...like I cannot look after this baby, like... I can't meet her needs. That, that was the thing that was just playing... like “I can't meet this baby's needs. I can't...” p.37*

For Marta it combined with guilt.

*“Like why cannot I provide for her? Like why... like why ... she, she doesn't deserve this...” p.25*

Pippa also described feeling guilty. However, the following extract shows how with two differently difficult experiences breastfeeding and with the first having felt more profound, things became confused between the two children and the guilt focussed on her eldest. Throughout our interview, Pippa frequently confused pronouns when describing her experiences with her firstborn and Daisy and it was often hard to know who she was talking about. I noticed she rarely used Daisy's name, referring to her as “this one” in contrast to her frequent use of her firstborn's name. Possibly, her mind was so full of her traumatic experiences with him it was hard to find her sense of identity as Daisy's mother.

*“So, I think... although people have told me about the guilt, that you feel that you're not giving your first... born, as it were, all the attention. I wasn't prepared...um... for that ...as much of that...And I remember t... having the sort of... the big jaggy weeps, you know*

*of...erm... but it was more about erm [firstborn's name] than her..."*

*p.70*

Eleanor clearly articulated her sense of the impact of the early difficulties breastfeeding on her maternal confidence.

*"I just feel like the tongue-tie and all the stress that it brought kind of fed into so much of like those first few weeks and my feelings about like...my ability as a parent." p.63*

Anna, spoke of her surprise at its impact.

*"...you know I braced myself emotionally for the experience. The rest of the mo-motherhood... I found it easier... um... mentally but the breastfeeding I... I... I had not realised how difficult it was." p.20*

In contrast to the crushing effect of difficulties were the boosts that came with success. Anna's previous sense of inadequacy was replaced with ones of pride and capacity.

*"... if I could be part of that minority of women that I could do it up to six months that would be great. Now that I've gone past six months..." p.62*

Similarly in the following extract, when the lactation consultant described Eleanor feeding Ariel more naturally at her visit following the frenotomy, I could not help but share her pleasure and relief as she spoke.

*"...doesn't seem like a big deal (sighing and laughing slightly)) but I'm saying like, "Oh my God! Someone says something good" I don't... (laughing naturally and with relief) I was just so ... in a*

*headspace where I was failing. That just someone saying, “you've done something really well!” was huge.” p.55*

## ***Group Experiential Theme 2 - The hope of connection and the pain of disconnection***

This GET describes the shared experience of disconnection among participants' accounts both in relation to their babies and their sense of being able to access care within the healthcare system. This disconnection seemed all the more painful in its sharp contrast to a hoped-for sense of connection. The sub-themes below describe different aspects of these experiences.

### *2.1 – Trying to make a physical and emotional connection with baby*

This sub-theme narrates how participants struggled to make both a physical and emotional connection with their baby during the post-natal period amidst their difficulties and influenced by their delivery experiences.

For both Anna and Eleanor, an emergency caesarean meant a sudden and unexpected disruption from the outset - very different to Eleanor's planned home delivery. Eleanor's following description brings a sense of a rather alien first encounter with Ariel.

*“...it was... utterly bizarre... like I couldn’t picture being handed a ...baby and so when I... put this baby on me I was just like “Oh my word! A human baby” p. 22*

The shock of the emergency caesarean and loss of sense of connecting continuity was compounded for Anna when she was immediately put under general anaesthetic only then to wake up alone later to find George in a cot next to her. His constant feeding initially felt like a good connection between them but soon felt very different, with George unsettled and seemingly never satisfied. In the following extract her sense of something not quite connecting is demonstrated as she describes the missing anticipated synchronicity in supply and demand, his poor latch (the physical connection) and her difficulty in making a mental connection between things.

*“ So, that’s when I basically realised, “Oh is there an issue with my supply?” I never knew how to assess whether I’m producing enough milk and... they tell you that supply is never an issue as in it regulates based on the demands, right? And I had a **lot** of demand... So... you know non-stop. So, I didn’t think supply would be an issue. I didn’t... yeah. I couldn’t connect the fact that he might have had a poor latch.” p.40*

During the interview she repeatedly described a continuing “mismatch” between her milk supply and George’s need. Delivery inevitably brings a disconnection, ending the ‘in utero’ union, something likely only compounded for Anna by the caesarean and general anaesthetic. George’s difficulty latching due to his tongue-tie perhaps not only added to this but also represented a lost opportunity to heal it through a mutually satisfying breastfeeding relationship.

Ariel's tongue-tie meant she could not latch to the breast. Eleanor's following description of their mutual distress in unsuccessfully trying to come together was painful to hear.

*"I was just continually trying to get her on the breast, and she just couldn't. She was just kind of ...opening her mouth a little bit and not really going on. And then getting really, really, upset. And it got to the extent (voice breaks) like... early days... kind of every time we tilted her into the position to like latch she'd just scream and scream and scream. And... newborns don't have the loudest cry but it's quite an intense... cry...erm... to have and... (inhales deeply) ..."* p.29

Her sense of disconnection is palpable in the next extract, as she describes being physically distanced from Ariel and the rather mechanical and convoluted process of the finger feeding system they were using. This is perhaps also demonstrated in her move from using her partner's name to a noun.

*"It was this kind of ...bleak scene of Ben.... Ben.... in the bed, my partner erm... with the ...next to me... like cot on his side ...because I had always pictured I would go on that side but then obviously with the caesarean... I couldn't climb in and out ...erm...with Ariel next to him and then me on the other side kind of... s... sat up because I had the caesarian I couldn't lie down. And... I was kind of hand expressing into syringes as he fed them to Ariel."* p.31

She described feeling that Ariel made no mental connection between feeding and Eleanor's breast (and perhaps herself) at all. Her sense of a lost connection is

painfully evoked in the next extract as she describes watching her partner feed Ariel in perhaps what might have been the experience she had hoped and imagined for herself.

*“Ariel would kind of gaze at him, and they’d have this bonding experience. So, he was really keen to do it out because he had... it was kind of lovely for him. It was this great thing and he’d get to do it...” p.76*

This was made all the more difficult when Ariel initially smiled more at him.

*“...that just kind of fell into this narrative in my mind that actually, “No, she doesn’t...You’re not bonded” and... it was interesting (voice strained), I Googled it ... it was basically saying your baby will smile at the person who’s their... most securely bonded to. So again, I’m thinking, “Yes, I’ve messed this up. This is...this is gonna be terrible”. p.61*

These grave doubts about connection with Ariel felt very raw in the present of the interview. Her following words felt devastating:

*“I was very, very worried that I’d kind of messed up my bond and that... I’d kind of... I... I guess it must have felt like irreparable damage had been done, that could never be undone.” p.59*

So too with Marta’s following description of trying to reach her earliest maternal feelings for Kaya.

*“I do have pictures from the time like obviously, like you take pictures of your baby. Right? And I think few months ago if I look at*

*them, I would see a cute baby but I would see the struggle more than the cute baby. Like I would get transported in time. It was painful to look at those pictures. And now if I look at them I don't... I don't... I don't feel like that anymore. I just I just see a small baby that I love so much (emotion in voice) ...” p.59-60*

As with Eleanor, the rawness of her emotion left me wondering if perhaps some residual but hard to acknowledge feelings remained. Marta was the only participant who chose not to have her baby with her during the interview, electing to pause it to feed her in another room, causing me to wonder if something less certain lay beneath her manifestly confident description of breastfeeding in the present.

Waiting in the kitchen I felt rather alone, with the flow of the interview feeling ruptured - worried I wasn't quite understanding things properly but also painfully aware of how exposed and vulnerable she seemed to me. When Marta returned, something of the sense of disconnection seemed echoed as she described her frustration and disappointment in her partner's family's lack of honest communication and it took a little while to recover the flow of the interview and sense of connection between us.

She described that breastfeeding only seemed to become fully established several weeks later when Kaya was unwell. Perhaps caring for Kaya in her illness sparked Marta's sense of being needed by and of being able to provide for her, bringing back a feeling of synchronicity. In the next extract, as she seeks to describe this, struggling to connect seems echoed in our disjointed syntax and shared difficulty in finding the right words, culminating in a moment of relief when we finally do.

*“...that’s when I ... well... when I’m sure like she’s... she properly learned how to latch and how to...well, nurse and I felt a difference too. And it became more... I don’t know...erm*

*Researcher: More ordinary?*

*Participant: Yes. Yes. Sorry. Yeah. Yeah. Yes,*

*Researcher: Like it was just sort of... it ...it was a thing that you did, as opposed to...j... I dunno...*

*Participant: Yeah, yeah. No, like, yeah, that's funny. Yeah, I...maybe ...we just became*

*Researcher: it clicked? (slightly interrupting)*

*Participant: Yes, yes. That's what it clicked. Thank you! (both laugh) Yeah.” p.38*

Pippa’s two experiences of breastfeeding through tongue-tie were very different as captured in the following extract - whilst her firstborn could not latch at all Daisy’s was powerful but painful.

*“And then....um... and she latched... much better than [firstborn’s name]. [Firstborn’s name] didn’t latch at all. Like he just kept on slipping off... kept on slipping off. So, he didn’t have any... milk at all... um... from me...even when I got nipple shields... and everything... um... So, I ... because I knew all about that I thought “Oh! Amazing maybe... we... I’ve got a baby that, actually... you know... you hear people “Oh! I didn’t have any problems at all!” You*

*just ...internally slightly seethe (grimaces in playful way). Erm... it's like people who say "Oh, yes, she sleeps eight...eight hours a night!" ... erm... so... "Brilliant!" ... Erm... yeah... so... I thought it was okay. But... actually, even in the recovery bit from the C section, she was making one of my nipples bleed..." p.16*

An aggression, maybe more easily playfully directed towards other mothers, permeates this extract, something I was left wondering might perhaps be disrupting the connection she felt with Daisy. Feeding Daisy was not only physically painful but in the following extract it also seemed linked in Pippa's mind with intruding upon and relinquishing the hard-won, settled and deeply connected breastfeeding relationship she had finally built with her firstborn.

*"...I remember thinking "Oh my God... this is... I've missed this" of lying down ... because we used to also lie down with him to fall asleep ...now since she was born, we sit in the same room to him ...with him as he falls asleep..." p.131*

Pippa described Daisy 'clicking' and slipping off the breast as she fed – evoking a sense of a rather stop/start, intermittent contact. Daisy was noisy, irritable and easily distracted whilst feeding and sitting with Pippa, making it hard to maintain the flow of the interview. At one point Daisy posseted a large amount of milk. Pippa placed her on a playmat where she was immediately more settled and soon fell asleep. I was aware of my own anxiety levels settling. In the following extract a touching moment of intimacy before she fell asleep seemed to get rather quickly broken off.

*"...so... yes, we're talking about you! (baby looking and smiling at her) ... Yeah (baby makes echoing noise which sounds like 'yeah')*

*Yeah! Are you copying my voice, or am I copying your voice... who knows? (baby and Pippa exchange mirroring vocal sounds) ... Yeah! ... Yeah! Um... (baby vocalizes, participant chuckles briefly then makes slight growling sound) err...ergh! Do you want something to play with?" p.43*

## *2.2 – Trying to connect with support*

A sense of trying but failing to access healthcare was present in all participant accounts. Anna described having been given a leaflet with email addresses which were never replied to and of unanswered telephones. Marta had the feeling of being purposefully ignored when calls and text messages were invited but not responded to. Pippa and Eleanor described experiences of specialist support promised but never followed up and a sense of different services failing to join up. Marta's following description suggests that when contact finally was made, connection felt futile and useless:

*"...it took a couple of days to get in touch with her in which... like and in that time...I'm not... I can't really say ...that...um... the question I had, it resolved itself, but... I don't know like... it's almost like I forgot what I wanted to ask why... maybe I worked it out or maybe I didn't and it was just all sort of like disconnected. Erm. Yeah...(pause) Yeah... And I... I...I was almost ...well desperate again to like get in touch with her, to talk to her and like she knew that but once she did, I suddenly, like didn't know what to say or*

*what to ask. Because the time has passed and whatever issue I was having, or I wasn't sure about something, like, um... It was not urgent anymore, but it was at that moment". p. 49*

So too, Pippa, Marta and Eleanor described feeling alienated from their partners in different ways and for different reasons. Rather than face-to-face support, all turned to the internet (including for three of them the breastfeeding social media group through which they were recruited).

***Group Experiential Theme 3 – Internal relationships with dependency and care in interaction with lived external experiences***

Ideas of dependency and care were present throughout participants' accounts. Through the material there was a sense of each participant having their own specific individual internal relationship with both - resonating through their narratives of providing care to their baby, their sense of their baby's needs and dependency, in describing their own and then combined with my experience of being with them and as recorded in my field notes. For Marta there seemed to be echoes of a hungry desire for care with little in return in both her sense of the care she received having tried so hard to get help in frantically calling helplines, but also her sense of Kaya in having to work so hard for so little milk. This perhaps then echoed in my feeling after the interview that despite her open and generous account I had somehow failed to make a good connection with her and had perhaps not been able to get enough material.

Pippa's description of needing to be resourceful by sorting out a lactation consultation prior to Daisy's birth in anticipation of there being no engaged support available based on her prior experiences with her firstborn and perhaps too her sense of parental experiences of carers likely to avoid rather than engage with emotional complexity, seemed to have echoes in her sense of Daisy as a robust baby that could get what she needed but was perhaps messy and tenacious along with it – something that was perhaps sometimes hard for a carer to know what to do with. There were perhaps too some parallels in my engagement with her, in feeling a pull to move beyond the boundaries of the interview into something more familiar and in going beyond the planned interview length and afterwards being left with a niggling uncertainty as to whether the interview had being a positive or negative experience for Pippa.

Anna's expressed fear both at the beginning and end of the interview of perhaps never stopping once she started speaking about her experiences seemed at odds with her apparent self-assurance and self-reliance. This worry seemed to resemble her sense and fear of George's voracious appetite and unending need – making me wonder if it was perhaps a self-protective projection of her own deep, unconscious sense of need and vulnerability - also managed by staying close to feelings of not needing to rely on others. This confusion felt reflected in my feelings after the interview – as well as finding it hard to leave and having a powerful sense of her vulnerability, I felt keenly aware of my comparative inexperience as a novice researcher.

Eleanor's narrative had themes of emotionally inattentive and misattuned care, and fears about a disrupted connection with Ariel were a strong theme in her narrative. This seemed echoed in my field notes recording my concern after the interview that I have been somehow misattuned – meant to be someone understanding but not quite managing it.

These reflections and my interpretations represent my experience of each interview on that particular day and cannot summarise or represent the richness and complexity of the constellations of each participant's internal object relationships. However, notwithstanding this, the clarity of individual repeating patterns, themes and connections of ideas about dependent relationships experienced in differing relationships – past and present - and in different identifications offered a convincing picture of individual underlying internal emotional frameworks informing perceptions of lived external experiences of dependency and care – with participants' sense of their external experiences of both their baby and the care they received in the early weeks of motherhood then imbued with and seen through the lens of this internal framework of expectations - an essential context to considering their lived experience of care needed, received and given.

This said, alongside this individuality of internal experience, there were consistent themes across participants of ideas of what constituted good or ideal care and that which was disappointing.

### 3.1 – Ideals of care

One aspect of desired care was about comfort. Pippa spoke of the relationship between a soothed mother and baby.

*“And actually, (baby unsettled and crying) if you possibly could calm the baby, the mother would be calmer too...” p.28.*

Particularly so when thrown into the shock of a new and unfamiliar environment as Anna identifies in the following extract.

*“I think ... initially, when he came into this world, the fact that he had the boob erm, and you know my closeness ...and the boob on demand really helped him cope with the novelty of it, with the shock... So, I think that really helped him cope erm... and feel safe and secure and loved (tone softens)” p. 65*

Whilst ostensibly describing what George needed, I felt keenly aware of her first real moments of awareness of motherhood: waking up from anaesthetic, completely alone and suddenly thrust into responsibility for her newborn. Throughout, themes of things apparently going well seemed underpinned by a more difficult and complicated picture beneath. In her description above, there was perhaps something not only of George’s need to be soothed but also partly her own unconscious need– something she protected herself from by projecting it into George.

She spoke of the value of having readily available care without needing to seek it out, something which perhaps felt particularly important as someone for whom acknowledging her need and difficulty might be complicated. Marta, seemed to find it easier to get close to her sense of vulnerability and need:

*“I remember feeling like, “What can I do? How can I ..b... go back to the birth-centre where they take care of you and the baby?”” p.18*

She too appreciated the readily available support in the birth-centre, sorely feeling its lack when she went home.

*“... we kinda are alone in this and yeah, obviously like you can always call somebody but it's very different when you ...erm...are in regular touch with someone rather than just you know, erm calling them every once in a while...” p.28*

For both, I couldn't help but think of their circumstances as immigrant mothers away from the familiarity of their birth country and those they had grown up with. This felt poignantly present in Anna's description below, with references to movement between spaces and “luggage” suggesting not only a transience but also perhaps a lost internal sense of home and stability - highlighted by her mention of the doula going home.

*“ I had just woken up from general anaesthetic. I was on my own... I had a doula during birth but she had just gone... er... home erm, after the days of staying with me. Erm... I was on my own with the baby, and with the luggage... erm... and I was brought to the ward... to the... after the... yeah ... to the post-natal ward.” p.56*

Another recurring aspect of good care was of being attended to. Something captured by Pippa in describing her lactation consultant.

*“... she was wonderful. She was a lovely woman who came and just listened to me... I think... that's often ninety per cent of the....” p.22*

This idea of careful attention to the needs of both mother and baby and seeking to understand the whole situation was apparent in all participants' accounts. Anna described the lactation consultant coming and through her careful attention seeing something in George's latch unseen by others and perhaps too something of her own unseen needs. She describes the value of face-to-face engagement as opposed to the virtual engagement of the internet and social media - her lifeline until then.

*“...because you can read a lot online and you can talk to people on groups and that helps but nothing compares to like actually the specialist looking at the baby, at the sucking, at the situation, at my nipples... um...yeah... yeah (sighs and pauses)... Weeks of researching didn't help as much... as you know ...half an hour of consultation...” p.60-61*

In the following extract Pippa seemed surprised at, but profoundly appreciative of, the patient attention of her lactation consultant - perhaps particularly at the focus on her.

*“... and she didn't... she... of course...you know, they have to stay for hours because they have to w...wait till th...these sleeping newborns wake up. So, she... we just sat upstairs...um...which was also a relief because I didn't have [firstborn's name]” p.23*

The following extract demonstrates how with both physical and emotional difficulties taken seriously there seemed almost immediate relief, something which seems to promote her connecting with Daisy in a vocal exchange.

*“Yeah. Yeah. It was astonishing. She's...she m...she shifted it and she just...and she just ...she showed me and she latched on while she was there... and it was like ...on ..on the painful boob ... with a nipple shield which the lactation consultant brought. Um...and she was... you know (baby vocalises)... um...chin bobbing up and down, drinking away, and I was like, “Oh, okay, this is so much better”. So...um... and it was all very, very quickly the pain...(baby vocalizes) ... Yeah? Yeah? (to baby)...” p.89*

A sense of surprise and relief at receiving attention is also apparent as Marta describes below her excitement at the lactation consultant's arrival.

*“...she was so lovely. She actually came home to like... to see me... in person. Erm...I'm not sure they do that but I...I was just so, so, so happy.” p.14*

Eleanor's possible internal expectations of mis-attuned care with attention leading to further anxiety rather than relief seemed reflected in the lactation consultant's visit which felt deeply uncomfortable and rather intrusive as she towered over Eleanor causing Eleanor to break into a sweat. Yet, Eleanor recognised the meaningful difference that the lactation consultant's deeper understanding of her needs and difficulties made in restoring her confidence.

*“And I do have dyspraxia, so I do find... kind of just... maneuvering a bit tricky”, and straightaway she's like, “Oh, my son has dyspraxia.*

*So, I completely get that". So, I was like "Oh God" because someone actually can understand that... and I just needed someone to get that and she did, which was amazing. And I think she just left us feeling like... this is entirely possible...um...which was lovely, because ...I was at a point where I was really worried that we weren't going to establish breastfeeding at all (upward intonation). Um... I just thought an expert has seen me and seen us and she gets it and she's gonna help." p.104*

It seemed that all participants at different levels experienced the value of close attention - of being observed and having their difficulties emotionally contained – something captured by Pippa who commented:

*"...lactation consultants are worth their weight in gold!" ... p.91*

### *3.2 - Disappointments in receiving care*

Alongside ideals of care, participants spoke of disappointments - invariably painfully raw moments within the interview - something which seemed linked with the themes of disconnections in care and ambivalence. Again, I understood these within the context of my sense of each participant's individual internal framework relating to dependency and care.

All but one participant had sought the services of private lactation consultants, frustrated at NHS services. Eleanor, Pippa and Anna had each been told of specialist teams which never materialised. Marta, on the verge of seeking a private consultation received an NHS appointment at the last minute.

Anna's possible pre-existing internal difficulty in seeking care was perhaps exacerbated by a care pathway that felt so dictated by the professional network (with tongue-tie support available only through professional referral - with connotations of superior expertise - and in advance by appointment - emphasising its limited availability), possibly leaving her finding it hard for her to acknowledge professionals' value or expertise, as suggested in the extract below.

*"... the ones in my borough are far away and... the health visitors have... I know... I have to schedule weeks in advance. They only have mornings...um... and I don't feel like they're...I mean they're good as generalists but they don't have the qualifications." p.60*

Feelings of being left to manage too much alone were common amongst participants, as Anna describes below waking up alone after anaesthetic.

*"Er... and I had absolutely no one saying hello to me (baby grumbles insistently) for half an hour. And when she did come eventually... but...ev... in the meantime I had to like put... you know... stuff...er... from my bags and ... I don't know if you even meant to be moving so quickly after surgery ... what's like literally an hour or two after surgery. So, I guess that contributed to my*

*recovery very quickly 'cause I moved ... yeah I had to move within ...you know hours...er and minutes from my bed... “ p.56*

Similarly, having felt terribly left to manage alone with her firstborn (amidst the pandemic, a traumatic birth and tongue-tie), Pippa went to great lengths to find a private lactation consultant prior to Daisy's birth - determined to avoid being in the same position - doubts perhaps rooted in internal expectations of needing to be self-reliant in the absence of care. Self-reliance and complaint seemed echoed in her sense of Daisy who (in sharp contrast to her firstborn) she seemed to experience as a self-sufficient but noisy and demanding baby, leaving me wondering about an internal confusion between individuals, the past and present.

Another recurring disappointment was a sense of rather faceless care. Anna struggled to identify or ascribe professionals any names, perhaps partly but not solely a reflection of her difficulty allowing their significance and authority. She described care that felt too preoccupied and busy with other things to pay attention – as did other participants.

*“And whenever I would go and ask, she said, “Oh you know I'm very tired...I'm very busy now ... there are lots of things happening here and ya,na,na, nah... ” (exhales) anyway... er... so ...any...yeah, it wasn't a great experience.” Eleanor, p.56*

A sense of impersonal, fleeting care was at times paired with the experience of professionals failing to take the time to stop, look and identify problems. Eleanor described a stream of pre-occupied professionals:

*“Anyone who came in the room was kind of asking “Oh, like can... is she feeding?” and a couple of times, where she'd say, “Well, she can't ...she's been on such a tiny amount of time...” And then I think they were just busy and assured enough that... that... those brief periods that happened. It was like “Oh, okay, if she's been on and she's sucked and she's had food... she's fine”.” p27*

Marta spoke emotively of how much pain could have been avoided if staff had more time and training. She described how Kaya's tongue-tie had been very thick - easily spotted if only someone had looked. In the following extract she describes her moment feeling most unsupported as at the birth-centre, the very place where she had described feeling the most supported, suggesting that for Marta, hopes for care might quickly and devastatingly be ruptured.

*“They were great... erm... I mean I don't know like maybe it would be good if they had some training on tongue-ties or something similar, but they already have so much on their plate. Um, so like I don't blame them for anything but also...I ... I do feel like somebody should have spotted this...um... in the beginning because again, like if it was done whilst we were still in hospital, you wouldn't have to come back to the hospital right ... for the surgery because it could have been done straight away” p.54*

Marta's underlying anger at what should have been done but was not, was palpable, but remained only covertly articulated, suggesting an aggression that could not be safely expressed. She was not alone amongst the participants in this struggle and reluctance to complain, something which is explored further in the GET,

“Ambivalence - managing feelings of hurt and anger and upset”. The sense of being let down by someone in a position of trust was echoed in Marta’s anger at her partner’s family’s failure to warn her about the prevalence of tongue-tie in the family, leaving her to suffer unnecessarily. She described:

*“And I was like, “If you knew...like why didn't you tell me?” Erm. So that's when I felt anger (apologetically) Er, 'cause like you struggle...like you've been through... like down that road? Sure. Like it's common, but like, you ... you... you were... you gave birth in a foreign country like you were alone. Like, you know what it feels like... you could have...I don't know, told me ...erm...just like, this is something to, to look out for... But also, I feel like when it's something like this serious, like, you should say something, just like... just in case like... you know...and you can be... you can be kind.” p.25-26*

In this extract feelings of being let down seem linked with being alone in a foreign country and away from family. Marta and Anna both conveyed a sense of something absent but better available elsewhere, leaving me wondering about the particular emotional sensitivity for immigrant mothers. A sense of working so hard to get care only to be shortchanged felt captured in Marta’s account, both in describing frantically calling any helpline she could with little in return, but also in her perception of Kaya’s experience.

*“I later learned that she just wasn't getting enough... and she was working so hard.” p.10*

Each participant's feelings of lack of support seemed closely related to feeling supported and then its loss. Eleanor's earlier description of a rather faceless parade of professionals was in the context of her dedicated midwife's absence. When Pippa's lactation consultant left, her feelings of being held and seen were quickly replaced with crushing feelings of missing her firstborn and of him missing her; perhaps at a deeper level representing a painful reminder of the loss and absence of her own mother. A sense of an absence of care permeated Pippa's account: in her father's benign but distant care; her partner's absence and preoccupation with work; and her surprise at the lactation consultant's attention and care. External reality seemed to meet Pippa's internal expectations of being left to manage alone whilst craving some attendance of her emotional needs:

*"And ...you know, and...um... [partner's name] went home and had a McDonald's (laughs). I was like, "Right!" And all you wanted was someone to be there... basically, sort of... to emotionally support you." p.122*

Care could also be experienced as more actively problematic. Pippa describes her mother as having had little time for emotional vulnerability but also hints at an awareness of her own tendency to do the same.

*"I come from such a medical family that I go into my ... I turn into my mother who was a f... formidable nurse... I'm... I think... I clamp down any emotions... which isn't necessarily good either because I think they come out later but... um... I'm quite good and in emergency..." p.103*

In the following extract she describes an experience of harsh, misjudged and overbearing, practical care, with infuriatingly little empathy or concern for the underlying difficulty or vulnerability, perhaps aligned with her internal expectations.

*“... I was very wobbly then and I burst into tears on her then and then she actually... in a sort of “Right, come here... I’ll show you what to do” sort of thing (adopting brusque voice). Um... Showed me how to use the hospital grade pump. And I had no idea why she was telling me how to do it. She didn’t rea... she didn’t explain why I needed to do it. But I did it. It wasn’t very pleasant but... you know that obviously brought my milk in .... gave me a bit of an oversupply in the end.” p.32-33*

For Anna too, care felt devastatingly critical and judgemental just as she felt most alone and unsure having just awoken from anaesthetic but perhaps with echoes of her internal expectations playing their part.

*“...she started criticising me basically. So, she was very blunt with you know with “Oh did you... you know... did you breastfeed him? When was the last time you breastfed him?” and that was I...I didn’t know... even know what day was, so I was so confused. I didn’t know what time it was and then she said “Why is he just wrapped in a towel. Why’s he not dressed?” (adopting stern voice) Erm and yeah...I...again, someone had left him in a towel while I was under... erm... so you know it was er... yeah she was... she was*

*very... basically she was not supportive...she was critical erm... and actually ... I burst into tears..." p.54*

Eleanor's sense seemed to be of anxious, confused care, describing different hospital departments unhelpfully airing their confusion and indecision in front of her prior to delivery. I was struck by parallels in her description of her parents' anxiety, leaving her feeling she needed to conceal and try to manage her difficulties alone.

*"... they're like, "What's happening, any movements?" (adopting anxious voice) And I think because my strategy with them is always kind of hide what's going on. I just like "Everything's fine, everything's fine". p.15*

#### ***Group Experiential Theme 4 - Alone and stuck in an unbearable situation – reaching breaking point***

This theme illustrates the powerful feelings of desperation experienced by all mothers - feeling trapped and in need of urgent help. These were harrowing narratives to hear - emotionally very live and in each case feeling re-evoked in the present. They fell into four main sub-themes outlined below.

##### ***4.1 Not knowing what to do or what is happening***

Participants described feelings of confusion and simply not knowing what to do in the early weeks. Marta describes below uncertainty and difficulty that felt bearable in the

supported environment of the birth-centre but escalated into the unmanageable once alone at home.

*“...at the very early beginning...erm well in the hospital, I don't know like ...it was a bit of a struggle, but I just feel like that's normal. It's ...there's a learning curve ... it was when we came home... yeah...erm ...it was complete desperation.” p.24*

For Eleanor, it was in the hospital that these feelings of panicked bewilderment began. Initially pleased to have been given the privacy of a room to herself but soon, alone and with her one-to-one midwife on leave, things felt out of hand.

*“... and she was just crying and crying...kind of really screaming. I kind of didn't know what...to... do...because obviously I've never done this before.” p.26*

Feelings of being at a complete loss escalated further once home, then horribly compounded by her dog's death. In the following extract her disorientation seems closely linked to a sense of loss. This could be understood as linked not only with dashed expectations (in contrast to her meticulous preparation and clear vision of the initial weeks) and a loss of sense of capacity but also of care hoped for and needs adequately met. The emotion was visceral as she spoke.

*“I just ...started to think “What the hell is happening?” and kind of... there's a lot of feelings (emotion in voice) around kind of... I had this dog... had this dog for five years (voice breaking). And I knew how to care for him. And now suddenly he's gone and I've got this 'being' here. I was just ...I don't know...what... how to look after... (tearful and gathering herself).” p.32*

#### 4.2 Loss of structure and control

Feelings of being out of control amidst confusion permeated participant accounts with a concomitant loss of sense of the usual structures of time and order. In Anna's already provided description of waking up from anaesthetic only to feel scolded by the midwife she expressed her sense of confusion:

*"I...I didn't know... even know what day was, so I was so confused. I didn't know what time it was..." pg. 56*

Eleanor describes below a shift in the usual sense of time.

*"... when I look back on that period, it feels like it kind of was such a short time but also such a long time. I kind of... it's really hard for me to kind of... process that period in my mind and think about how long it lasted for and what I was feeling... But in retrospect, it wasn't very long. It was just felt interminable." p.56-57*

For Marta too - what had in fact only been a few weeks felt like forever.

*"...[in] hindsight, the real struggle only lasted for those two weeks. Like that was ...that was awful. Th...th...that was possibly the lowest I felt in my life." p.57*

She describes a sense of only a very desperate present:

*"... waking up every morning and I couldn't believe we lived to see another day. That's literally how I felt. It wasn't one day at a time - for*

*me it was like a one hour at a time. Like literally I'm getting goosebumps as I remember (touches arm).” p.58*

In the following extract with its rhythm of repetition of “it’s always going to be like this” and loss of the usual connectivity of Pippa’s speech, a sense of a loss of a usual sense of time and of time stuck in a loop seems apparent.

*“... you think “it's always gonna be like this” with either it's ... you know, when it's really bad no sleep... “It’s always gonna be like this”. They're not eating, they'll never eat, you know...they've ...you know, the... my...and then I have, “Is this what breastfeeding is like?” ...you know... is th... that sort of ...um...and pregnancy is like, “Is this gonna be like this forever?”” p.96*

### 4.3 Feeling trapped

The sense of being stuck in endless time seemed linked with a theme of participants feeling trapped, unable to escape or take a break. Anna’s description below of trying to find a comfortable position to feed George at night evoked in me a powerfully vivid image of her alone, naked and broken in the dark. She went on to describe frantically searching the internet through the night for solutions only to find that every answer seemed to be “carry on doing the same”.

*“... most of the feedings were sitting, even the night ones but I was ... I was actually in lots of pain for many weeks because of the C-section... erm and he was kind of pressing on it... I was just kind of*

*trying to find a position where he wouldn't be on my belly so I remember you know being like this (hunching over to demonstrate) and my back was hurting... er... and I was cold, 'cause it was cold in the room and ah ...yeah (exhales) it's like you know... boobs out and everything and then over time ...yeah and I remember it... it hurts ...yeah I remember the pain.” p.24*

In Marta's following description, her repetition heightens the sense of relentlessness and of being unable to move at all, completely stuck.

*“...well that was a really difficult night. She only fell asleep, like properly, when I say probably for two hours... erm...in very...in early morning. I think maybe like at 4am. And until then she was just like... she was feeding. So, she was on the breast... er ... but she would like fall asleep. So, she would feed for 10 minutes. And then she would fall asleep for 10 minutes and as soon as I tried to move her or like I moved myself she would wake up and she would feed again...” p.9*

Eleanor too described an endless cycle of milk production with no reward and no opportunity for rest.

*“And... I was kind of hand expressing into syringes as he fed them to Ariel. And I'd be...constantly be “Like how many... how many on your side?” And he'd say like “two or three or four or five” and I'd be like “Okay. I can't sleep now. I've got to keep going. Keep going...”” p.31*

As she movingly put it:

*““Oh my God, I can't do this. I'm completely stuck, and I can't feed my baby” (emotion making it hard to speak) ...” p.34*

Eleanor’s powerful and articulate way of describing her experiences was emotionally raw, bringing them painfully into the present. Breastfeeding difficulties led not only to a physical loop of feelings of failure but an inescapable one of mental and emotional defeat as described below.

*“So, I... in an ideal world, I'd have been fel... feeling well enough to like try a latch every time and then if that failed, then I could give the finger feed, so I could... still kind of do that bonding. The problem was that... often I just didn't... not feel up to trying to latch... I was so devastated... and lost (voice breaking)... and so sad. That I just couldn't try... and that... just... I'd kind of wake up every morning, dreading like, “I have to try latching all day”. And I'd really dread that because I knew it wasn't working. And I'd go to bed at night feeling... de... like just so upset with myself – “I haven't tried enough” (upset in voice).” p.40*

The crushing sense of despair, disappointment and defeat meant staying at home with Ariel felt unbearable.

*“...just basically just spend time with your baby and just bond and just r...rest and recover. So, I kind of mentally that was what I wanted to do. But then I couldn't ...bear it essentially because it wasn't going very well (voice breaking again, breathing heavily).”  
p.69*

Yet being out felt equally so, with feelings of shame and embarrassment at what felt the exposure of her difference and failure in the finger-feeding system. She described an attempted trip to join a baby group leaving me with a devastatingly bleak image in my mind of her crying alone in the corridor.

*“Also, I just thought it's just a ... symbol of my failure that people will see me do this. Whereas I think if I was feeding with a bottle, I'd think...I'd have been just like, “Oh, there's just another woman feeding with a bottle but there was something about finger feeding in public that I was just very embarrassed about so I kind of had to leave the group and sit in the corridor and do it and I just... I was so paranoid that they were ... I knew there was a break during the group, and I thought that all the mums would just see me, and I was really... Yeah, I was a bit of a mess. I was very tearful (voice breaking).” p.77*

#### 4.4 Desperation and urgently needing to find a way out

Participants described reaching physical and emotional breaking point, desperately and urgently needing a way out; a possibility offered by a frenotomy but unavailable in the short term from the NHS. As Pippa spoke emotively about trying to feed Daisy in the following extract, the anxiety seemed to be in all of us, Daisy cried and fussed whilst trying to feed and I found my own anxiety rising and tolerance dropping.

*“...you're all over the shop, you haven't slept (baby noisily feeding) because you don't in those first three days. Um...You feel... I had been told and I was slightly prepared but obviously you can never be fully prepared, how...um... it's proper and ..and also you... you know, your boobs go so enormous in that first ...sort of...as your milk comes in (baby cries) and they're like absolutely rigid (baby still crying) and hard...um....yeah (speaking to baby), ...and you're bleeding (baby crying) and I'd... had a C-section as well... yeah, you know ... so you feel ... both... physically... broken and emotionally, you know (baby crying in dissatisfied, intermittent way) um...emotionally all over the place. So, to feel that you then... can't concen...and then you know, she...she would be...she would do this, and then some ...you know, when she couldn't have any milk. So, it then...it...to... adding a screaming baby, which I think I don't know biologically makes your ...nerves jangle... even if you're feeling relaxed ...” p.26*

Marta describes below the impact of sleep deprivation and the anxiety of trying unsuccessfully to meet Kaya's needs and soothe her, capturing a sense of physical breakdown between the communicating functions of her body and mind - particularly any sense of her own needs.

*"... when I was awake for those 36 hours, I remember thinking like I... I... I also had a breaking point. I felt like my body was just gonna shut down at any moment and... I was just gonna, I don't know...blackout or something out of exhaustion because like I was still trying to breastfeed so like, you know, so you need energy for that. I've just given birth. I haven't slept. I haven't eaten...I couldn't eat. ...I was struggling like... to... to eat.... Like it...it...it tasted like chalk ... like I was ... like I was hungry but I just I couldn't eat. I wasn't like...like... I wasn't feeling hungry but I...I... I was hungry, if that makes sense. Er...Yeah... and I yeah, I just wanted desperately like somebody to come and like, I don't know. I suppose take care of me so I can take care of the baby. Erm...Yeah!" p.18-19*

A lost sense of internal disconnection seems linked with the themes of disconnection described in GET 2

Anna's use of the word "emergency" in the following extract suggests a matter of life and death; something that she links with her milk supply. Perhaps too, unconsciously, her ability to produce milk felt inextricably linked with the survival of her sense of capacity as a mother.

*"I knew that a tongue-tie issue if you don't address it as quickly as possible ... there... you know you can lose supply or you know I, yeah, I basically felt like it was an emergency ..."* p. 39

Ideas of survival and of matters of life and death inevitably surround pregnancy and delivery and were articulated by participants. However, participants' accounts suggested that it was also experienced in relation to their breastfeeding difficulties. This was articulated in Marta's relief when specialist help and the hope of a possible way out came.

*"Well, that was honestly like, I feel like she saved our life. That's genuinely how it felt ..."* p.51

Something about the level of desperation for a way out can perhaps be discerned in participants' fear that the frenotomy would not solve things. Marta was consciously aware of her worry, fearing that the tongue-tie might grow back afterwards.

*"... it was so scary because...um... yeah, just having to imagine we would have to go through all of this again... I was like, "No, no, no, no, no, this cannot happen!""* p.36

For Anna it was perhaps less conscious as she sought to suppress any expectations of an improvement, just as she had during pregnancy. For Eleanor, the devastation she describes in the following extract suggests that although consciously aware it might take some time for things to improve, unconsciously she needed immediate relief.

*"...even though I felt that she wouldn't be able to do it straightaway, because ...from what I knew about tongue-tie...when babies have it*

*cut, they're kind of not used to using that tongue and the muscles aren't developed and they can't kind of move it around enough. It still ...kind of ...there's still a bit of hope in me. So, when obviously it didn't work straightaway, I was a bit devastated (voice wobbles). But...(deep breath) kind of ...at least at that point, we felt there might be a solution and there might be some progress. So, we kept trying." p.48*

It took several weeks for her to feel more confident and her ongoing decision to continue using nipple shields suggested lingering doubts.

### ***Group Experiential Theme 5 - Ambivalence – managing feelings of hurt and anger and upset***

Themes of ambivalence and how to manage more aggressive feelings were present within all the GETs in different ways. The difficulty of allowing feelings of hurt, anger and upset permeated mothers' accounts both in relation to their baby and the care received.

It seemed that ideas of aggression in and being caused pain by their baby, as well as mothers' own ambivalence in response to feelings of being hurt or depleted by them were hard to acknowledge. For Anna it seemed that it was very hard for her to locate the source of her extreme pain feeding as being George. She described being convinced the reason for the pain was within her - mastitis, blocked milk ducts or milk blebs – a blockage getting in the way of their connection through feeding. In

the interview, her narrative turned from speaking about the pain to describing her early pressing anxiety that there would be something wrong with George and then in the external reality of George spluttering on her milk as he fed, anxiously about her ongoing grave concern about George choking on her milk. I couldn't help but wonder if perhaps something felt very dangerous about any feelings of upset or aggression towards George, with perhaps a sense of a blockage working in her mind to protect him from them as they were unconsciously projected into her milk as something life-threatening. The word "battle" in the following extracts suggests feelings of conflict which were hard to know what to do with as she seems to struggle where to locate it, within herself, in others or between them.

*"... yeah that kind of in... inner battle I would say..." p.21*

*"Like I see some of my friends now who are going through that newborn stage... you know she was telling me oh you know it's a battle to like and I'm like you're not in a battle with your baby... Er, it's a hard time but yes ... you know ... it's gonna pass. It felt like a battle"  
p. 35*

A similar sense of conflict is apparent between Pippa and Daisy in the following extract:

*she's quite like...she's quite strong... she'll often... won't be... if you... if you pull her ...I...arm she'll go "No, I'm not going to do that!" ... And you have to really like ...erragh... (moving and slightly forcing Daisy's arm) ...p.46*

As she spoke about this whilst feeding Daisy, the sense of conflict and upset between them seemed to be re-evoked in the present of the interview in an unsettled and irritable feed.

*“she didn't seem to be in a huge amount of pain, she... she would do proper projectile...you know... it would reach you... from here, kind of thing (baby coughs)... and [firstborn's name] never did that ... ..(baby grumbles) ... Erm...so...I think on the ...I think the third day after some quite horrific nights, (baby cries) ... and she was ... (baby cries)... I was having to absolutely grimace through the pain (baby cries more intensely)...” p.18*

Pippa brought a sense of Daisy as a rather messy and tenacious baby, describing her dramatic reflux, farting and tendency to throw things. Pippa spoke lightly and in good humour but there was a sense of an underlying feeling of something of an attack on her, as captured in the following extract.

*“Oh my word! ...That's what you did over my shoulder. Sometimes, I think...(in a slightly false sounding upbeat tone) (baby cries lustily as participant moves to get muslin)... sometimes I think you have too much (in the same tone) and it all just comes up... at least you missed my slipper this time”. p.37-38*

Pippa's own feelings of aggression seemed frightening to her and psychologically hard to acknowledge and manage. Throughout the interview there were themes of things being too forceful. She recalled how she had been reluctant to do tongue-exercises following the frenotomy for this reason and in the extract below having bravely

spoken about having struggled with intrusive thoughts about causing harm to both her babies, she speaks of her relief once Daisy was bigger and more robust.

*“... I'm so happy when she's at... this big as well compared to when they're tiny... Because they're so vulnerable... and you're worried about ... basically doing something that will harm them. I think that's where all those intrusive stuff comes in, isn't it?” p.99*

It is perhaps interesting to note that the intrusive feelings were less extreme with Daisy than her firstborn and I was left wondering if this had something do with feeling more able to locate some of the aggression within Daisy in her tenacity to feed than in her firstborn who could not feed at all but with whom she experienced terrible emotional anguish and pain. After she had told me about his frenotomy she described:

*“Oh! The one thing I had forgotten ... what was very scary...was the day after... he actually had a bit of bleeding from his tongue. So it... I remember... he was wearing a little white...um... Babygro. And it...he just looked like he was bleeding out of his mouth (pointing to her own mouth)... and cos it was mixed... mixed with milk and ...you know, posset and stuff.” p.102*

Here, something of her fear in relation to the potential danger of her aggression to such a vulnerable baby seems apparent in her vivid description of his bleeding mouth against the whiteness and smallness of his Babygro, all combined with her breastmilk.

As already mentioned, aggression also seemed difficult to express or articulate in relation to disappointments in care. All participants expressed a reluctance to complain about the NHS citing a sense of an overstretched and under-resourced healthservice. Perhaps the upset at being left to manage alone and reach such a state of desperation was hard to express to me as an NHS professional, perhaps experienced as a fragile maternal object or perhaps a retaliatory one. Yet the feelings of frustration were palpable. As Pippa touchingly identified in the extract below, struggling to manage alone when exhausted and overwhelmed is however likely to stir upset and angry feelings notwithstanding the one you hoped for support from is ailing and overworked.

*“ he (firstborn) was basically...erm...er...missing me and I was missing him... he had a big ...shout and [partner's name] then got ill...um...which didn't help ...and he'd been working... all the time for the...all year actually last year and... like literally every hour of the day, so I was quite furious with him as well. And I think... when I get tired and upset, I get angry.” p.128*

## Chapter 4 - Discussion

### ***Aims***

This qualitative study aimed to gain insight into the emotional experience of mothers who have experienced difficulties breastfeeding their baby with tongue-tie.

### ***Summary of findings***

The generosity of the mothers in telling their stories has meant that overall, the study's aim has been met. Using a FANI interview brought rich data. Through bringing elements of FANI (Hollway, 2013) and RRM (Holmes, 2018) within the overarching structure of data analysis by IPA (Smith et al., 2021) the study offered a novel way of accessing unconscious material, with the aim of promoting and deepening my understanding of participant lived experiences and becoming part of the IPA hermeneutic process. This combined method enabled me to find GETs presenting a compelling picture of the emotional experience of these mothers. The IPA analysis retrieved five GETs, narrating the common experiences of these mothers: "The psychological and emotional complexity as a breastfeeding mother"; "The hope of connection and the pain of disconnection"; "Internal relationships with dependency and care in interaction with lived external experiences"; "Alone and stuck in an unbearable situation – reaching breaking point"; and "Ambivalence – managing feelings of hurt, anger and upset".

Throughout this Chapter (including below) I consider all GETs together in summarising and discussing my findings in the light of existing literature.

Analysis of the accounts of these participants suggest the following findings:

- Breastfeeding is an emotional and psychological as well as physical experience.
- As mothers that wished to breastfeed, breastfeeding success was closely linked with feelings of maternal confidence and capacity, and difficulties with feelings of failure and doubts about capacity.
- Participants experienced feelings of disconnection with their baby and with the support around them.
- Experiences of care, both positive and negative were profoundly experienced. Care experienced as timely, attentive care promoted feelings of connection and containment; whilst feelings of being left to manage alone by what felt scant, inconsistent and impersonal attention fuelled feelings of disconnection, bewilderment and feeling unable to manage.
- Ambivalent feelings stirred by hurt and disappointment were hard to acknowledge and express leaving them live and unattended.

- Understanding the lived experience of participants requires attention to both perceived present experience and unconscious internal experience founded in earlier experiences of care, need and dependency.
- Participants experienced a breakdown of normal ordering structures and were left feeling trapped and alone in a state of confusion and dismay from which they desperately needed to find a way out.

These findings align with the three existing empirical studies about mothers' perceptions of tongue-tie as described in the literature review. In particular with the themes of "Expectations" and "Approaching the wall - it's all too much" from Edmunds et al. (2013); the frustration, sadness, dread and dismay reported by Wong et al. (2017); and the impact on mother's wellbeing and frustrations with the healthcare system reported by Waterman et al. (2021).

Interest in the field of the maternal experience of infant tongue-tie has continued during the time I have conducted this research. In particular, three studies (Burton et al., 2025; López-Segura et al., 2025; Rodriguez Lara et al., 2025) have been published since my data analysis and literature search. A search of the PROSPERO repository suggested there are others under their review – however I was unable to access them. Rodriguez Lara et al. (2025) conducted a systematic review of maternal experiences and challenges in breastfeeding infants with tongue-tie and concluded that these mothers are more likely to suffer from breastfeeding complications leading to maternal stress, frustration and strained relationships. In

their discussion they noted the limited focus that has been placed on exploring maternal experiences of tongue-tie and the need for further research to deepen understanding of maternal experiences to develop effective interventions.

Something this study aimed at addressing. López-Segura et al. (2025) conducted a qualitative descriptive study of 20 participants in Spain prior to tongue-tie treatment using ATLAS.ti computer software for data analysis. Their findings of dashed idyllic perceptions of breastfeeding and physical and emotional difficulties associated with tongue-tie align with the findings of this study – as do those of frustrations and a sense of shortcomings in professional care, particularly after discharge. The authors' note that mothers often turned to the internet for information rather than professional or peer support and found themselves disconnecting from other relationships both echo the narrative of the mothers in my study. Burton et al. (2025) conducted qualitative research into maternal experiences of tongue-tie when breastfeeding twins. It comprised part of a wider study of breastfeeding mothers of twins and used reflexive thematic analysis to analyse data collected by a mixture of qualitative survey and interview. Their found themes of “feeling disempowered by tongue-tie denial” and “the avoidable impact of diagnostic delay” (2025, pp. 3-4) again resonate with my findings.

### ***Links between results and psychoanalytic concepts***

My findings align with psychoanalytic ideas that the early days of motherhood are ones of heightened sensitivity, vulnerability and disturbance (Raphael-Leff, 2000; Stern, 1995) - a time when exposure to a baby's raw emotions revives issues from a

caregiver's own, with a contagious effect on those around the baby (including both caregivers and those supporting them) (Birksted-Breen, 2000).

Raphael-Leff writes of blurring boundaries with confusions as to self and other – the confusions of a baby within the body and now without (Raphael-Leff, 2003).

Feelings of separation must be negotiated and adjustment made to the new reality of a baby - no longer entirely the subject of pregnant phantasy but as an individual.

This is a gradual process of coming to know one's baby and oneself as a mother (Birksted-Breen, 2000). However, in the interim the boundaries are blurred. As Winnicott said there is no such thing as just a baby (1960). A mother's sense of having a contained self becomes confused and unclear. The external boundaries to the sense of self are in doubt whilst simultaneously negotiating a seismic renovation within (Stern, 1995). Having given birth, previously familiar and reliable foundations of identity are displaced as a mother negotiates the move to an integrated identity of being both a 'mother to her child' and 'child of her mother' (Stern, 1995, p. 172). She has to relinquish her psychic separateness, allowing her infant's demands on her inner space and internal resources (Raphael-Leff, 2003).

Exposure to the raw emotions of infantile primitive anxiety – borrowing the words of one participant - "jangles the nerves". Raphael-Leff writes:

*A close encounter with a baby throws us into the deep end amid the primitive wild things by violating all the rules. An infant forces awareness of much we have defended against. Disarming adult defence, a baby compels his/her mother to re-experience what it is*

*to be helpless, needy, frustrated, enraged, tantalised, abandoned and betrayed.” (2003, p. 54)*

This is necessary for survival and is how a baby activates their caregiver into action. A mother needs to be available to receive her baby's emotions but not so much that she is overwhelmed by them, cannot contain them and herself is beset with feelings of simply surviving. Such a state of mind leaves no space for a sense of internal space and of resources available to meet the relentless demands and anxieties of a newborn.

Psychically then, a new mother is under profound pressure from both within and without, with the normal order of things under threat and reorganisation. Klein described constantly shifting states of mind, the “paranoid-schizoid” and the “depressive” positions as ways of maintaining an internal equilibrium (Klein, 1959). At times of internal security and stability and in the depressive position we can think creatively, wait, symbolise (Segal, 1957) and are better able to see and accept things as they are. At times of anxiety and in a bid for psychic survival, we shift protectively into the paranoid schizoid position using defences such as splitting and projection, idealisation and denial. In such a state of mind, it is difficult to see things as they are without powerfully imbuing those around us with characteristics informed by our internal expectations or putting our most terrifying and unbearable feelings into them rather than experiencing them ourselves (Klein, 1946, 1959). In these states there is no time to wait or space to think “about” things with any distance. Things and people are either “good” or “bad” with nowhere in between.

The GETs suggest that these mothers found themselves in this state of mind. The theme, “Internal relationships with dependency and care and lived external experiences in interaction” identifies splits and idealisations about care both as “mother to the baby” and as “baby in the mother needing to be mothered”, with extremes of what was desired and crushing disappointments in both identifications when it did not feel available, leading to a sense of disconnection with baby and support (GET, “The hope of connection and the disappointment of disconnection”) and within (GET, “Alone and stuck in an unbearable situation – reaching breaking point”). Ideas of disconnection were suggestive of the sense of fragmentation associated with the paranoid-schizoid position (Klein, 1946). Within the theme of “the psychological and emotional complexity as a breastfeeding mother” the psychological and physical confusion of breastfeeding is apparent, with breastfeeding and breastmilk seemingly becoming rather concretely equated with maternal goodness and capacity (Friedman, 1996; Stone, 2014); and the difficulties with incapacity and failure - existentially threatening maternal identity (with not breastfeeding being unthinkable for these mothers).

*An erect nipple producing a powerful substance could be likened to the potency of a penis, bringing both pride but also anxiety; with a crushing effect on her maternal sense of capability and potency if the ability to provide milk and nourishment, through breastfeeding is compromised (Friedman, 1996).*

New mothers will likely struggle to keep an expansive and calm state of mind amidst the primal and existential anxieties surrounding birth. Pregnancy and delivery put both mother and baby at risk of death. With various experiences of miscarriage, emergency caesarean and congenital health conditions this was perhaps accentuated for these participants. So too, a baby needs to be fed in order to

survive. Not being able to do so is likely to stir terrifying fears, particularly if one's maternal identity relies on breastfeeding (meaning formula feels not an alternative). Accordingly, the external reality of the circumstances of these baby's births compounded by breastfeeding difficulties associated with tongue-tie will only have amplified an already fraught emotional landscape. Furthermore, with each participant's own internalised "unprocessed acute moments with her own fallible early caregivers now revitalised in the demanding arena of baby care" the situation can only be heightened (Raphael-Leff, 2000). In such a situation mothers are unlikely to have the psychic space to restore emotional balance (Raphael-Leff, 2003).

Recovery from such a state of anxiety to a more stable and integrated, "thinking" state of mind relies on containment (Bion, 1962). In order to contain a baby's raw emotions, the primary caregiver needs containment too. The parental partner (if present) and support network have a key role in managing the surrounding environment so the primary caregiver can be available for preoccupation with their baby's needs (Winnicott, 1956). Both the internal and external need attending to. It would seem that for participants both were compromised in different ways. Participants reported external experiences of not being able to access the care they needed within the healthcare system and of feeling left to manage their breastfeeding difficulties alone. When care was available frequent changes in personnel and overstretched staff led to it being experienced as impersonal and inattentive. As to the internal, mothers expressed their sense they needed something beyond the immediately apparent and physical - an availability and attention to their emotional state - something they did not feel was available. It

cannot be ignored that in addition to the tongue-tie difficulties, these particular mothers' personal situations meant the support networks around them were diminished. Anna had chosen to parent alone and Marta and Pippa's partners' work commitments meant they were largely absent. Marta and Anna's wider family were in a different country. All participants' actual mothers were absent for differing reasons. Within Stern's "grandmother" constellation, whatever the circumstances, this represents a painful and complicated reality to be negotiated (1995).

Bradley writes of the criticality of the availability and nature of the support available to new parents - with both care and support received and failures of care always remembered - good experiences fuelling a fulfilling and reparative cycle and bad ones, one of anxiety and inadequacy with long-term effects on the developing dyadic relationship (2000). This feels highly relevant to the experience of the mothers in this study.

The raw emotion within interviews was powerful, the past felt very much in the present as participants told their stories – evidenced by how some intruded into my dreams. I came away exhausted, rather overwhelmed and struggling to create a coherent narrative in my mind of participant experiences or any confidence as to the facts. This was repeated having transcribed interviews and then writing the pen portraits, requiring me to refer back to the text and original questionnaires several times to straighten out in my mind the order of events and simplest of facts. What was not difficult to remember were the visceral visual scenes evoked as participants told their stories. Scenes undoubtedly reflected an interaction with my own internal

landscape, continuing to remain in my mind and echoing those which had so struck me in the baby group, inspiring this study.

Garland describes trauma as a “piercing of the mind”, a wound created by events breaking its protective envelope (2002). She gives as context, a primary caregiver’s role to protect a baby so that its experience stays within the manageable, away from extremes of emotional and external experience. So too, she argues, normally functioning, autonomous adults can be thrust by events into a similarly unmanageable situation where stimulation is such that normal functioning and sense of order is lost, amounting to a kind of breakdown (Garland, 2002).

The GET, “Alone and stuck in an unbearable situation – reaching breaking point” with sub-themes of loss of order, confusion, feeling trapped, and desperation, combined with descriptions of the loss of sense of time, internal connections between body and mind and of pervading confusion, resonates with this definition.

As already discussed, even in the best of circumstances new mothers are in a vulnerable psychic state, with sense of identity under threat and awash with infantile anxieties belonging both to themselves and their baby. One might then consider them needing a level of a psychic protection akin to that of a newborn. Without it, and with compounding external factors it follows that mothers are likely to be highly susceptible to Garland’s definition of a traumatic response. This GET suggests that the difficulties these mothers experienced breastfeeding their baby with tongue-tie - against a background of each individual early experience and internal making sense of that experience - combined with their experiences of pregnancy, delivery and

support, or lack of it, amounted to a “piercing of the mind” akin to a trauma response. Their particular lived experiences of parental loss, migration, difficulties conceiving and miscarriage likely only heightened their susceptibility.

My countertransference experience of struggling to create a narrative whilst being left with powerful vivid images resembles the encoding of traumatic memory (Herman, 1992, p. 54). The palpable emotional presence of something from the past within the present is suggestive of something left unprocessed which felt a matter of ‘survival’ to participants, lending further evidence to the argument of a traumatic response in these mothers. The prolonged nature of their exposure over days and weeks to the unbearable situation of being unable to feed their baby is likely to have added to its psychological impact (Herman, 1992).

Alongside the collapse of meaning, trauma brings a failure of belief in the protection afforded by good objects (Garland, 2002, p. 11). Herman writes:

*“A secure sense of connection with people is the foundation of personality development. When this connection is shattered, the traumatised person loses her basic sense of self. Developmental conflicts of childhood and adolescence, long since resolved are suddenly reopened. Trauma forces the survivor to relive all her earlier struggle over autonomy, initiative, competence, identity and intimacy.” (1992, p. 75)*

Effects will likely be amplified when the betrayal is felt to be by someone important or in a position of care/trust (Garland, 2002; Herman, 1992). This seems to resonate with the devastation felt within sub-theme of “Disappointments in receiving care” and

the sense of disconnection within the sub-theme “Trying to connect with support”. It also echoes themes of previous studies demonstrating mistrust and doubt of and frustrations with the healthcare system (Edmunds et al., 2013; Waterman et al., 2021; Wong et al., 2017). My findings suggest that these frustrations and disappointments are hard to express and to feel will be understood (“Ambivalence – managing feelings of hurt, anger and upset”) and were most likely a combination both of the external present reality of the care experienced but also a re-opened sense of past struggles and earliest caregiver failings.

A mind struggling to make sense of a flood of the senseless tries to create order by latching onto what order it can muster and in this state of mind, a mother’s experience of her baby, motherhood and the demands of dependency and care are likely to become linked in her mind with the disturbing attachment material of the past (Garland, 2002). Participant accounts suggested a confusion between mothers’ relationships with dependency and care and their sense of their baby’s. Additionally, my findings suggest that ambivalent feelings stirred by external failures and lack of containment left participants finding it difficult to stay connected with ideas of a “good” internal mother, further exacerbated by a conjugation with their own reactivated, unconscious internal expectations and disappointments of dependency and care, rooted in their earliest experiences and heightened by their distress. Without consistent care, mothers struggled to hold onto the benefits of the containment they had received: Marta after the hospital; Pippa after the lactation consultant left; and Eleanor in her assigned midwife’s absence. My findings are in this context and in recognition that one cannot know what belongs where, between the external and internal for these individuals, but what can be known is that each

individual internal emotional landscape, created as a way of making sense of earliest infantile experience, will be at keenly at play, informing how others are experienced with the potential of profoundly impacting the ability to receive care and support. Negative experiences will likely have a compounding effect both in themselves and in a mother's ongoing relationship with care and dependency on those around her and her availability for containment (Bradley, 2000).

With a lost sense of good care internally, a sense of trust in the outside world is lost. Herman (1992, p. 81) writes how trauma "impels people to both withdraw from close relationships and cling to them desperately" something echoed perhaps in the cravings for care experienced by participants in the group sub-theme, "Ideals of Care" but also the sense of disconnection with it, identified within the GET "The hope of connection and the pain of disconnection" .

It was painful to hear participants speak of their sense of disconnection with their baby. Yet with systems of attachment in disarray it would be unsurprising - trauma has an emotional impact on mother and baby getting to know each other (McClatchey, 2024).

The experiences of profound hurt as a consequence of feelings of being let down by and feeling disconnected from surrounding support systems contrasted with the relief and gratitude described by these participants in finally receiving the care they felt was needed, then followed by reconnection with their baby seeming to echo ideas that whilst negative responses can compound the impact of traumatic events,

supportive responses can mitigate it (Herman, 1992). Psychoanalytic thinking argues that relief and the opportunity for recovery comes through containment (Bion, 1962). Rustin describes,

*“understanding, naming and elaborating is what will be of most help to parents whose desire for a relationship with their child is at risk under the impact of intense unacknowledged anxieties”. (2017, p. 159)*

Each mother’s narrative clearly demonstrated their sense that something beneath beyond the immediately apparent and physical needed attending to. For them, feelings of being seen, emotionally gathered up and understood coincided with the visit from a lactation consultant and the subsequent performance of frenotomy. Participants seemed to sense that the two were in some way linked. They spoke of being alert to the complexity and controversy surrounding causation between tongue-tie, breastfeeding difficulties and the efficacy and necessity of frenotomy. None saw the frenotomy as having been an immediate fix-all. Yet at a time of absolute desperation, it offered a way out and solution without which they felt there would be complete emotional breakdown.

It was notable that all participants had very little to say about the frenotomy itself, reporting a simple routine procedure. Their descriptions carried little emotional affect and little about their perceptions of their baby’s experience of it. The main concern was a fear that it might not work thrusting them back into the unbearable situation they were so desperate to leave. This contrasts with the findings of the recent study by López-Segura et al (2025) who reported mothers’ reservations about the procedure and concerns about causing pain for their baby. I wondered if this might

be rooted in that study having been conducted prior to treatment rather than afterwards. After the event, mothers have already had the experience but perhaps too, might push the possibility of pain for their baby out of their mind, which perhaps unconsciously felt psychically linked with their ambivalence, and having taken the decision to have the frenotomy and felt the benefits.

Only Pippa ascribed any distress to it – in relation to her firstborn - his mouth had bled the following day. She described swabbing and stemming the bleeding – moving into a self-described clinical, “emergency” frame of mind in which she acknowledged the emotional content of a situation gets pushed away only to resurface later.

One might understand the frenotomy as attending to the immediacy of the situation in a similar way, but leaving raw anxieties and traumatic experiences unacknowledged, unattended and uncontained – as suggested by the emotional immediacy of interviews - so potentially continuing to play their part in the present in the development of the dyadic relationship and personality of the baby (Fraiberg et al., 2003). Arguably too, impacting future children as indicated through Pippa’s account where unresolved emotional material associated with her firstborn’s tongue-tie seemed to be so relevant to her relationship with Daisy.

Nonetheless, all of these mothers were able to recover a sufficiently non-anxious internal and external environment to bond and establish a reparative breastfeeding relationship with their baby. Perhaps this and their sense of success enabled them

to share their stories with me. What then of those that are not able to do so – those who want to breastfeed but cannot find a way out or through the difficulties, and are forced to abandon it?

### ***Reflexivity***

My findings are within the context of my place in the study's conception, project design, recruitment, data production and data analysis as an NHS trainee child and adolescent psychotherapist and older, white, professionally educated mother with reasonably comfortable means.

My interest in the field of study came both professionally in relation to child development and personally, in my own experiences of early motherhood and difficulties breastfeeding. My position likely brings preconceptions of the potential risks to maternal wellbeing and child development. Efforts at minimising bias through project design and data analytic method cannot eliminate it.

At the suggestion of the founder of the social media group where I advertised the study, I included a friendly looking photo of myself, with the intention of reassuring mothers of my approachability and who they were getting involved with. Yet at the same time, it perhaps unwittingly invited responses from those similar to me.

Participants were selected on the basis of the selection criteria and then in order of original response time but all proved to be middle-class, white and educated. The demographic of those that responded but were not selected is unknown.

My gender, age and ethnicity are visible, my professional identity known and my socio-economic status likely apparent to participants. All will have influenced participants' experience of me and the emotional engagement between us at interview, so becoming an inherent part of the data produced. Data collected regarding mothers' experiences cannot be seen discretely from the intersubjective experience of being with me in interview and with the presence, or indeed absence, of their baby during it. Although I did not say I was a mother, my manner and responses may have unconsciously communicated it, likely having its own impact. I was struck by how openly and willingly mothers told their stories, left unsure whether this came from a sense of me as someone that might understand or a pressing need to tell a story as yet untold to someone that represented the NHS, from where so much of the hurt seemed felt to originate and with whom the wrong needed to be righted. Perhaps linked to this was the reluctance to complain that all participants articulated which I wondered might speak to the deeper and broader internal seam of unallowable aggression that seemed present but unacknowledgeable.

My age and probably apparent identity as a mother may also have evoked a "grandmother constellation" (Stern, 1995). Results showing split relationships with care may have had their roots in anxieties and ambivalence in the immediate present of the interview about the type of researcher I was – offering care/understanding or criticism/judgment. My age, experience and professional expertise could have been experienced as reassuring or threatening. I felt particularly aware of this when mothers fed their babies (in my presence or otherwise), sensing that my observation

was keenly felt - perhaps putting them in touch with continuing anxieties about breastfeeding.

A sense of power imbalance may have been heightened for Anna and Marta as immigrants to this country, affecting the data produced. Privilege is undoubtedly conferred by speaking in one's native language and by birth origin, providing innate knowledge of social and cultural systems and context. Both narratives included themes of a sense of unfairness at getting less than others alongside themes of an absence of care.

### ***Limitations***

Despite prompts mothers had little to say about future feeding plans but all were reluctant to stop breastfeeding having worked so hard to establish it. I was left wondering if the reluctance to wean or even bring it to mind in the interview were simply normally present anxieties surrounding separation or potentially amplified ones rooted in the early breastfeeding difficulties. I had been interested to understand something of mothers' perceptions of their baby's experience but this did not develop in participant accounts. I was left unsure whether this was mothers making the most of what perhaps felt a rare opportunity to be the focus of attention rather than their baby, a reflection of a continued psychic blurring between mother and baby, or of muted maternal reflective capacity with potential roots in their difficult experiences.

Turning to the more general limitations of the study, my findings cannot discern what the situation or experience would have been without tongue-tie or to what extent experiences were informed by each participant, each baby's disposition and individual previous and current experiences unrelated to tongue-tie. Breastfeeding difficulties may have been experienced even without tongue-tie.

Recruitment by self-selection predominantly through the social media group may have meant respondents were more likely to have suffered from the effects of breastfeeding difficulties both as individuals who had firstly joined it and then been motivated to volunteer. Furthermore, the experiences of these participants included complex conception, pregnancy and delivery profiles, history of trauma/ loss, and reduced support networks, all potentially predisposing factors for difficulties in early motherhood likely affecting both the motivation to participate and the findings of this study.

Yet at the same time, the responses to my advert were rapid and numerous with many not meeting inclusion criteria because respondents' experiences of tongue-tie were some years ago. This in itself suggested a lingering and still keenly felt effect of the experience and desire to tell their story. I felt guilty both at not being able to hear them but also perhaps - as an NHS professional - aware of a sense of underlying anger at the care felt to have been received or not. All participants in this study articulated a hope that my research would raise awareness, improve understanding, diagnosis and healthcare provision; and prevent other mothers suffering as they had done.

The small sample size is a limitation to generalisability as is its homogeneity. As already stated, this may be partially attributable to sameness in having included my photo in the recruitment advertisement but also the common connection for three participants of the social media group founded through a private breastfeeding support service (also perhaps making use of private lactation consultants more likely). Yet these demographics mirror those of most studies looking into the effects of tongue-tie, raising questions as to why.

Current wider discourse identifies the loss of wider family and community support around new mothers particularly in the Western culture - the predominant culture in which this and most previous studies have been conducted and that of these participants. Possibly this makes mothers within Western society more vulnerable to the difficulties associated with tongue-tie. Perhaps, in a context of societal individualism, expectations are higher and disappointment keener when they are not met, with the digital age arguably accentuating ideas of perfection and in its immediacy, frustration. All make it harder for new mothers to tolerate the impossibility of attaining perceived ideals of motherhood particularly when shattered by breastfeeding difficulties and in the midst of re-evoked infantile anxieties about frustration and dependency,

Herman writes about the role of community in healing trauma – noting society's unwillingness after the Vietnam war to acknowledge veterans' traumatic experiences leaving them remaining frozen in time. The soldiers had stories to tell but no-one

wanted to hear, other than other soldiers with similar experiences (1992, p. 97). So too, perhaps for motherhood, in a society arguably without an appetite to hear dark and painful stories, challenge ideas of the benign, bountiful and blissful ideal. Yet without it, traumatic events associated with birth such as those related to tongue-tie remain unprocessed, and the wounds associated with being left unprotected by those expected to provide care, unhealed - wreaking ongoing effects on the developing mother-infant relationship and the care relationships surrounding mothers.

The GET, “Ambivalence – managing feelings of hurt, anger and upset” perhaps reflects an endemic societal and cultural difficulty with acknowledging maternal and infant ambivalence, leaving it unprocessed – a “ghost” in developing mother/infant relationships (Fraiberg et al., 2003). Despite an increasing willingness to acknowledge and engage with more negative aspects of maternal experience (Ditum, 2025), the continuing controversy surrounding tongue-tie’s diagnosis and significance might be understood as representative of a wider societal deafness and unwillingness to engage with the more challenging and unwanted aspects of early motherhood. Accordingly, mothers, rather like the Vietnam veterans, can only find willing ears amongst fellow peer sufferers. Yet without the acknowledgement of community, healing cannot be found (Herman, 1992). Burton et al., (2025, p. 5) discuss how disbelief and dismissal by healthcare providers left mothers of babies with tongue-tie feeling confused, distressed and disempowered. This sense of something denied perhaps offers some explanation of the rush to respond to my advertisement even years after the initial experience. Possibly, the demographic participant profile reflects that only those mothers with the societal advantages

afforded by ethnicity, education and socio-economic status feel confident enough to be able to stand up and have their voices heard; so too perhaps those with the reassurance that their identity as “good mothers” is intact having managed to continue breastfeeding.

Aware of the homogeneity of sample groups in previous research studies, my initial intention to recruit through an inner-city, community NHS midwifery service with a diverse service user population proved untenable despite the willingness of the midwives. I was unable to secure any interest or consent within management structures and needed to change my recruitment method. I was left unsure whether this might be a manifestation of such a societal reticence to engage, fear of judgement and criticism, or simply lack of resources or appetite for it in an already beleaguered NHS.

Nonetheless there remains a fundamental gap in understanding about tongue-tie. Often whilst at the baby group I saw noticeably highly distressed mothers representing a more diverse demographic waiting for their midwifery appointment only to later discover that their baby had tongue-tie. It remains unknown what story these mothers had to tell or whether they would have felt able to tell it. This limitation is one that had the time and resources of the study allowed, I would have persisted in seeking to address by pursuing my original method of recruitment through the NHS.

I would also have included a second FANI interview. As the study stands it represents a single moment in time, dependent on the states of all three of us participating in each interview on that day. A second interview in accordance with the FANI method would have increased the validity of results and given opportunity not only to identify similarities/ differences but also how themes developed between interviews lending further insight into the dynamics between us.

The timing of the interview in relation to each baby's age also seems relevant to the results. I was aware that at 6/7 months George, Kaya and Daisy were each approaching the age where issues of separation are likely to have started to become very live within each dyad, so playing a part in the emotional landscape I encountered, further affected by my presence as a stranger. Results may have differed had I interviewed at another stage of development with consequently different live maternal and infant preoccupations. A wider age-range in the selection criteria - particularly including participants with older children - might have allowed further insight but compromised the comparability of findings.

Finally, it is acknowledged that this study's focus was limited to breastfeeding mothers. All participants were in heterosexual relationships. Both mean that the experiences of those in same-sex relationships or of bottle-feeding caregivers, irrespective of gender, are not represented.

### ***Implications for clinical practice***

My findings suggest that participants' experiences had a profound effect on maternal confidence, sense of internal structuring and emotional stability - compromising mothers' ability to contain and be contained and their sense of connection both with their baby and the support networks around them. In the complexity of human experience it would be a fool's errand to seek a single point of causation for the experiences of these mothers, yet amidst all the other constellations of internalised previous experience, external experiences of conception, pregnancy and care/ support or lack of it, my findings suggest that in compromising the ability to breastfeed, tongue-tie can be a serious contributory factor towards maternal distress carrying the potential to disrupt mother-infant bonding and maternal confidence and wellbeing, bringing risks of negative impacts for both mother and baby. The critical nature of early childhood experiences for future development is widely acknowledged (Department of Health and Social Care, 2021), making this a matter of clinical importance.

My findings support previous studies highlighting the need for empathic care encouraging mothers to seek support rather than manage alone (Wong et al., 2017) and the negative impact of the number of professionals seen, lack of support at home and complications in birth and pregnancy on maternal wellbeing and mother-infant bonding (Hill et al., 2021). Therefore, the provision of care for a mother experiencing difficulties breastfeeding her baby should be consistent, timely and readily available as well as compassionate and emotionally alert to the potential

impact and particular vulnerabilities of mothers based on both past and present circumstances. Training of professionals responsible for care of mothers should be emotionally informed so that they are equipped to offer containment and understanding. Accordingly, I would argue that assessment of new mothers and allocation of clinical resources should take full account of breastfeeding difficulties associated with tongue-tie within these contexts.

Additionally, in assessing mental health difficulties in older children and adolescents, CAMHS professionals should include breastfeeding difficulties caused by tongue-tie as a significant event in a child's developmental history just as a traumatic birth or early maternal separation might be - tongue-tie can become an interference which "reveals itself in character development as unmistakably as the 'shakes' in a piece of timber mark early periods of drought" (Meltzer & Williams, 2004, p. 194).

### ***Implications for future research***

These results add new depth to the findings of previous studies identifying emotional consequences for mothers of babies with tongue-tie and as such provide a valuable context for framing future qualitative and mixed-method studies examining maternal experiences. Future studies would helpfully explore more diverse experiences of mothers breastfeeding their babies with tongue-tie from (including race, socio-economic group and geography – paying particular attention to attitudes towards social and familial support for mothers; maternal healthcare provision; and breastfeeding) as well as potential compounding vulnerabilities to difficulties associated with tongue-tie (e.g. complications in conception, pregnancy and delivery; previous experiences of loss/ trauma; immigration; and those without strong support networks around them) would allow further insight into. Enquiry into the experience of babies using observation and of partners' experiences would likely add fruitful insight into the emotional impact of tongue-tie. Finally, the potential longer-term emotional and relational effects on both mothers and babies of difficulties associated with tongue-tie deserve attention through future longitudinal and in-depth investigations.

### ***Conclusion***

My study was inspired by a curiosity about whether the maternal experience of infant tongue-tie carried emotional weight. Its aim was to understand more about mothers' experiences of difficulty breastfeeding as a result. Overall, the results of my study show that the emotional experience of these mothers was profound, going to the

core of their sense of identity and capacity as mothers, shattering their expectations and undermining the ordering structures of their mind in something akin to a trauma response. Furthermore, their combined experiences of care by healthcare professionals through pregnancy and delivery as well as diagnosis, referral and treatment of tongue-tie in their baby had a significant impact on their state of mind and sense of wellbeing (positively and negatively). Threats to participants' sense of identity, internal ordering structures and perceptions of lack of available care created a compounding sense of disconnection with both their baby and support systems around them with the latter compromising their ability to access care.

Using psychoanalytic understanding and aligned with existing research literature, I argue that care of these mothers needs to be attentive, timely and offer emotional containment, to enable them to maintain a sufficiently stable internal framework to allow emotional availability for containment of their baby and foster an environment in which a sense of connectedness with others supports the development of the relationship with their baby, and the maintenance of links with the wider support network, including healthcare.

## References

- Alvarez, A. (1996). The clinician's debt to Winnicott. *Journal of Child Psychotherapy*, 22(3), 377-383.
- Balsam, R. H. (2000). The Mother Within The Mother. *Psychoanalytic Quarterly*, 69(3), 465-492.
- Bion, W. R. (1962). *Learning from experience* (Third ed.). Maresfield Library, Karnac.
- Birksted-Breen, D. (2000). The experience of having a baby: a developmental view. In J. Raphael-Leff (Ed.), *Spilt milk: perinatal loss and breakdown* (pp. 17-27). Routledge.
- Borra, C., Iacovou, M., & Sevilla, A. (2015). New evidence on breastfeeding and postpartum depression: The importance of understanding women's intentions. *Maternal and Child Health Journal*, 19(4), 897-907.
- Bradley, E. (2000). Pregnancy and the internal world. In *Spilt Milk: perinatal loss and breakdown* (pp. 28-38). Routledge.
- Brown, A., Rance, J., & Bennett, P. (2016). Understanding the relationship between breastfeeding and postnatal depression: the role of pain and physical difficulties. *Journal of advanced nursing*, 72(2), 273-282.
- Brown, A., Raynor, P., & Lee, M. (2011). Healthcare professionals' and mothers' perceptions of factors that influence decisions to breastfeed or formula feed infants: a comparative study. *Journal of advanced nursing*, 67(9), 1993-2003.
- Burton, A. E., Cassidy, H., Taylor, J., & Owen, A. (2025). Experiences of tongue tie when breastfeeding twins: A qualitative study. *Midwifery*, 142.
- Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: The SPIDER tool for qualitative evidence synthesis. *Qualitative Health Research*, 22(10), 1435-1443.
- Cooklin, A., Amir, L., Nguyen, C., Buck, M., Cullinane, M., Fisher, J., Donath, S., & Team, C. S. (2018). Physical health, breastfeeding problems and maternal mood in the early postpartum: a prospective cohort study. *Archives of Women's Mental Health*, 21, 365-374.
- Cooper, H. (1998). *Synthesizing research: A guide for literature reviews*, 3rd ed. Sage Publications, Inc.
- Cordray, H., Mahendran, G. N., Tey, C. S., Nemeth, J., Sutcliffe, A., Ingram, J., & Raol, N. (2023). Severity and prevalence of ankyloglossia-associated breastfeeding symptoms: A systematic review and meta-analysis. *Acta Paediatrica*, 112(3), 347-357.
- Davies, S. M., Silverio, S. A., Christiansen, P., & Fallon, V. (2021). Maternal-infant bonding and perceptions of infant temperament: The mediating role of maternal mental health. *Journal of Affective Disorders*, 282, 1323-1329.

- Della Vedova, A. M., Santoniccolo, F., Sechi, C., & Trombetta, T. (2023). Perinatal Depression and Anxiety Symptoms, Parental Bonding and Dyadic Sensitivity in Mother–Baby Interactions at Three Months Post-Partum. *International Journal of Environmental Research and Public Health*, 20(5), 4253.
- Department of Health and Social Care, H. G. (2021). *The best start for life: a vision for the 1001 critical days*. (CP 419). Department of Health and Social Care.
- Dermott, K. (2006). *Clinical guidelines and evidence review for post natal care: routine post natal care of recently delivered women and their babies*. NICE.
- Devi, E. S., Sankar, A. S., Kumar, M. M., & Sujatha, B. (2012). Maiden morsel-feeding in cleft lip and palate infants. *Journal of International Society of Preventive and Community Dentistry*, 2(2), 31-37.
- Diaz Bonino, S., & Ball, K. (2013). From torment to hope: Countertransference in parent-infant psychoanalytic psychotherapy. *Infant Observation*, 16(1), 59-75.
- Ditum, S. (2025, 10 May 2025). 'My baby is ugly' - a candid warning about the horrors of motherhood. *The Times*.
- Earls, M. F., Child, C. o. P. A. o., & Health, F. (2010). Incorporating recognition and management of perinatal and postpartum depression into pediatric practice. *Pediatrics*, 126(5), 1032-1039.
- Edmunds, J. E., Fulbrook, P., & Miles, S. (2013). Understanding the experiences of mothers who are breastfeeding an infant with tongue-tie: a phenomenological study. *MIDIRS Midwifery Digest*, 23(3), 390-390.
- Excellence, N. I. f. H. a. C. (2005). *Division of ankyloglossia (tongue-tie) for breastfeeding (IPG149)*. (9783319435695).
- Fallon, V., Komninou, S., Bennett, K. M., Halford, J. C., & Harrold, J. A. (2017). The emotional and practical experiences of formula-feeding mothers. *Maternal & child nutrition*, 13(4), e12392.
- Feenstra, M. M., Jørgine Kirkeby, M., Thygesen, M., Danbjørg, D. B., & Kronborg, H. (2018). Early breastfeeding problems: A mixed method study of mothers' experiences. *Sexual & Reproductive Healthcare*, 16, 167-174.
- Foundation, P.-I. (2021). Evidence Brief 1: The first 1001 days; an age of opportunity. In P.-I. Foundation (Ed.). Website: Parent-Infant Foundation.
- Fraiberg, S., Adelson, E., & Shapiro, V. (2003). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. In J. Raphael-Leff (Ed.), *Parent-infant psychodynamics: Wild things, mirrors and ghosts*. (pp. 87-117). Whurr Publishers.
- Freud, S. (1912). *Recommendations to Physicians Practising Psycho-Analysis*.
- Friedman, M. E. (1996). Mother's Milk: A Psychoanalyst Looks at Breastfeeding [Article]. *Psychoanalytic Study of the Child*, 51, 475-490.
- Garland, C. (2002). Thinking about trauma. In *Understanding trauma. A psychoanalytical approach*. (pp. 9-31). Karnac.
- Gerhardt, S. (2004). *Why love matters. How affection shapes a baby's brain*. Routledge.

- Glasheen, C., Richardson, G. A., & Fabio, A. (2009). A systematic review of the effects of postnatal maternal anxiety on children.
- Grace, S. L., Evindar, A., & Stewart, D. E. (2003). The effect of postpartum depression on child cognitive development and behavior: A review and critical analysis of the literature. *Archives of Women's Mental Health*, 6(4), 263-274.
- Grond, S. E., Kallies, G., & McCormick, M. E. (2021). Parental and provider perspectives on social media about ankyloglossia. *International journal of pediatric otorhinolaryngology*, 146, 110741.
- Harrison, A. M., & Tronick, E. (2025). Trevarthen's primary intersubjectivity: An appreciation and an elaboration. In *Intersubjective minds*. (pp. 101-113).
- Henshaw, E. J., Fried, R., Siskind, E., Newhouse, L., & Cooper, M. (2015). Breastfeeding Self-Efficacy, Mood, and Breastfeeding Outcomes among Primiparous Women. *Journal of Human Lactation*, 31(3), 511-518.
- Herman, J. (1992). *Trauma and recovery: the aftermath of violence - from domestic abuse to political terror* (4th ed.). Basic Books.
- Hill, R. (2019). Implications of Ankyloglossia on Breastfeeding. *MCN. The American journal of maternal child nursing*, 44(2), 73-79.
- Hill, R., Lee, C., & Pados, B. (2020). The prevalence of ankyloglossia in children aged < 1 year: a systematic review and meta-analysis. *Pediatric research*, 90(2), 259-266.
- Hill, R. R., Wong, J., & Parikh, G. S. (2021). Relationship Between Infant Tongue-Tie and Maternal Wellbeing. *MCN Am J Matern Child Nurs*, 46(5), 258-263.
- Hinde, R. A., & Stevenson-Hinde, J. (1976). Towards understanding relationships: Dynamic stability. In P. P. G. Bateson & R. A. Hinde (Eds.), *Growing points in ethology*. Cambridge U Press.
- Hollway, W. (2013). *Doing qualitative research differently: a psychosocial approach* (Second Edition ed.). SAGE Publications.
- Holmes, J. (2018). *A Practical Psychoanalytic Guide to Reflexive Research : The Reverie Research Method* (1st edition. ed.). Routledge, an imprint of Taylor and Francis.
- Hsieh, H.-F., & Shannon, S. E. (2005). Three Approaches to Qualitative Content Analysis. *Qualitative Health Research*, 15(9), 1277-1288.
- Jackson, L., Fallon, V., Harrold, J. A., & De Pascalis, L. (2024). Psychosocial predictors of post-natal anxiety and depression: Using Structural Equation Modelling to investigate the relationship between pressure to breastfeed, health care professional support, post-natal guilt and shame, and post-natal anxiety and depression within an infant feeding context. *Maternal & child nutrition*, 20(1), e13558.
- Josefsson, A., & Sydsjö, G. (2007). A follow-up study of postpartum depressed women: recurrent maternal depressive symptoms and child behavior after four years. *Archives of Women's Mental Health*, 10(4), 141-145.
- Kam, R. (2021). A mother's experience of tongue-tie diagnosis and management: Her concerns and lessons for others. *Breastfeeding Review*, 29(3), 7-16.

- Klatzkow, H., Gitomer, S., St John-Larkin, C., Scholes, M. A., & Cooper, E. (2023). Prevalence of Postpartum Depression in Mothers Presenting to a Pediatric Otolaryngology Clinic. *The Laryngoscope*.
- Klein, M. (1946). Notes on some schizoid mechanisms. *The International Journal of Psychoanalysis*, 27, 99-110.
- Klein, M. (Ed.). (1957a). *Envy and Gratitude*. Vintage.
- Klein, M. (1957b). *Love, guilt and reparation and other works 1921-1945*. Hogarth Press and Institute of Psychoanalysis.
- Klein, M. (1959). Our Adult World and its Roots in Infancy. *Human Relations*, 12(4), 291-303.
- Klein, M. (1975). *Envy and gratitude and other works 1946-1963. Melanie Klein*. Hogarth Press and Institute of Psychoanalysis.
- Kroenke, K., Wu, J., Bair, M. J., Krebs, E. E., Damush, T. M., & Tu, W. (2011). Reciprocal relationship between pain and depression: a 12-month longitudinal analysis in primary care. *The Journal of Pain*, 12(9), 964-973.
- Kurtz Landy, C., Sword, W., & Valaitis, R. (2009). The experiences of socioeconomically disadvantaged postpartum women in the first 4 weeks at home. *Qualitative Health Research*, 19(2), 194-206.
- Labbok, M. (2008). Physicians' Focus. *J Hum Lact*, 24, 1.
- Leahy-Warren, P., & McCarthy, G. (2011). Maternal parental self-efficacy in the postpartum period. *Midwifery*, 27(6), 802-810.
- Lewis, M., & Rosenblum, L. A. (1974). *The Effect of the Infant on Its Caregiver. Volume 1 in the Origins of Behavior Series*.
- López-Segura, G., Alarcón-Rodríguez, R., Romero-Del Rey, R., Murillo-de Las Heras, M. D. M., Requena-Mullor, M., & García-González, J. (2025). Experiences of Breastfeeding Mothers of Infants With Ankyloglossia: A Qualitative Study. *Journal of human lactation : official journal of International Lactation Consultant Association*, 41(2), 196-206.
- Lyon, T. (2016). Emerging life: an essay about rhythms of encounters and missed encounters in the parent–infant early interactions. *Infant Observation*, 19(3), 210-223.
- Mariotti, P. (2012). *The maternal lineage. Identification, desire, and transgenerational issues*. Routledge.
- McCarter-Spaulding, D. E., & Kearney, M. H. (2001). Parenting self-efficacy and perception of insufficient breast milk. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 30(5), 515-522.
- McClatchey, J. (2024, 11th December 2024). *Untimely Ripp'd: An exploration of some of the unconscious processes active in a Parent Support Group in a Neonatal Intensive Care Unit (NICU) M80 Whole Course Event Tavistock and Portman NHS Foundation Trust, 120 Belsize Lane, London NW3 5BA*.
- McLeish, J., Harvey, M., Redshaw, M., Henderson, J., Malouf, R., & Alderdice, F. (2020). First-Time Mothers' Expectations and Experiences of Postnatal Care in England. *Qualitative Health Research*, 30(12), 1876-1887.

- Meltzer, D., & Williams, M. H. (2004). Aesthetic conflict: Its place in the developmental process. In *Psychoanalysis and art: Kleinian perspectives*. (pp. 178-200).
- Messner, A. H., Walsh, J., Rosenfeld, R. M., Schwartz, S. R., Ishman, S. L., Baldassari, C., Brietzke, S. E., Darrow, D. H., Goldstein, N., & Levi, J. (2020). Clinical consensus statement: ankyloglossia in children. *Otolaryngology–Head and Neck Surgery*, *162*(5), 597-611.
- Monti, F. (2015). The 'times' of maternity. In G. F. Mori (Ed.), *From pregnancy to motherhood: Psychoanalytic aspects of the beginning of the mother-child relationship*. (pp. 107-119). Routledge/Taylor & Francis Group.
- Morrison, T. (1987). *Beloved*. 1987. *New York: Vintage*. (2004) (1987.)
- Mosse, K. (1993). *Becoming a mother*. Virago.
- Murray, L., Halligan, S., & Cooper, P. (2010). Effects of Postnatal Depression on Mother–Infant Interactions and Child Development. In *The Wiley-Blackwell handbook of infant development* (pp. 192-220). Wiley-Blackwell.
- Nassar, E., Marques, I. L., Trindade Jr, A. S., & Bettiol, H. (2006). Feeding-facilitating techniques for the nursing infant with Robin sequence. *The Cleft palate-craniofacial journal*, *43*(1), 55-60.
- Nelson, A. M. (2006). A metasynthesis of qualitative breastfeeding studies. *Journal of midwifery & women's health*, *51*(2), e13-e20.
- NHS. (2024). *Tongue-tie*. [www.nhs.uk](http://www.nhs.uk). Retrieved 10th September from
- O'Shea, J. E., Foster, J. P., O'Donnell, C. P., Breathnach, D., Jacobs, S. E., Todd, D. A., & Davis, P. G. (2017). Frenotomy for tongue-tie in newborn infants. *The Cochrane database of systematic reviews*, *3*, CD011065.
- Ogden, T. H. (1996). Reconsidering Three Aspects Of Psychoanalytic Technique. *International Journal of Psycho-Analysis*, *77*, 883-899.
- Pados, B. F., & Hill, R. (2019). Parents' descriptions of feeding their young infants. *Nursing for women's health*, *23*(5), 404-413.
- Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., . . . Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ*, *372*, n71.
- Parker, R. (1995). *Torn in two: The experience of maternal ambivalence*. Virago.
- Pietkiewicz, I., & Smith, J. (2014). A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *CPPJ*, *20*, 7-14.
- Raes, F., Smets, J., Wessel, I., Van Den Eede, F., Nelis, S., Franck, E., Jacquemyn, Y., & Hanssens, M. (2014). Turning the pink cloud grey: Dampening of positive affect predicts postpartum depressive symptoms. *Journal of Psychosomatic Research*, *77*(1), 64-69.
- Raphael-Leff, J. (2000). Introduction: Technical issues in perinatal therapy. In J. Raphael-Leff (Ed.), *Spilt milk: Perinatal loss and breakdown*. Routledge.

- Raphael-Leff, J. (2000). 'Climbing the walls': therapeutic intervention for post-partum disturbance. In J. Raphael-Leff (Ed.), *Spilt milk: perinatal loss and breakdown* (pp. 60-81). Routledge.
- Raphael-Leff, J. (2001a). *Pregnancy. The inside story* (Rev. ed.). Karnac Books.
- Raphael-Leff, J. (2001b). Primary maternal persecution. In B. Kahr (Ed.), *Forensic psychotherapy and psychopathology* (pp. 27-42). Karnac.
- Raphael-Leff, J. (2003). Where the wild things are. In J. Raphael-Leff (Ed.), *Parent infant psychotherapy: Wild things, mirrors & ghosts* (pp. 54-69). Routledge.
- Ray, S., Hairston, T. K., Giorgi, M., Links, A. R., Boss, E. F., & Walsh, J. (2020). Speaking in Tongues: What Parents Really Think About Tongue-Tie Surgery for Their Infants. *Clinical pediatrics*, 59(3), 236-244.
- Redshaw, M., & Henderson, J. (2012). Learning the Hard Way: Expectations and Experiences of Infant Feeding Support. *Birth*, 39(1), 21-29.
- Rodriguez Lara, F., Carnino, J. M., & Levi, J. R. (2025). Maternal Experiences and Challenges in Breastfeeding Infants with Tongue-Tie: A Systematic Review. *Maternal and Child Health Journal*, 29(7), 870-878.
- Rustin, M. (2017). Creative responses to compromised beginnings in life: how to support families struggling with early difficulties. *Infant Observation*, 20(2-3), 148-160.
- Saunders, I., Geary, L., Fleming, P., & Gregg, T. (1989). A simplified feeding appliance for the infant with a cleft lip and palate. *Quintessence international (Berlin, Germany: 1985)*, 20(12), 907-910.
- Schlatter, S. M., Schupp, W., Otten, J. E., Harnisch, S., Kunze, M., Stavropoulou, D., & Hentschel, R. (2019). The role of tongue-tie in breastfeeding problems—A prospective observational study. *Acta Paediatrica*, 108(12), 2214-2221.
- Schore, A. N. (1994). *Affect regulation and the origin of the self. The neurobiology of emotional development*. Lawrence Erlbaum.
- Segal, H. (1957). Notes on symbol formation. In E. Bott-Spillius (Ed.), *Melanie Klein today: Volume 1: Mainly theory* (1st ed., Vol. 1, pp. 160-177). Routledge.
- Shakespeare, J., Blake, F., & Garcia, J. (2004). Breast-feeding difficulties experienced by women taking part in a qualitative interview study of postnatal depression. *Midwifery*, 20(3), 251-260.
- Smith, J. A., Flowers, P., & Larkin, M. (2021). *Interpretative phenomenological analysis : theory, method and research* (Second edition. ed.). SAGE.
- South, L.-M. (2016). "But the latch looks perfect!": breastfeeding with posterior tongue-tie. *Midwifery Matters*(149), 14-16.
- Stern, D. N. (1985). *The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology*. Basic Books.
- Stern, D. N. (1995). *The motherhood constellation: A unified view of parent–infant psychotherapy*. Basic Books.

- Stern, D. N. (1998). *The Interpersonal World of the Infant : A View From Psychoanalysis and Developmental Psychology* [Book]. Routledge.
- Stone, R. (2014). *Breastfeeding in the psychoanalytic imagination* ProQuest Information & Learning]. APA PsycInfo.
- Tran, J., & Hill, R. R. (2022). Breastfeeding Experiences and Changes in Feeding Plans Among Parents of Infants Diagnosed With Tongue-Tie. *Nurs Womens Health, 26*(1), 21-29.
- Trevarthen, C. (1998). The concept and foundations of infant intersubjectivity. In *Intersubjective communication and emotion in early ontogeny*. (pp. 15-46).
- UNICEF, W. H. O. a. (2003). *Global strategy for infant and young child feeding*. W. L. C.-i.-p. data.
- Van Manen, M. (2016). *Researching lived experience: Human science for an action sensitive pedagogy*. Routledge.
- Wakelin, R., Howe, A., Fleetcroft, R., & Stöckl, A. (2017). Tongue-tie and breastfeeding: Identifying problems in the diagnostic and treatment journey. *British Journal of Midwifery, 25*(9), 579-584.
- Waterman, J., Lee, T., Etchegary, H., Drover, A., & Twells, L. (2021). Mothers' experiences of breastfeeding a child with tongue-tie. *Maternal & child nutrition, 17*(2), e13115.
- Watkins, S., Meltzer-Brody, S., Zolnoun, D., & Stuebe, A. (2011). Early Breastfeeding Experiences and Postpartum Depression. *Obstetrics & Gynecology, 118*(2 Part 1), 214-221.
- White, P. (2017). *Developing research questions*.
- Winkel, T. (2021). *Assessment of Maternal Perceptions on Post-Surgical Follow-up in Managing Tethered Oral Tissues* Tennessee]. Tennessee Research and Creative Exchange.
- Winkel, T., Wilson, J., Spence, M., Colby, S., Springer, C., Hedrick, M., & Kavanagh, K. (2023). Tethered oral tissue release among breastfed infants: maternal sources of information and treatment. *Journal of Human Lactation, 39*(3), 505-514.
- Winnicott, D. W. (1956). Primary maternal preoccupation. In P. Mariotti (Ed.), *The maternal lineage: Identification, desire and transgenerational issues*. (pp. 59-66). Routledge/Taylor & Francis Group.
- Winnicott, D. W. (1960). The theory of the parent-infant relationship. In P. Buckley (Ed.), *Essential papers on object relations*. (pp. 233-253). New York University Press.
- Winnicott, D. W. (1964). *The child, the family and the outside world*. D. W. Winnicott. Penguin Books.
- Wong, K., Patel, P., Cohen, M. B., & Levi, J. R. (2017). Breastfeeding Infants with Ankyloglossia: Insight into Mothers' Experiences. *Breastfeeding medicine : the official journal of the Academy of Breastfeeding Medicine, 12*, 86-90.

## Appendices

**Appendix 1 –Table of papers for literature review**

Tongue tie and maternal experience - Results after hand search of abstracts

	Name of Paper	Author	Date	Research Design	Findings	Limitations	Eligible
1.	Tongue-tie and breastfeeding – a review of the literature	Edmunds, Miles and Fulbrook	2011	Literature review	Does negatively affect breastfeeding for mothers and infants and causes symptoms in mother  Frenotomy is safe and effective  Lack of consensus about frenotomy		N - not about psychological experience
2.	How LLL saved my breastfeeding relationship	Ashton, A.	2012	Personal narrative, Journal article	Author's experience	Unable to retrieve. Low quality data. New beginnings Journal	N - unavailable

3.	Breastfeeding: a personal and professional story	Albert, J.	2013	Journal Article	Author's experience as a lactation consultant and breastfeeding mother – and tongue-tie	Not relevant  Predominantly article setting out different breastfeeding problems including tongue-tie but not specifically about tongue-tie.	N -
4.	A Tale of Tongue-Tie	Slagle, Adryana	2013	Personal Narrative, Journal Article	Personal narrative of author's experience nursing and breastfeeding baby with tongue-tie	Unable to retrieve  Low quality evidence	N - unavailable
5.	Understanding the experiences of mothers who are breastfeeding an infant with tongue-tie: a phenomenological study	Edmunds, Fulbrook and Miles	2013	Focussed interview – open-ended questions - Hermeneutic phenomenological analysis. Description and interpretation of breastfeeding experiences Interviewed  10 participants – invited to participate at first visit to the breastfeeding clinic when	Tension between maternal expectations and their actual experiences of breastfeeding.  'Harrowing journey' -  Six stages:  <ul style="list-style-type: none"> <li>• Expectations;</li> <li>• Something is wrong;</li> <li>• Questioning seeking advice; no real answers;</li> <li>• Symptoms and perseverance;</li> <li>• Approaching the wall – it's all too much; relief</li> </ul>	Not generalisable – small sample  How would these experiences compare to mothers whose babies did not have tongue tie?  Inter-researcher consistency?	Y

				<p>tongue-tie was first diagnosed and the next 2 weeks later</p>	<p>Lack of knowledge and advice from professionals and lack of consistency</p> <p>Loss of feeding relationship they had imagined</p> <p>BF an infant with TT – leading to frustration and disappointment</p> <p>Researchers recommend TT should be checked for routinely and then immediately referred for frenotomy if initial breastfeeding management is unsuccessful</p>	<p>Reflexivity – who are researchers and who are they in the research? Interview bias?</p>	
6.	Ankyloglossia its impact breastfeeding	Henry, L and Hayman, R.	2014	Case Report, Journal Article	Differing experiences of one mother feeding two sons – one with and one without ankyloglossia	Single case report – low quality evidence	N – low quality evidence
7.	Tongue-tie and breastfeeding in	Riskin, Monsofsky,	2014	Single-centre observational study using a structured survey asking about:	TT infants had similar rates and durations of breastfeeding and of breastfeeding problems but TT mothers	Only at one centre – specific to that centre – limits	N. Some information about motivations and beliefs but not about

	<p>newborns – Mothers' perspective</p>	<p>Coler-Botzer et al.</p>		<p>breastfeeding experience/challenges/ lactation consultation and frenotomy</p> <p>183 tongue-tie mothers</p> <p>314 control mothers (all the medical records of babies born at one centre – 2 gender matched control babies with same birthdate for each TT baby)</p> <p>Aim to approach the debate about whether frenotomies should be performed from the mother's perspective – (but it is mostly based on physical stuff – although some things about motivations for frenotomy and beliefs about TT.</p>	<p>reported more latching problems, prolonged feeding, infant exhaustion and other breastfeeding problems</p> <p>Did not find significant increase in pain or sore nipples for TT mothers - level of degree?</p> <p>Only 50% attributed breastfeeding problems to TT</p> <p>Procedure satisfaction poor for frenotomy other than if to help with BF.</p> <p>TT mothers more likely to seek consultation and to find lactation consultant support beneficial.</p> <p>Significantly more prevalent in males and in Jewish babies than in Arabic babies</p>	<p>generalisability but mitigated by the control group</p> <p>Covers a wide range of time – in some cases a long time ago – recall/ different perspective after 6 years?</p> <p>Inconsistency of medical record data</p> <p>Does not account for severity of TT</p> <p>They have accounted for statistical significance and interrater reliability and of questionnaire</p> <p>How reliable was TT diagnosis – low incidence rate in overall</p>	<p>psychological experience</p>
--	--	----------------------------	--	--	--	--	---------------------------------

				Telephone interview – 1-6 years later	TT mothers - more likely to seek lactation consultation  Lack of awareness in TT mothers that it could affect BF	number of babies born.  Increase over time. 11 subsequently found to have TT(counted as TT)  Subjective bias.  Recall bias	
8.	“But the latch looks perfect!”: breastfeeding with posterior tongue-tie	South, L-M.	2016	Journal article, Personal narrative	Author’s experience of motherhood including breastfeeding with posterior tongue-tie.  Speaks to the emotional difficulties of struggling to find out what is causing BF difficulties and getting TT diagnosis.  Importance of addressing psychological and physical factors, Importance of listening and acting quickly	Low quality  Individual personal account	N – low quality evidence
9.	Tongue-tie and breastfeeding: Identifying	Wakelin, R.; Howe, A.;	2017	Qualitative Interview Study of professionals and	Common story from mothers of having to push for support, diagnostic and treatment delay	Research Lead with personal experience of tongue-tie –	[N] – not about psychological

	<p>problems in the diagnostic and treatment journey</p>	<p>Fleetcroft, R.; and Stöki, A.</p>		<p>mothers regarding facilitators and barriers to diagnosis and treatment for tongue-tie</p> <p>23 participants – data saturation reached. 5 GPs (male and female), 4 Midwives, 5 health visitors and 9 mothers (focus group). Professionals with a range of rural and urban settings and experience. No training in relation to TT.</p> <p>Semi-structured telephone interviews</p> <p>Excluded mothers who had fed an older child with TT</p>	<p>and ongoing distress. Maternal vulnerabilities in neonatal period. Variable professional knowledge, conflicting advice and delayed diagnosis all in the context of resource limitations, organisational difficulties and private/NHS interface can lead to a difficult patient pathway.</p> <p>'desperation' 'trying to do the right thing and not managing'</p> <p>'lucky' to see the right person</p> <p>'loneliness and lack of support'</p> <p>'no-one listened'</p> <p>'feeling dismissed'</p> <p>'doing something wrong' or a 'lazy baby'</p>	<p>potential bias but also enriching? Mitigation of bias through data analysis techniques and triangulation</p> <p>Small samples size and in one geographic location</p> <p>Lack of diversity in participant mothers – all white and higher degree (except 1). Says this group is more likely to breastfeed but not sure that is enough.</p> <p>6 out of 9 had private frenotomies – is this representative of the wider UK?</p>	<p>experience but relevant</p>
--	---	--------------------------------------	--	---	--	--	--------------------------------

				Purposive sampling for transferability vs generalisability	Inequity in better sense of experience and care in going privately	Mostly first time mothers – problems amplified?	
10.	Breastfeeding Infants with Ankyloglossia: Insight into mother's experiences	Wong, Patel, Cohen and Levi	2017	<p>Review of online discussions</p> <p>Ethnographic content analysis of online forums to understand the thoughts, experiences and perspectives of mothers breastfeeding infants with TT.</p> <p>Non-human subjects Research.</p>	<p>Difficulties feeding a commonly voiced concern.</p> <p>Concerns exacerbated by healthcare providers overlooking/ missing TT.</p> <p>Subjective and physical improvements after frenotomy.</p> <p>Controversy about treatment; diagnosis and clinical significance</p>	<p>Context dependent - Not generalisable</p> <p>Selection bias – only mothers experiencing difficulties are likely to have posted.</p> <p>No demographic or geographic information available for those who posted on forums.</p> <p>Design does not allow for understanding of individual</p>	Y

				<p>Sampling from multiple sources – 221 threads met the criteria – of which 76 selected by random number generator – 501 relevant posts</p> <p>Categorised using six 'domains' (using themes found in Edmunds paper) and then subdivided into 22 subtopics.</p> <p>Posts reviewed and attributes recorded on a binary scale</p>	<p>Most common thread about breastfeeding difficulties</p> <p>Emotions surrounding these difficulties as a sub-topic</p> <p>Other topics: diagnosis and treatment</p> <p>Changes in expectations of breastfeeding</p> <p>Forum analysis as a way of gaining insight as to patient's experiences</p> <p>Initial expectations to breastfeed thwarted by nipple pain and difficulties latching, compounded by healthcare workers who missed or disregarded TT. Both resulting in making "parenting an emotionally challenging experience; sadness, anger and even despair were emotional motifs commonly identified in forum posts"</p> <p>Invites health care-providers to maintain a high degree of empathy for mothers with TT.</p>	<p>biographical underlying emotions/ or recognition of defended subjects – although arguably more uninhibited and intimate due to anonymity</p>	
--	--	--	--	---	---	---	--

<p>11.</p>	<p>Speaking in Tongues: What parents really think about tongue-tie surgery for their infants</p>	<p>Ray, S.; Hairston, T.K.; Giorgi, M.; Link A.R.; Boss, E.F.; Walsh, J.</p>	<p>2019</p>	<p>Mixed-method study seeking thematic saturation and get sufficient data for a descriptive statistical analysis.</p> <p>Evaluation of online baby forums examining maternal perspectives on frenotomy specifically – 2012 to 2017</p> <p>Looking to get insights that may never be directly expressed to physicians or researchers</p> <p>305 posts (with 227 unique authors)</p> <p>Inter-rater agreement assessed</p>	<p>74.7% posted about BF issues and experience</p> <p>Discomfort - 30.6%</p> <p>Satisfactory outcome of frenotomy – 43.8% but 10.2% had a dissatisfactory outcome. 28.1% neutral</p> <p>Use perspectives on frenotomy to guide counselling and improve shared decision making</p> <p>Three domains identified:</p> <ul style="list-style-type: none"> <li>- maternal concerns</li> <li>- surgical issues</li> <li>- attitudes and experiences</li> </ul> <p>Most maternal concerns did not include physical discomfort – most related to the child or general problems for both. Worries about poor weight-gain, low supply and engorgement, teeth and air-sucking. Physical pain and discomfort (15.08%)</p> <p>Surgical issues – cutting more than laser</p> <p>Attitudes and experiences</p> <ul style="list-style-type: none"> <li>- conflicting opinions among professionals re diagnosis and treatment</li> </ul>	<p>Not a classic TT population?</p> <p>Only those who have had difficulties.</p> <p>Minimal demographic information.</p> <p>May not be generalisable</p> <p>Not verifiable</p> <p>Double coded but analysis is subjective</p> <p>Quantitative data is univariate and does not account for external confounding factors</p>	<p>[N] – only frenotomy.</p> <p>Explores concerns but not directly about psychological experience but relevant</p>
------------	--	--	-------------	--	---	--	--

					<p>- Significant relationship between overall experience and treatment conflict/ indecision, diagnostic provider indecision conflict/ error and surgical outcome</p> <p>Diversity of maternal concerns</p>		
12.	Implications of Ankyloglossia on Breastfeeding	Hill, R.	2019	<p>Integrative Review to synthesise literature on the relationship between breastfeeding and ankyloglossia. To identify gaps in the literature on whether maternal wellbeing is affected based on mothers of infants with TT reaching their breastfeeding goals.</p> <p>Search of literature between 1999 and 2018 – 3 qualitative and four quantitative studies remained for inclusion</p>	<p>Identifies need for investigation of psychological sequelae of ankyloglossia, including maternal stress, postpartum depression, and mother-infant bonding.</p> <p>No studies were found that examined psychological ramifications of feeding difficulties with ankyloglossia – maternal wellbeing, maternal-infant relationship and postpartum mental health disorder progression – lack of attention to these aspects is identified as a ‘major gap’ in evidence.</p> <p>More evidence is “imperative” to describe TT, disseminate knowledge, interventions supporting higher BF rates, greater comfort</p>	<p>Limitations of search terms, databases and parameters</p> <p>Sources older than 5 years – things have changed in BF promotion</p>	[N] – not psychological experience but relevant

				<p>(excluded studies examining results for treatment of ankyloglossia)</p> <p>BF, identification of maternal stress and implications for the mother-child relationship</p> <p>All articles with aims of identifying issues with breastfeeding found difficulties related directly to TT</p> <p>Wide range of <b>prevalence</b> – suboptimal screening tools.</p> <p>Ricke et al – prevalence using a screening tool – but did not predict which babies would struggle to BF</p> <p>Edmunds – <b>psychosocial and interpersonal relationship difficulties</b>. Conflicting advice – Wong</p>		
--	--	--	--	---	--	--

					<p>Edmunds – tumultuous experiences whilst searching for a reason for the struggles amidst conflicting profession opinions and expertise</p> <p>Wakelin – variation in provider knowledge resulting in delayed diagnosis and detrimental effects on BF.</p> <p>Wong – similar – emotional hardship, painful BF and delay of identification and treatment of TT.</p> <p>Physical pain. Emotional hardship for mothers struggling to BF in Edmunds, Wong and Wakelin</p> <p>Edmunds – mothers questioning themselves and their abilities to breastfeed (Maternal confidence)</p>		
--	--	--	--	--	--	--	--

					Conflicting advice and expertise causing anxiety (Wong) and negative emotions about BF (Wakelin)		
13.	Mothers' experiences of breastfeeding a child with tongue tie	Waterman, Lee, Etchegary, Drover and Twells	2021	<p>Qualitative description study design exploring experiences of mothers who have BF a child with TT – descriptive accounts and the resultant meaning mothers have ascribed to them</p> <p>Canada</p> <p>2 x Focus groups – semi structured. Focus groups to encourage sharing with limited researcher input</p> <p>Breastfed within the last 3 years</p>	<p>Incongruity between breastfeeding expectations and actual experiences</p> <p>Themes: Mother's wellbeing; strained interpersonal relationships; and frustration with the health care system</p> <p>Significant impact on physical and emotional wellbeing</p> <p>Maternal wellbeing</p> <ul style="list-style-type: none"> <li>Physical pain (affecting emotional wellbeing)</li> <li>Desperation</li> <li>Guilt – for not being able to feed and feeling of dread each time baby attached to the breast</li> <li>disappointment</li> <li>resilience – self-advocacy and determination to continue</li> </ul>	<p>Homogenous sample from one urban location – educated, financially well off and with partners,</p> <p>All elected for frenotomy and continued BF.</p> <p>So limited transferability</p> <p>Strength – rich descriptions of taxing emotional journey</p> <p>Selection bias – self-selected sample of mothers who had difficulties</p>	Y

				<p>Purposive sampling – 9 mothers</p> <p>Recruited by advert in social media</p> <p>At times of focus groups notes were taken of the questions which elicited the greatest emotional response, agreement or discordance</p>	<p>Strain on relationships – partners, parental and other children. Not all – but more often when not their first child.</p> <p>Frustration with healthcare (HC) system</p> <ul style="list-style-type: none"> <li>• dismissal – voices not heard – feeling very left alone</li> <li>• lack of priority for BF relationship (being told to stop BF) – lack of systemic support for dyads with TT</li> <li>• distrust – lack of knowledge causing doubt in credibility or lack of belief in diagnosis or difficulties`</li> </ul> <p>Recommendation for more clarity and individual patient centred care.</p>	<p>No respondent validation – to check findings with participants</p>	
14.	<p>The value of frenotomy for ankyloglossia from a parental perspective</p>	<p>Illing, S.; Minnee, M.; Wheeler, J; Illing, L.</p>	<p>2019</p> <p>Prospective survey of infants receiving frenotomy and with feeding difficulties</p> <ul style="list-style-type: none"> <li>- reasons for seeking frenotomy</li> <li>- impressions of its value; and</li> <li>- its impact on feeding</li> </ul>	<p>High level of parental satisfaction. 80% reported a moderate/significant improvement in presenting difficulties. 77% moderate/significant improvement in feeding quality.</p> <p>97% said that they would have the procedure again.</p>	<p>Large population sample and follow up rate. Includes an account for method of follow up rate to discount selection bias or reporting bias.</p> <p>Mean age of infants was 44 days (relatively old – no public</p>	<p>N</p> <p>Not directly to do with psychological experience</p>	

				<p>New Zealand</p> <p>176 Infants under 6 months</p> <p>Pre-procedure questionnaire and follow up telephone call (with standard questionnaire)</p> <p>GP and lactation consultant reached consensus on diagnosis</p>	<p>Improvement in rates of full breastfeeding and feeding duration.</p> <p>35% of those that had not been breastfeeding at all started breastfeeding.</p> <p>Reduction in nipple pain.</p> <p>Parents willing to go to significant lengths to access the procedure – had travelled far (40% travelling over 200km)</p> <p>More males than females</p> <p>For those that BF decreased afterwards (6%) – 11 mothers – 2 already planning to stop and 4 said that milk supply had diminished and wished they had come back.</p>	<p>provision for frenotomy in NZ)</p> <p>so perhaps not generalisable</p> <p>72% New Zealand European/Pakeha</p> <p>15% Māori</p> <p>No control</p> <p>Measurements reported from parent experience.</p> <p>The fact that the more severe cases showed more improvement suggests not related to reporter bias/ placebo effect; also delay in reported benefits and absolute criteria of previously non-BF</p>	
--	--	--	--	--	--	---	--

					<p>Average feeding time reduced from 39 minutes to 20 minutes.</p> <p>Mean time for improvement – 2.3 days.</p> <p>Median of two days and standard deviation of 3.4 days</p> <p>A few minor adverse events.</p> <p>Benefit of improvement is linked to the grade of tongue-tie – the more severe offering the most benefit</p>	<p>mothers starting BF after the procedure.</p> <p>However reporter bias/ placebo effect remains a limitation.</p> <p>Limited to those mothers more committed to BF? More motivated – expended more energy – more likely to believe that the procedure was beneficial? On the flip side – only likely to go to those efforts if the difficulties are more severe</p>	
15.	Three case reports of infants with ankyloglossia affecting breastfeeding	Jamani, N.A.; Ardini, Y.D.; Harun, N.A.	2020	Case Report  Malaysia	Post frenotomy – infants BF easily - beneficial to BF continuation and pain reduction in mothers	Small sample  No discussion of limitations or selection of participants	N – physical characteristics of BF not psychological

				<p>Description of 3 cases of ankyloglossia affecting breastfeeding, highlighting the experience of mothers and their difficulties breastfeeding babies with it.</p>			
16.	<p>Breastfeeding experiences and changes in feeding plans among parents of infants diagnosed with tongue-tie</p>	Tran, Hill	2021	<p>Qualitative descriptive study – content and thematic analysis</p> <p>To explore parent's plans for infant feeding before birth and their perceptions of feeding success in light of TT diagnosis</p> <p>Survey for infants scheduled for frenotomy</p>	<p>Found themes corresponding to parents' plans before birth and the way goals/plans may have changed because of TT – categorised by 1. plans before birth; 2. Experiences feeding with TT; 3. How plans/goals changed because of TT</p> <p>-There are challenges feeding infants with tongue-tie</p> <p>- Feeding plans may change as a result of those challenges</p>	<p>Taken whilst procedure happening – might impact the results?</p> <p>Narrow demographics – all married, predominantly white, graduates and middle class and with employer health insurance although more than half did not cover frenotomy procedure.</p>	<p>[N] – not about psychological experience but relevant</p>

				<p>Excluded for weaning</p> <p>25 parents – infants 1 to 28.6 weeks – recruited from patients at a dental office awaiting frenotomy. Limited to under 7 months because of intro of solid food and because most difficulties seen to present early on.</p> <p>Completed on tablet whilst frenotomy was happening</p>	<p>21 out of 25 intended to exclusively breastfeed with 2 more intending to combine but with breast milk in bottle</p> <p>Most parents said BF goals were unchanged they did need to supplement with pumped milk or increased time to adjust to the challenges. Some supplemented with formula</p> <p>“hard work”; “challenging” ; “painful” – of the negative feeding experiences. But positive experiences too.</p> <p>18 of 25 either no longer BF or not as much as expected</p> <p>Despite the challenges parents were committed to attaining the feeding goals</p>	<p>Anonymous nature of study – could not follow up on responses.</p> <p>Possibly some bias in thematic analysis depending on discipline of analysts.</p> <p>Does not cover effect of frenotomy.</p>	
--	--	--	--	---	--	---	--

<p>17.</p>	<p>Relationship between Infant Tongue-Tie and maternal wellbeing</p>	<p>Hill, Wong</p>	<p>2021</p>	<p>The purpose of the study to explore the risk for altered maternal wellbeing (e.g. stress and maternal-infant bonding) – limited information about the risk of altered maternal wellbeing of mothers with TT</p> <p>Mixed methods – exploratory; cross-sectional – seeking to describe dyads in terms of bonding and maternal stress and examine associations with factors surrounding diagnosis and treatment of TT</p> <p>Facebook – tongue tie support group and dental surgery</p>	<p>Mothers of infants with tongue-tie links with increased stress especially if delay in treatment.</p> <p><b>Quantitative:</b></p> <p>Maternal-infant bonding / parental stress not associated with age, education level or employment status – but there was for both stress and bonding where there was no support at home.</p> <p>Complicated birth/ pregnancy associated with higher parental stress.</p> <p>Parental stress higher when more professionals were seen</p> <p>Qualitative:</p> <ul style="list-style-type: none"> <li>- One third reported bottle feeding due to poor latch; weight-gain; long feeds and fussiness</li> <li>- Half reported improvement in BF after treatment.</li> </ul>	<p>Power analysis was conducted – strength</p> <p>Accounted for factors likely to alter maternal wellbeing (age, education level, support at home and employment status)</p> <p>Small, homogenous sample. Predominantly educated to graduate or above, married/ with support at home; not working out of the home</p> <p>No ethnic data collected</p> <p>One setting and Facebook group – self-selection of participants. Only those with particular views chose to participate?</p>	<p>[N]– not psychological experience – but relevant</p>
------------	--	-------------------	-------------	--	---	--	---

				<p>Infants under a year when diagnosed. N =113</p> <p>Assessment of maternal infant bonding (Postpartum Bonding Questionnaire) and maternal stress by Parental Stress Scale) (quantitative) and some open text entry questions (qualitative).</p> <p>Inductive content analysis of qualitative data – using Romana Mercer’s theory of becoming a mother (maternal role attainment) as conceptual framework</p>	<ul style="list-style-type: none"> <li>- Mothers were persistent in seeking answers to get help</li> <li>- The maternal experience improved after TT correction.</li> <li>- Maternal perception of a happy baby</li> </ul> <p>Things improved after treatment.</p> <p>Implications:</p> <ul style="list-style-type: none"> <li>- Importance of early assessment, diagnosis and management</li> <li>- Partner support helpful in fostering mother-infant relationship</li> <li>-</li> </ul> <p>What are the barriers to appropriate referral and delays in treatment</p> <p>Determination of mothers to keep BF (half approx.) despite difficulties</p> <p>Healthcare provision – seeking advice from several providers – suggesting differences in assessment and evaluation</p>	<p>Did not do member checking of qualitative data.</p> <p>Recall bias for those with older children looking back?</p> <p>In assessing maternal bonding cannot exclude factors other than tongue-tie which might affect parental stress or bonding.</p> <p>Did not account for other things that might have improved BF (e.g. Lactation consultant support)</p>	
--	--	--	--	--	---	---	--

				<p>Two components of maternal role:</p> <ul style="list-style-type: none"> <li>- Childcare activities;</li> <li>- Affective activities</li> </ul>	<p>Early diagnosis and treatment may not only improve feeding and temperament but also the experiences of the family unit.</p> <p>Importance of including partners in care plan and discussions.</p> <p>Educating health care workers and interdisciplinary work</p>		
18.	Parental and provider perspectives on social media about ankyloglossia	Grond, S.E.; Kallies, G.; and McCormick, M.E.	2021	<p>US study</p> <p>Qualitative analysis of social media posts about ankyloglossia – to investigate and identify concerns and opinions expressed by parents – those that might not have</p>	<p>Spectrum of opinions. Often based on non-scientific information.</p> <p>Parents – themes:</p> <ul style="list-style-type: none"> <li>- Feeding problems 32.4%</li> <li>- Lip tie 22.5%</li> <li>- <b>Anxiety/emotion 21.7%</b></li> <li>- BF complications 13.3%</li> </ul>	<p>Difficult to account for bias – only those who wanted to post publicly</p> <p>and likely to post only if really bad/good.</p> <p>No demographics</p>	<p>[N](except results showing 21.7% themes of anxiety/ Emotion)</p>

				<p>been expressed to healthcare providers</p> <p>Search by ankyloglossia and paediatric identifiers</p> <p>Tweets (5951) (982 parent/782 provider)– conventional content analysis of qualitative data</p>	<p>17.9% offering help. 8.8% seeking help</p> <p>Large increase in tweet about frenotomy</p> <p>When opinion was expressed about frenotomy 94% positive</p> <p>Most tweets by dentists 31.9; then lactation consultants 29.7; then non-otolaryngologist physicians 10.1%; and then otolaryngologist 8.7%</p> <p>Finding demonstrated spectrum of opinions – aiding shared decision making – a large amount of non-scientific information and opinions that may be shaping decisions</p>	<p>Limitations of search terms</p> <p>Subjective nature of themes</p>	
19.	A mother's experience of tongue-tie diagnosis and management: Her concerns and lessons for others	Kam, Renee	2021	Single Case Report of the experience of a BF mother whose first baby had TT	Lack of consistency of diagnosis and management of tongue-tie	Narrative of factual elements of a mothers' experience – making clear lack of consistency of professional healthcare advice	N – low quality data and not psychological

					Nipple pain might be due to other things e.g. positioning – so need to check those things before frenotomy	No statement given as to how data was collected.  Low quality data – although some description of feelings – lack of trust in professional advice; intimidation about feeding due to pain; and frustration at lack of progress	
20.	Does neonatal ankyloglossia interfere in the growth of infants during the first 6 months of life? A case series nested in a cohort study	Batista, C.I.; Pereira, AL.	2022	Case series in cohort study  Cross sectional study – including maternal perceptions of breastfeeding.  The goal of the study was to record the progression of the growth of babies with TT	BF is often unaffected even when TT is present and when no frenotomy is performed  The infants overcame initial difficulties in breastfeeding and maintained normal growth course in the first 6 months of life  Suggests that management by extended and multi-discipline follow up was important component of efficient BF.	Lack of clarity about selection of sample  In discussion section hard to glean what are findings and what is discussion of other papers - confusing	N – not about psychological experience. Low quality evidence/

				<p>8 clinical cases – in a specialised BF centre (3 cases supplemented with formula)</p> <p>Brazil</p> <p>Measured:</p> <ul style="list-style-type: none"> <li>-standards of growth</li> <li>- mothers' perception of BF</li> <li>- pain indicator</li> <li>- assessment of BF</li> </ul>	<p>Mothers told to continue exclusive BF.</p> <p>Correct training of professionals and patient engagement reducing diagnostic errors and unnecessary procedures.</p>		
21.	<p>Severity and Prevalence of Ankyloglossia-associated Breastfeeding Symptoms: A Systematic</p>	<p>Cordray, H., Mahendran, G., Tey, C. S., Nemeth, J., Sutcliffe, A.,</p>	2022	<p>Primary objective – to understand symptom severity of BF symptoms with <b>untreated TT</b> through meta-analyses of validated outcome measures.</p>	<p>Ankyloglossia is adversely associated with breastfeeding success and maternal wellbeing.</p> <p>1 in 5 dyads stopped BF earlier than intended.</p>	<p>14 countries</p> <p>Accounted for demographics, TT classification, maternally reported BF symptoms, BF</p>	<p>N – not psychological experience but relevant for more general evidence about TT and BF.</p>

	<p>Review and Meta-analysis</p>	<p>Ingram, J., &amp; Raol, N.</p>		<p>Secondary objective to determine prevalence of BF difficulties and characterise the scope of symptoms</p> <p>5 databases – peer review of search strategy.</p> <p>Accounted for asymptomatic dyads</p> <p>Systematic review included 5RCT's, 19 pre/post intervention studies; 10 observational and cross-sectional studies and 3 qualitative studies.</p> <p>Excluded low quality studies. 5 were high quality. 34 were medium quality.</p>	<p>Symptoms in infant :</p> <ul style="list-style-type: none"> <li>- Fatigue or falling asleep whilst feeding (20.3% overall)</li> <li>- Reflux (18.1%)</li> <li>- Poor weight-gain (13.5%).</li> </ul> <p>(Also failure to thrive, jaundice, choking, hiccups and gassiness)</p> <p>LATCH (below good BF threshold) and BF Assessment tool (not significantly below) and Reflux (GERD) consistent with GERD.</p> <p>Maternal symptoms:</p> <ul style="list-style-type: none"> <li>- Nipple pain (29.9% overall)</li> <li>- Nipple damage (20.3%)</li> <li>- Engorgement (25.1%)</li> <li>- Also low milk supply and mastitis.</li> </ul> <p>3 qualitative studies of maternal perspectives include (Waterman, Edmunds and Wong)</p> <p>Emergent themes of Maternal wellbeing:</p> <ul style="list-style-type: none"> <li>- Physical pain</li> <li>- Desperation</li> <li>- Guilt/ shame</li> <li>- Disappointment</li> <li>- Strained interpersonal relationships</li> </ul> <p>Also:</p>	<p>cessation, non-exclusive BF and quantitative BF outcomes.</p> <p>Two reviewers evaluated quality and bias using standardised tool.</p> <p>Disagreements resolved by discussion.</p> <p>Data not published in version I've seen – so can't examine it.</p> <p>Biased towards symptomatic dyads</p> <p>Not able to provide comparative results – only prevalence results</p> <p>Lack of homogeneity of data was a limitation</p>	
--	---------------------------------	-----------------------------------	--	---	--	---	--

				<p>1996 to 2021 – from 14 countries</p>	<ul style="list-style-type: none"><li>- Frustration with the healthcare system (distrust, dismissal, desire for greater consistency amongst professionals)</li><li>- Maternal resilience/ persistence</li><li>- Relief after frenotomy</li></ul> <p>BF self-efficacy scale – measuring maternal confidence – mean significantly below the at risk range – below threshold predict BF cessation</p> <p>Nipple Pain – mean ratings were 'moderately intense'. Whilst most mother experience nipple pain when start BF in TT associated BF mean was significantly greater than for ratings of mother without nipple damage (<i>Coca et al, 2019: Measurement tools and intensity of nipple pain among women with or without damaged nipples: a quantitative systematic review</i>)</p>		
--	--	--	--	---	---	--	--

## Tongue tie and maternal experience – Results of Citation Search

	Name of Paper	Author	Date	Research Design	Findings	Limitations	Relevant
1.	Psychological aspects of nipple pain in lactating women	Amir, L.H.; Dennerstein, S.M.; Garland, S.M.; Farish, S.J.	1995		IEPDS (Depression scale) and POMS (Profile of mood states) indicated women with <b>nipple</b> pain were experiencing high levels of emotional distress. However, once the pain had resolved their distress also resolved.		N - not TT
2.	Assessment of Maternal Perceptions on Post-Surgical Follow-up in Managing Tethered Oral Tissues	Winkel, T.	2021	Tongue-tie and Lip-tie  To explore experiences of mothers of babies	Confidence in mothers in identifying the 'tie' – unable to verify accuracy – but possibly indicating consumer driven nature?	Homogenous sample – 96% white and married.  Retrospective questioning risks increased bias – decreasing potential for generalisability.	N – not psychological

			<p>under 6 months with at least one oral tethered anomaly and receiving surgical intervention</p> <p>Cross sectional, observational study – online survey</p> <p>Limited studies that have surveyed mothers directly to explore how they learn about procedures; what disciplines they perceive are referring and diagnosing.</p> <p>Aims to identify the source of mothers' information about links between TT and</p>	<p>Lactation consultants are important source of information and referral.</p> <p>Followed by social media and friends and family.</p> <p>Surgical intervention more likely to be by a dentist or otolaryngologist</p>	<p>Not designed to test relationships between variables – only descriptive</p>	
--	--	--	---	--	--	--

				BF problems, who is referring, who is doing frenotomies and how confident mothers were in identifying TT being released and perceptions of pain post release			
3.	(2017). Effect of frenotomy on breastfeeding variables in infants with ankyloglossia (tongue-tie): A prospective before and after cohort study. <i>BMC Pregnancy and Childbirth</i> , 17(1). Doi: 10.1186/s12884-017-1561-8	Muldoon, K., Gallagher, L., McGuinness, D., & Smith, V.	2017				N – not psychological

4.	The management of ankyloglossia and implications for breastfeeding: A review of the literature	Bertenshaw, C, Jackson, J.E.; Pemberton D.	2023	Literature Review	Benefits of frenotomy may not last. Education of professionals to inform care.		N – not psychological
5.	Tethered Oral Tissue Release Among Breastfed Infants: Maternal Sources of Information and Treatment	Winkel, T.; Wilson, J.;Kavanagh, K.; Spence, M.; Colby, S.; Springer, C.; Hedrick, M.	2023	Online, cross-sectional, observational survey of maternal experience of surgical release of tongue-tie	Participants reported being confident, involved, and in agreement with surgical release and lactation support professionals were frequent information and referral sources.  High-quality, well-designed research is needed to identify the appropriate approach(es) that lead to improved latch, improved milk transfer, and reduced	Q a lot of demographic information collected  Online survey more likely to attract participants with higher income and education levels and be younger (Darko, 2022)  Study population - mostly white, non-Hispanic and in a partnership	N – not psychological experience of TT itself – just frenotomy

					maternal pain, among infants diagnosed with one or more tethered oral tissues		
--	--	--	--	--	---	--	--

Tongue tie and maternal experience – Results of Snowballing search and search of Cochrane Library

	Name of Paper	Author	Date	Research Design	Findings	Limitations	Eligible
1.	Treatment of ankyloglossia and breastfeeding outcomes	Francis, Krishnaswami,	2015	Systematic Review of literature on surgical and nonsurgical treatments for TT	Small body of evidence suggesting that frenotomy associated with mother reported improvements in BF, and nipple pain.  But inconsistent methodology, and small, short-term studies – strength of		Not relevant for this study – about frenotomy and not psychological/emotional

					evidence low to insufficient		
2.	Prevalence of Postpartum Depression in mothers presenting to a paediatric Otolaryngology Clinic.	Klatzkow, H., Gitomer, S, St John-Larkin, Scholes MA, Cooper, E.	2023				[N] – not about psychological experience or specifically about tongue-tie but of interest
3.	Systematic Review - Frenotomy for tongue-tie in newborn infants	O'Shea	2017	To determine safety and efficacy of frenotomy  Sub analysis of severity of TT, gestational age at birth, method of feeding, age at frenotomy, severity of feeding difficulty	Frenotomy reduced nipple pain in short term.  No consistent positive effect of frenotomy on BF  No serious complications	Limited number and quality of research limits certainty of finding  High Quality RCT's needed	

## Other articles regarding either other minor surgery or breastfeeding difficulties (retrieved by online search and snowballing)

1.	What parents say about their child's surgeon: parent-reported experiences with pediatric surgical physicians	<i>Espinel, Shah, Beach et al.</i>	2017		<i>Effective patient provider communication about sexual concerns: a qualitative study</i> – Reese, Beach and Smith, 2017 Institutional and individual barriers to effective communication facilitated by positive patient-provider relationship; patient communication as a driver of provider communication and vice versa. Preferences for open collaborative communication (patients) and for focussed intervention targets and convenience (providers)	
2	New evidence on breastfeeding and post-partum depression	(Borra, Iacovou, Sevilla –		Effects of BF on maternal mental health at 8 weeks, 8, 21 and 32 months  Avon Longitudinal Study – EPDS – PPD measures taken at the various points and mothers asked how they intended to feed babies and then actual feeding	Differed according to whether had intended to BF and on depression during pregnancy  Of those not depressed during pregnancy – highest risk of depression was amongst those that intended to BF but who did not	Not clinical diagnosis of PPD or AND  Self-selecting bias  Self-report on BF outcomes Limited ethnic diversity

				<p>Not previously been clear whether BF is driving mental health or mental health is driving BF – previous studies have not accounted for other factors – socioeconomic, quality of relationships and stressful life events</p> <p>Hypothesis that the relationship between BF and MH is mediated by maternal intention to BF. Biological factors but if also affected by mothers' feelings of success or failure in relation to aspirations and plans</p>	<p>For the majority of mothers without symptoms of depression before birth, BF decreased the risk of PPD among mothers who had intended to BF but increased the risk of PPD among mothers who had not intended to breastfeed.</p> <p>Beneficial effects strongest at 8 weeks and weakest at 8 months</p>	
3.	Maiden Morsel – Feeding in cleft lip and palate infants.	Devi, E, Said Sankar A, Manoj, M., Sujatha, B.	2012			
4.	The emotional and practical experiences of formula feeding mothers	Fallon, V., et al.  (Can't download but	2017	Study into emotional and practice experiences of mothers who formula feed and whether experiences would vary depending on feeding intention and feeding methods.	Negative emotions as a result of decision to use formula	Predominantly married, first time mothers and UK - Limited generalisability

		<p>available online)</p>		<p>Examining emotional <b>and</b> practical factors. Aims</p> <p>a) describe experiences of infant feeding support, information, respect, stigma, guilt, satisfaction, and defence in mothers who use formula in any quantity; (b) examine whether these experiences would vary among different cohorts of formula feeding mothers; and (c) examine whether these experiences would differ according to feeding intention in pregnancy.</p> <p>890 mothers of babies up to 26 weeks</p> <p>Online Survey</p> <p>Predictors of emotional experiences of guilt, stigma, satisfaction and defence</p>	<p>Highlighting need for more balance, woman-centred manner</p> <p>67% experienced guilt – more likely to be internally motivated (30%) than externally (13%) - both 55%</p> <p>Negative feelings of guilt (67 percent), stigma (68%), and dissatisfaction. Need to defend decision to formula feed (76%)</p> <p>External sources of guilt, stigma, and defence were primarily perceived to come from other mothers in similar quantities (68%, 62%, and 69%, respectively), although this was closely followed by health professionals (64%, 59%, and 58%, respectively).</p> <p>Majority felt respected in everyday environment in terms of feeding choices</p>	<p>Large samples size – allowing for assessment and adjustment for a number of confounders but retaining statistical power.</p> <p>Self-selecting population – bias and possibly more likely to participate with more extreme experiences.</p> <p>Retrospective – response bias</p> <p>No comparison data with EBF women.</p> <p>No comprehensive validity testing of survey questions.</p>
--	--	------------------------------	--	--	---	---

			<p>Predictor practical variables – support from health professionals, source of information and respect in everyday environment</p>	<p>64% experiences low to moderate levels of feeding support from healthcare professionals</p> <p>First study providing numerical evidence to support qualitative research</p> <p>In discussion – indication that self-reproach is the likely consequence of discordant feeding outcome</p> <p>External sources of negative emotions – primarily other mothers – mummy wars between BF and FF mothers.</p> <p>Secondary external catalyst – healthcare professionals – majority of mothers feeling unsupported [grandmother in mind?]</p>	
--	--	--	---	---	--

					<p>Those who had intended to EBF or had started EBF and now FF at significantly higher risk of feeling guilty</p> <p>Those who intended or started EBF but now EFF significantly higher risk of expressing dissatisfaction about method of feeding.</p> <p>Associations for both guilt and dissatisfaction stronger in feeding intention analyses rather than feeding type analyses</p> <p>EFF and IFF mothers more likely to experience stigma – more likely to be alienated by 'breast is best) – and bringing emotional difficulties – needs adjustment in higher income countries</p> <p>Do BF benefits outweigh the risks brought to maternal and infant wellbeing</p>	
--	--	--	--	--	---	--

6.	<p>Parents' descriptions of feeding their young infants</p> <p>(didn't manage to get full text)</p>	Pados et Hill	2019	<p>Descriptive Study</p> <p>Online Survey – 29 parents with infants of less than 7 months selection and open-text questions.</p> <p>Qualitative data analysed by directed content analysis</p>	<p>Feeding concerns common</p> <p>Parents made changes to facilitate feeding</p> <p>Parents described characteristics of the infant, task of feeding and external factors,</p> <p>Some described feeling happy, calm and bonded when feeding.</p> <p>Others described feeling terrified, anxious and worried.</p> <p>Significance of support of healthcare provider but sometimes conflicting and unsafe advice</p>	
7.	<p>The relationship between chronic paediatric feeding disorder and caregiver stress</p>	Silverman et al	2021	<p>To explore caregiver stress associated with paediatric feeding difficulties – compared with community norms.</p>	<p>Negative child behaviours and lower developmental function predicted higher levels of parental stress, distress, dysfunctional parent-child interaction and</p>	<p>Reliant on parent reporting</p>

			<p>There have been previous studies but lacked statistical power.</p> <p>Caregivers of 840 children aged between 18 months and 5 years</p>	<p>care-giver perceptions of their child as difficult.</p> <p>Parents of younger children more likely to be 'defensive responders' – i.e. under-reporting stress (place of FANI and psychoanalysis)</p> <p>Overall parents of children with paediatric difficulties have more care-giver related stress</p> <p>Found that developmental delay was a predictor of stress associated with interactions – the child's ability to socially engage with parent</p>	
--	--	--	--	---	--

8.	First-Time Mothers' Expectations and Experiences of Postnatal Care in England	McLeish, Harvey, Redshaw et al.	2020	<p>Expectations and experiences of 32 mothers</p> <p>Semi-structured interviews during pregnancy and then 2/3 months after birth</p> <p>Trajectory analysis looking for thematic patterns between postnatal care expectations; needs; experiences and confidence</p>	<p>Maternal satisfaction with postnatal care and confidence primarily influenced not so much by the extent to which expectations were met but the way their individual postnatal needs were met.</p> <p>Suggesting need for rapid and responsive assessment of needs with appropriate adjustment of care.</p>	<p>Varied demographic but some lost to follow up.</p> <p>Rich, in-depth qualitative analysis</p> <p>Some very short interviews – notably with young mothers who had not formed any expectations</p>
9.	A psychoanalytic perspective on hospital midwifery and birth	Louise McNally	2011	Psychoanalytic observational study	Importance of role of midwives to provide containment at birth.	
10.	Understanding the relationship between breastfeeding and postnatal depression: the role of pain and	Amy Brown, Jaynie Rance & Paul Bennett	2015	<p>To examine the relationship between specific reasons for stopping BF and PND - the role of pain and physical difficulties – trying to delve into what specific BF difficulties</p> <p>Cross-sectional self-report study – over 3 months</p>	<p>Short breastfeeding duration and multiple reasons associated with higher PND score.</p> <p>The longer the BF duration the lower the EPDS score</p>	<p>Demographic information collected but not ethnicity</p> <p>Age, education, profession, marital status – lack of diversity in the sample - older, more educated and professional</p>

	<p>physical difficulties</p>			<p>217 women with babies of under 6 months who had started breastfeeding but stopped before 6 months – part of a larger study</p> <p>Questionnaire and completion of Edinburgh Postnatal Depression Scale</p> <p>Questionnaire examined biological, psychological and social reasons for stopping – and used in other studies. Likert scale – items based on previous qualitative research and recurrent themes in current literature</p>	<p>Regression analysis – only specific reasons of pain and physical difficulty predictive of PND score</p> <p>Importance of understanding women's reasons for stopping – critical in understanding BF experience and providing emotional support – enhanced support should be directed to mothers who stop BF for pain or physical difficulties</p> <p>Breastfeeding experience rather than duration is predictive of depressive symptoms</p> <p>Partial correlations (controlling for maternal age and education) showed EPDS score positively correlated with pain, physical difficulty, lack of support and pressure from others to stop.</p>	<p>Those that took part interested in infant feeding</p> <p>Both mean hard to make generalisable</p> <p>Limitations of EPDS scoring system</p>
--	------------------------------	--	--	---	--	--

					Importance of ensuring good continued support for BF mothers through the postnatal period and encouraging them to make use of BF groups.	
11.	The association of breastfeeding difficulties at the 6th week postpartum with maternal psychological wellbeing and other perinatal factors: a Greek retrospective longitudinal study	Dagla	2021	<p>Aim to investigate whether maternal breastfeeding difficulties at six weeks is associated either with maternal psychological wellbeing and the presence of a mental health disorder in the perinatal period or with other perinatal factors</p> <p>perinatal day centre in Greece</p> <p>retrospective longitudinal study</p> <p>622 women under care and with support of centre from pregnancy to 1 year Postpartum</p> <p>Data:</p> <ul style="list-style-type: none"> <li>- Patient history during pregnancy</li> <li>- Patient history at 6 weeks</li> </ul>	<p>increased scores for PND during postpartum or pregnancy are associated with increased maternal breastfeeding difficulties at six weeks postpartum</p> <p>Demonstrated a relationship between increased scores on maternal PND in the perinatal. and other perinatal factors (such as unplanned conception, being given formula in the hospital, unsatisfactory labour, mastitis, sleep difficulties and colic) and BF difficulties at 6 weeks</p>	96% married

				<p>-Psychometric tools before and after birth and in weeks postpartum</p> <p>- questionnaire about feeding</p>		
12.	Confidence and Mastery in mothering occupations	Odgers	May 2023	<p>To investigate the relationships between occupation and positive wellbeing in mothers through an occupational health perspective.</p> <p>Delphi Survey - elicit expert opinions by reaching consensus</p> <p>Mothering literature added to by 15 participants – mothers of infants 10 to 18 months old.</p>	<p>Most highly ranked mothering occupation for maternal confidence and mastery was 'watching' their baby.</p> <p>Some occupations and in particular co-activities promote maternal confidence and mastery</p>	Small samples size
13.	Physical health, breastfeeding problems and maternal mood in the early postpartum: a prospective cohort study	Cooklin, A.R, et al	2017			

14.	Persistence in Breastfeeding: a phenomenological investigation	Bottorff, J.L	1990			
15.	Breastfeeding difficulties experience by women taking part in a qualitative interview study of postnatal depression	Shakespeare, J	2004			
16.	A meta synthesis of qualitative breastfeeding studies	Nelson, A.M	2006			
17	Psychosocial predictors of post-natal anxiety and depression: Using Structural	And Jackson et al.	2023	To provide quantitative evidence between relationships mapped between post-natal social context, infant feeding method and emotional wellbeing		

	Equation Modelling to investigate the relationship between pressure to breastfeed, health care professional support, post-natal guilt and shame, and post-natal anxiety and depression within an infant feeding context.			Used Structural Equation Modelling		
--	--	--	--	------------------------------------	--	--

## Appendix 2 – Letter of Approval from TREC

The Tavistock and Portman   
NHS Foundation Trust

Quality Assurance & Enhancement  
Directorate of Education & Training  
Tavistock Centre  
120 Belsize Lane  
London  
NW3 5BA

Tel: 020 8938 2699

<https://tavistockandportman.nhs.uk/>

Linda Atkinson

**By Email**

22 January 2024

Dear Linda,

**Re: Trust Research Ethics Application**

**Title:** *'A psychoanalytic investigation of the maternal emotional experience of infant tongue-tie'*

Thank you for submitting your updated Research Ethics documentation. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

**Please be advised that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.**

If you have any further questions or require any clarification do not hesitate to contact me.

I am copying this communication to your supervisor.

May I take this opportunity of wishing you every success with your research.

Yours sincerely,

**Michael Franklyn**



Academic Governance and Quality Officer

T: 020 938 2699

E: [academicquality@tavi-port.nhs.uk](mailto:academicquality@tavi-port.nhs.uk)

cc. Course Lead, Supervisor, Research Lead

## **Appendix 3 - Recruitment advertisement**

### **Recruitment leaflet**

## **Was your baby born with tongue-tie?**

### **An inquiry into mothers' emotional experiences of their infant's tongue-tie**

Hello, I am Linda Atkinson - a Child and Adolescent Psychotherapist in doctoral training at The Tavistock and Portman NHS Foundation Trust. During my training I have been working with mothers and babies and have become very interested in finding out more about mothers' emotional experiences of their baby's tongue-tie. So much so, I have chosen it as my professional doctorate research project.

If you have a baby who was born with tongue-tie might you be willing to participate in a research study and tell me about your experiences? Participation would involve completion of a questionnaire and a single interview with me of about an hour and a half.

If you are interested in finding out more, please email me at [linda.atkinson@xxxx.nhs.uk](mailto:linda.atkinson@xxxx.nhs.uk) and I will get in touch. Agreeing to be contacted puts you under no obligation to participate and if you decide not to, all the information that you have shared with me will be destroyed.

The project is sponsored and supported by The Tavistock and Portman NHS Trust and it has been approved by the Tavistock and Portman Trust Research Ethics Committee (TREC). This course is overseen and certified by The University of Essex.

If you have any questions about the project or would like to discuss this further, please don't hesitate to contact me. My contact details are:

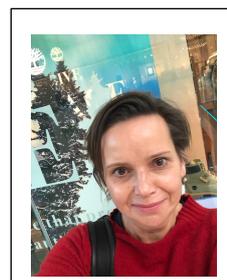
Linda Atkinson

Email: [linda.atkinson@xxxx.nhs.uk](mailto:linda.atkinson@xxxx.nhs.uk)

Alternatively, any concerns or further questions can be directed to my supervisor:

Lucia Genesoni Email: [luciagenesoni@gmail.com](mailto:luciagenesoni@gmail.com)

**Thank you for taking the time to read this information. I hope to hear from you.**



## **Appendix 4 – Participant information sheet**

### **Participants Information Sheet**

*Version number 1, 27.07.2023*

**Research Project title: An inquiry into mothers' emotional experiences of their infant's tongue-tie**

You have been given this information sheet to invite you to take part in a research project. This information sheet describes the study and explains what will be involved if you decide to take part.

#### **What is the purpose of this study?**

This research study is an exploration of the lived experiences of mothers when their baby has been diagnosed or referred for having tongue tie. As part of this study, I aim to explore the emotional experience of mothers and any effect the experiences of tongue-tie might have on past and future expectations about motherhood and the baby.

#### **Who is conducting the study?**

My name is Linda Atkinson

I'm training to be a Child and Adolescent Psychotherapist at The Tavistock and Portman NHS Foundation Trust and am conducting this research as part of my Research Dissertation and Professional Doctorate comprising part of that qualification. This course is overseen and certified by The University of Essex.

This project is being sponsored and supported by The Tavistock and Portman NHS Foundation Trust and it has been approved by the Tavistock and Portman Trust Research Ethics Committee (TREC).

#### **What's involved?**

**Explanation: purpose of and background to research**

Tongue-tie (ankyloglossia) is a congenital condition where the piece of skin joining the tongue to the base of the mouth (lingual frenulum) attaches near the tip of tongue or may be shortened and thickened, reducing the ability to move the tongue and can cause difficulties in feeding – particularly breastfeeding with the baby struggling to latch or reducing their intake of milk and causing painful nipples and reduction in milk production for mothers. The condition can sometimes be asymptomatic and be left untreated, managed through breastfeeding consultation, or treated by manual therapy or correction by a simple surgical procedure - a frenotomy (where the frenulum is cut). This is done without anaesthetic with some minor bleeding afterwards.

My professional interest in tongue-tie comes from my experiences co-facilitating a community psychoanalytic mother and baby group and hearing mothers' descriptions of their experiences surrounding their baby's tongue-tie. Their narratives were powerful, describing difficulties feeding their baby, and their experiences through referral, diagnosis and to treatment (or not) were emotively told. Struck by this, I became interested in trying to understand a bit more about the maternal experience of an infant having tongue-tie and in particular the emotional experience.

I found that although there is extensive literature about the physical and mechanical aspects of tongue-tie there is relatively little about the maternal experience of tongue-tie. The first weeks and months of motherhood and adjusting to the care of a baby are emotionally draining and highly charged. Understanding more about maternal emotional experiences in relation to tongue-tie might offer insight which aids providing congruent and compassionate support to mothers which promotes maternal wellbeing and confidence.

I am interested in understanding more about emotional experiences relating to diagnosis, referral, and treatment as well as around difficulties feeding and any effect the experiences of tongue-tie might have on past and future expectations about motherhood and the baby.

### **What will participating in this project involve?**

The project is an exploration into mothers' emotional experiences of their baby having tongue-tie. If you wish to participate:

1. I will ask you to sign and return the enclosed participant consent form.
2. Once I have received that back from you, I will send and ask you to fill in (and return by email) a brief factual questionnaire, about you and your baby, support network, your baby's delivery, their tongue-tie, diagnosis, referral and treatment/ care pathway and any feeding difficulties. I would anticipate this will take about 20 minutes to complete.
3. You will then be invited to take part in an individual interview with me which is expected to take between an hour and an hour and a half. We shall arrange a time and place for

interview, suitable for you. Possible locations might be [REDACTED]; [REDACTED] or at your home. The interview will mainly be for you to tell me about your experiences with some prompts from me and its aim will be to understand more about your emotional experience in the context of the factual information you have already provided me. Interviews will be audio recorded and then transcribed verbatim.

It is up to you whether you bring your baby.

### **Do I have to take part?**

No, it is completely your choice whether or not you take part in the study. If you agree to take part, you can withdraw without giving any reason at any time up to three weeks after the interview. This timescale has been decided as the data will then be processed and analysed. If you decide to withdraw, all data collected or about you will be destroyed immediately.

Taking part in the study and/or deciding to withdraw will not affect in any way the care you and your baby are receiving or will receive.

### **Criteria to take part in the study:**

- You are over 18 years of age;
- Your baby is aged between 3-12 months and has been diagnosed with tongue-tie by a medical professional or member of the Association of Tongue-Tie Practitioners;
- You are able to speak English sufficiently well to be able to give your informed consent to participate and to fully participate in the interviews which will be conducted in English;
- Your baby hasn't been diagnosed with any other physical oral anomaly or medical condition affecting feeding (e.g. cleft lip/palate);
- You do not have a pre-existing psychiatric condition;

### **What will happen to the results of the project?**

The results of this study will be used in my Research Dissertation Project and Doctorate qualification. It may also be used in future academic presentations and publications.

I would be happy to send you a summary of the results if you wish. Please contact me to request this if it of interest to you.

### **What are the possible benefits of taking part?**

There will be no direct benefits for you. However, by taking part you will be given the opportunity to offer your experience as a contribution to the understanding of mothers' experiences of tongue-tie in their babies. It is hoped that it will provide a space for you to consider and reflect on your experience in a way that may be helpful for you.

**Are there any risks?**

No, there are no direct risks. However, I am aware of how emotionally charged the early months of motherhood can be, especially when there have been unexpected changes or difficulties. It is possible that the interview may stir up unexpected feelings and emotions. If you needed details of somewhere you could access support, these will be provided.

**What will happen to any information I give?**

The Tavistock and Portman NHS Foundation Trust is the sponsor for this study based in the United Kingdom. I will be using information from you in order to undertake this study and will act as the data controller for this study. This means that I am responsible for looking after your information and using it properly. I will keep identifiable information about you from this study for 5 years after the study has finished. The interview will be audio recorded and transcribed by myself.

Your rights to access, change or move your information are limited, as I need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, I will use the minimum personally identifiable information possible. I will use your name and the contact details you provide only to contact you about the research study. I am the only person who will have access to information that identifies you. I may be assisted in the analysis of this information by senior colleagues, but they will not be able to identify you and will not be able to find out your name or contact details.

Quotes from the transcript will be used in the write up of the project and will be de-identified. However, please note, it is possible that anyone who knows you well may recognise you in some of the quotes used, although every effort will be made to prevent this. Any extracts from what you have said that are quoted in the research report will be entirely anonymous.

All electronic data will be stored on a password protected computer. Any paper copies will be kept in a locked filing cabinet. All audio recordings will be destroyed after completion of the project. Other data from the study will be retained, in a secure location, for 5 years.

If you would like more information on the Tavistock and Portman and GHC privacy policies please follow these links:

<https://tavistockandportman.nhs.uk/about-us/contact-us/about-this-website/your-privacy/>

<https://www.ghc.nhs.uk/privacy-notice/>

You can find out more about the legal framework within which your information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson:

[IHenderson@tavi-port.nhs.uk](mailto:IHenderson@tavi-port.nhs.uk)

There will be limitations to the confidentiality of information provided, if it is deemed yourself or someone else is at risk. Indeed, confidentiality is subject to safeguarding limitations of the Tavistock and Portman NHS Trust's Safeguarding Policy. If a disclosure is made that suggests that imminent harm to self or others may/has occurred, then confidentiality may not be able to be maintained and other relevant parties may need to be informed as appropriate. Where possible, this will be discussed with you beforehand.

### Contact details

I am the main contact for the study. If you have any questions about the project or would like to discuss this further, please don't hesitate to contact me. My contact details are:

Linda Atkinson

Email: linda.atkinson@[REDACTED].nhs.uk

Alternatively, any concerns or further questions can be directed to the Principal Investigator, my research supervisor:

Name: Lucia Genesoni

Email: [luciagenesoni@gmail.com](mailto:luciagenesoni@gmail.com)

If you have any concerns about the conduct of this research, the researcher or any other aspect of this research project please contact Paru Jeram, Trust Quality Assurance Officer ([pjeram@tavi-port.nhs.uk](mailto:pjeram@tavi-port.nhs.uk) or [academicquality@tavi-port.nhs.uk](mailto:academicquality@tavi-port.nhs.uk)).

**Thank you for considering taking part in this study and taking the time to read this information. If you are willing to take part in the research please complete and sign the consent form and questionnaire included with this information sheet.**

**Appendix 5 - Participant consent form****Consent Form**

*Version number 1, 27.07.2023*

**Project title:** An inquiry into the maternal emotional experience of infant tongue-tie

**Name of researcher:** Linda Atkinson

**Please initial the statements below, in the relevant box, if you agree with them:**

- I \_\_\_\_\_ voluntarily agree to participate in this research project.

- I confirm that I have read and understood the information sheet ( *Version number 1, 27.07.2023* ) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

- I understand that my participation in this study is voluntary and that I am free to withdraw, without giving a reason, at any time up to three weeks after the completion of the interview.

- I understand that the interview will be digitally audio-recorded and transcribed as described in the participant information sheet.

- I understand that the information I provide will be kept confidential unless I or someone else is deemed to be at risk of harm.
  
- I understand that direct quotes from the audio recording may be used in this research study but will be made anonymous by de-identification to the reader and held securely by the researcher.
  
- I understand that pseudonyms may be used for participants in the published results and that the researcher will endeavour to remove or alter any details that might identify the participant.
  
- However, I understand that I (or someone that knows me well) might recognise my words.
  
- I understand that the results of this research will be published in the form of a Doctoral research thesis and that they may also be used in future academic presentations and publications.

**Contact details:**

Researcher: Linda Atkinson

Email: Linda.Atkinson@[REDACTED].nhs.uk

Supervisor : Lucia Genesoni

Email: luciagenesoni@gmail.com

Participant's Name (Printed): \_\_\_\_\_

Participant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Thank you for agreeing to take part in this study.****Your contribution is very much appreciated.**

## **Appendix 6 – Questionnaire**

### **An inquiry into mothers' emotional experiences of their infant's tongue-tie Questionnaire**

Thank you for agreeing to participate in this study. I would be grateful if you could complete and return this questionnaire with your consent form. I anticipate that it will take you about 20 minutes to complete. The aim of the questionnaire is to find out a bit more about you and your baby and the details about your baby's tongue-tie, so that when we meet at the interview we are freed up to explore the wider emotional aspects of your experience.

#### **About you and your baby**

Your name:

Telephone no:

Email:

Your baby's name:

Your baby's date of  
birth:

Your age:                      18-21              22-25              26-30              31-35              Over 35

How would you  
best describe your  
ethnicity:

What is the highest educational qualification you have obtained	GCSE	A' Level	Higher level education	Graduate	Post-graduate
---	------	----------	------------------------	----------	---------------

Your family income:	Under x	Between x and y	Between y and z	Over xxx
---------------------	---------	-----------------	-----------------	----------

Who is living at home with you and your baby?

Other family/ friends support?

How was your baby delivered?

Were there any complications during pregnancy or at delivery?

Is this your first  
baby?

**About your baby's  
tongue-tie**

How old was your  
baby when their  
tongue-tie was  
diagnosed?

Who diagnosed it?

At birth, did your  
baby have (or have  
they since had) any  
other physical  
problems?

What care/  
treatment/  
support did you  
receive in relation  
to your baby's  
tongue-tie, and by  
whom?

Please provide  
approximate dates  
of any  
appointments if  
you can

Was any other  
care/ treatment  
offered to you?

**Feeding your baby**

Are you currently breastfeeding or bottle feeding your baby?

Was this your feeding plan before your baby was born?

Have you experienced feeding difficulties? If so, please describe them? Are you still experiencing any difficulties?

Did you experience any physical symptoms as a result of the tongue-tie? If so, please describe them.

If this is not your first baby, what were your previous

feeding  
experiences like?

Were there any  
other difficulties  
associated with  
tongue-tie that you  
or your baby  
experienced?

### **General**

How did you find  
out about this  
research project?

Is there anything  
else you would like  
to let me know?

Do you have any  
access  
requirements you  
would like me to  
be aware of?

### **Contact details**

I am the main contact for the study. If you have any questions about the project or would like to discuss this further please don't hesitate to contact me. My contact details are:

Linda Atkinson

Email: linda.atkinson@[REDACTED]nhs.uk

Alternatively, any concerns or further questions can be directed to my supervisor:

Lucia Genesoni

Email: [luciagenesoni@gmail.com](mailto:luciagenesoni@gmail.com)

If you have any concerns about the conduct of this research, the researcher or any other aspect of this research project please contact Simon Carrington, Head of Academic Governance and Quality Assurance ([academicquality@tavi-port.nhs.uk](mailto:academicquality@tavi-port.nhs.uk)).

**Thank you for considering taking part in this study and taking the time to read this information. If you are willing to take part in the research please complete and sign the consent form and questionnaire included with this information sheet.**

## **Appendix 7 – Interview schedule**

### **Free Association Narrative Interview schedule for mothers of babies with tongue-tie to explore their emotional experience**

**Title:** An inquiry into the maternal emotional experience of infant tongue-tie

#### **Welcome:**

- introduce myself, my role and explain my interest in the project
- explain that interview will be semi-structured – I will ask a few questions along the way but I am interested to hear their stories of their experience of the early weeks of motherhood and their baby's tongue-tie.
- Let them know that if they have their baby with them, it's OK for them to do what they need to look after them – e.g. feed or comfort them and where they can change the baby.

I will aim encourage participants to share their experiences by beginning the interview with an initial opening question:

**“Can you tell me about your experience and how you felt during the first few weeks with your baby and discovering their tongue tie and how you felt?”**

With this question I hope to find out about the following areas of the mother's experience:

- the first few weeks
- finding out about the baby's tongue-tie
- feeding their baby in the first few weeks and subsequently
- their expectations of motherhood and their baby during pregnancy and any changes in those as a result of their baby's tongue-tie
- their expectations of feeding their baby and any changes in those as a result of their baby's tongue-tie
- their experience of the diagnosis and treatment (or not) of their baby's tongue-tie
- their understanding of their baby's experience including feeding/ treatment

In accordance with the principles of the FANI (Free Association Narrative Interview) method my aim will be to encourage participants to share stories anchored to specific events. If the mother finds it

difficult to expand or gets stuck, I might use (as appropriate) one or more of the following indicative prompts:

***“Can you tell me about your experience of...and how you felt about/during...***

- *the first few weeks with your baby?*
- *finding out about your baby’s tongue-tie?*
- *a time when you fed your baby?*
- *what you think feeding was like for them?*
- *a recent time that you have spent feeding your baby?*
- *your plans for feeding your baby going forward?*
- *when you were pregnant and thought about your baby and being a mother?*
- *a time when you were pregnant and thought about your baby?*
- *your appointment to the tongue-tie clinic?*
- *a time that you felt supported in the early months of your baby’s life?*
- *a time that you felt unsupported?*

- *what you think treatment was like for your baby?*

**End:**

- Anything not asked but would like to mention?
- Thank them for taking part.
- Any questions or want any further information to contact me.
- Signpost them to Baby Buddy App; baby group; or health visitor and/or GP. Send debrief out to them.

**If things don't go to plan and interviewee (or if present, baby) becomes upset.**

- check in to see if they are OK to continue;
- if not, offer to move on from that question;
- if still not OK, offer to stop for a short while;
- if still too much offer to end the interview.

## ***Appendix 8 – Debrief Letter***

Dear....

I am writing to thank you for your contribution to my Research Dissertation for my professional doctorate. I hope you found it as interesting as I did.

If following taking part there are any issues that are concerning you, you might feel able to seek support from your friends and family or the organisation or professional through whom you first found out about and were invited to participate in the project.

However, if this isn't possible you might consider downloading the Baby Buddy App offered through:

<https://www.bestbeginnings.org.uk>

The app offers advice and support for parents, including a 24-hour text messaging emotional support service.

Alternatively, HomeStart ( <https://www.home-start.org.uk>) offer non-judgemental, compassionate and confidential support to families in the early years of parenthood, including some groups.

You can also of course seek advice and help from your health visitor and/or GP.

If you have any questions or would like further information here are my contact details:

Email: Linda.Atkinson@[REDACTED]nhs.uk

If you have any concerns about how the study has been conducted please contact myself, my supervisor Lucia Genesoni ([luciagenesoni@gmail.com](mailto:luciagenesoni@gmail.com)) or Paru Jeram, Trust Quality Assurance Officer ([pjeram@tavi-port.nhs.uk](mailto:pjeram@tavi-port.nhs.uk) or [academicquality@tavi-port.nhs.uk](mailto:academicquality@tavi-port.nhs.uk)).

Kind regards,

Linda Atkinson

***Appendix 9 - Extract annotated transcripts showing exploratory notes***

Participant 2 - Exploratory notes and experiential statements [Document title]

1  
 2 **Participant 2 - 03.05.24**  
 3 00:31  
 4 Researcher: First of all thank you very much  
 5 for agreeing to talk to me....erm....and ... I  
 6 suppose maybe the best way to start is ...I  
 7 mean we've spoken on the phone I know, but  
 8 to say a little bit about why I'm... what the  
 9 research project is...  
 10  
 11 Participant: **Yup**  
 12  
 13 Researcher: Erm... as you know, it's to  
 14 explore a bit about mothers' experiences of  
 15 tongue-tie in their babies, and that comes  
 16 from my experiences in the baby group and  
 17 listening to mothers talk about them...  
 18  
 19 Participant: **Yeah**

And going  
 Is space going to be allowed  
 for her?

Descriptive —  
 Conceptual —  
 Linguistic —  
 Emotional —  
 tone/rhythm  
 Reverb

Keen for me to stop  
 talking and give her to allow  
 her space to start talk  
 telling me her experiences?

In a bit of a hurry

11 just had to stop  
couldn't talk in words  
- empty of any number  
She was on the point  
of collapse

Trying but being unable to  
meet her baby's needs  
left her utterly depleted and  
unable to go on.

Disconnection between her  
body and mind

Her hunger was  
meaningless - the only  
hunger which mattered  
was her baby's

She ~~needed~~ needed help  
to meet her most basic  
needs just like her baby  
but there was no one there

Participant 2 - Exploratory notes and experiential  
statements [Document title]

- 326 gonna, I don't know...blackout or something
- 327 out of exhaustion because like I was still
- 328 trying to breastfeed so like, you know, so you
- 329 need energy for that. I've just given birth. I
- 330 haven't slept. I haven't eaten...I couldn't eat.
- 331 It's like I don't know it was like some sushi,
- 332 like...you know, like... it was finger food right
- 333 like sushi. (Researcher makes listening noise)
- 334 But I was...I was struggling like ...to...to eat
- 335 that. Like it...it...it tasted like chalk... like I
- 336 was ... like I was hungry but I just I couldn't
- 337 eat. I wasn't like...like.....I wasn't feeling
- 338 hungry but I...I... I was hungry, if that makes
- 339 sense. Er...Yeah...and I yeah, I just wanted
- 340 desperately like somebody to come and like, I
- 341 don't know. I suppose take care of me so I
- 342 can take care of the baby. Erm...Yeah (with
- 343 finality).

Wrappy tucks up  
- bag closing from - that's  
if closing down  
- 19 -  
Transcribed by

<https://otter.ai>

"blackout or something"

SEEMS far away despite when  
JUD come to a sudden stop <sup>describing</sup>  
- everything would stop - couldn't  
carry on.

Nothing really made sense  
- lost sense of her body as  
a <sup>functioning</sup> body  
NO one was looking after her  
and she desperately needed  
looking after

She couldn't satisfy her  
baby she couldn't feed herself.  
like <sup>was</sup> hungry but I just couldn't eat <sup>wasn't</sup> <sup>feeling</sup> hungry  
The only hunger there was, was  
her baby's insatiable hunger  
- NO ROOM to recognize her own  
hunger and need for rest  
and nourishment

"finger food" right - baby food

"it tasted like chalk"

Food tasted bad - of something  
dry + <sup>substance</sup> rather <sup>substance</sup>  
rather <sup>substance</sup>

She She just needed someone to  
take care of her <sup>see</sup>

"somebody to come and like ..... take care of  
me so I can take care of the baby"

findy some order in the chaos

She couldn't carry on - there's only so much someone can take - she was at breaking point.

She needed look after as well as the baby

left to manage too much on her own

She had felt looked after as the birth centre

Participant 2 - Exploratory notes and experiential statements [Document title]

308 interrupted (sic) sleep. That's that's  
 309 fine.. Yeah, we can manage...er...er... Yeah!  
 310 (laughs)  
 311  
 312 11:59  
 313 Researcher: It sounds really ...desperate.  
 314  
 315 12:01  
 316 Participant: Yeah, absolutely. Like I don't  
 317 think I've ... I've... I also... sorry. Yeah. Erm,  
 318 so when I was away for those 36 hours, I  
 319 remember thinking like I... I... I also had a  
 320 breaking point. I felt like my body was just  
 321 gonna shut down at any moment and I  
 322 remember feeling like, "What can I do? How  
 323 can I ..b... go back to the birth centre where  
 324 they take care of you and the baby? Er,  
 325 'cause I ...yeah, I was pretty sure I was just

left to manage too much

- 18 -

<https://otter.ai>

on her own

Transcribed by

Perhaps less sure that it will be enough and they will be able to manage?  
 Hestation  
 - but getting some order & control back.

hesitation and repetition

struggling to find order / place in her mind?  
 awake?  
 & something was going to break?  
 She A and R.

She couldn't carry on.  
 "I remember thinking like... I... I also had a breaking point. I felt like my body was just gonna shut down at any moment"  
 There's only so much a body can take... "you and the baby" emphasis is left without choices. Helpless &  
 She desperately needed help and both she and baby needed to be looked after. How can I go back to birth centre where they take care of you & the baby?

When her needs are so desperate  
and great it's hard to keep in  
mind the baby's needs too

Time is a blur and  
confusing

She just needed a break &  
with a break all  
next things felt manageable

She wasn't asking for much  
and didn't get much

Participant 2 - Exploratory notes and experiential  
statements [Document title]

- 290 put a pillow from one side. And from the other
- 291 side too in case she's gonna roll...like she
- 292 was like... she was not gonna roll off and
- 293 have a cup of tea or have a shower or you
- 294 need to take a break." And it was like "okay"
- 295 (extended). (Laughs a couple of times) And I
- 296 did take a shower. I'm not sure...I think... I
- 297 think I went to sleep. Um...I don't remember. I
- 298 know that day I got four hours sleep total
- 299 overnight. And, I remember waking the
- 300 following day I was like "Okay, we can do this
- 301 (laughs) 'cause.. cause... getting four hours
- 302 of sleep (Researcher makes an affirmative
- 303 noise but feels she has not given quite
- 304 enough of a response). Like in one night after
- 305 the week that I've had actually like yeah...that
- 306 was enough! And I just felt like yeah, yeah,
- 307 yeah, I can do this ...like four hours of

Can she  
in that state  
can she hold in mind the baby's  
safety? I see baby on one  
the bed - image.

Byron'ska She puts pillows  
around the baby so she doesn't  
to keep her safe.

Anxiety  
She needs to be nuzzled  
and rest too.

Wonder woman

Time is confusing and a  
blur but knows she got  
four hours sleep.

What happened when it  
confusing and a blur but does  
know she got four hours  
sleep. "Okay we can do this."

L14 getting comfortable but  
not much but enough.

She wasn't asking for much  
- she didn't get much but had  
to make do with what was  
available.

She probably deserved more  
she needed a break (even  
a small one) to manage.  
feel she could.

Relief that the baby and dog  
will be alive and together

The birth went without  
complication but was  
a disappointment -  
~~as she complain~~  
given her ~~her~~  
and not what she  
wanted

Is it OK to complain given  
my baby was delivered safely?  
Am I being too needy  
ingrateful? It could have  
been worse

How do my feelings/desires  
fit with those of my baby?

Being given a baby  
from nowhere leaves a  
feeling of disconnection  
↓ Shock - a grieving  
process missed at?

397 (researcher makes interested and slightly  
398 surprised noise). So, it was very sweet. So  
399 yeah, we were just in this side room waiting  
400 for a few hours before we got this call. They  
401 called to say he's definitely gonna make it  
402 through the night at least so made an  
403 arrangement for my dad to collect him and  
404 then (breath in) we kind of committed. (pause  
405 and sigh) And then it was fine... it was a fine  
406 caesarian... all went well. But I think just... it'd  
407 been about ...four... three or four weeks of  
408 like... not intense stress but moderate stress.  
409  
410 13:22  
411 Erm, so, I think I went into it slightly shaky...  
412 as lots of people do, I'm sure. But the  
413 caesarian went really well. It kind of ...it  
414 was...sss... utterly bizarre... like I couldn't  
415 picture being handed a ...baby and so when I

Something bizarre "Utterly bizarre"  
a baby from nowhere?  
something disconnected?

It felt touching and friendly

But then  
waiting in a side room. What was that like for  
her? Feels forgotten and not seen or  
grateful for the space?

Dog was off not going to die today he  
could come home. But only likely to arrive for  
asked dad for help in going to collect  
dog and bring him home. a short period of time.

They might be able to have both the baby  
and the dog alive at the same time.  
Maybe knowing the dog would survive and  
lead a night boosted her confidence that  
baby would be OK too? Unconscious  
worry about baby attempted?

Breathing, in, pause and sigh  
"we kind of committed. And then it was  
fine... it was a fine caesarian"

It was happening there was nothing that  
could be done about it. Things were safe  
but it was not what she wanted.  
She did not get the birth she wanted.  
Is there room to complain about that?

Downplaying things. Is the safety of  
the baby the only outcome that  
concerns - does it have any other  
validity?

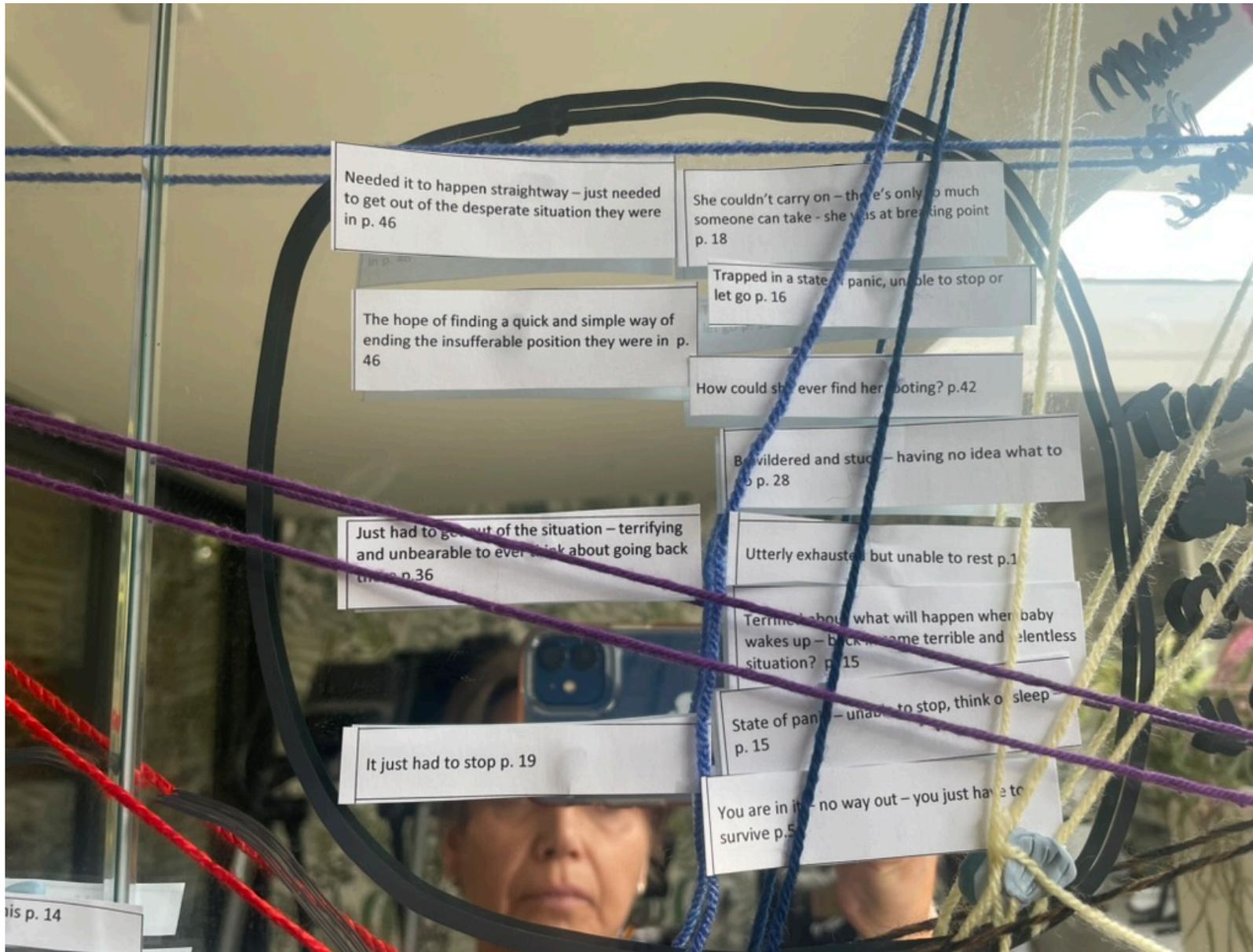
Things were knocked away the outset.  
I'm not special - no grounds for complain

Needing more?

Loop - reassurance?

***Appendix 10 - Photo showing clustering and re-clustering process***





Needed it to happen straightway – just needed to get out of the desperate situation they were in p. 46

She couldn't carry on – there's only so much someone can take - she was at breaking point p. 18

Trapped in a state of panic, unable to stop or let go p. 16

The hope of finding a quick and simple way of ending the insufferable position they were in p. 46

How could she ever find her footing? p.42

Bewildered and stupid – having no idea what to do p. 28

Just had to get out of the situation – terrifying and unbearable to even think about going back there p.36

Utterly exhausted but unable to rest p.1

Terrified about what will happen when baby wakes up – back to some terrible and relentless situation? p. 15

It just had to stop p. 19

State of panic – unable to stop, think or sleep p. 15

You are in it – no way out – you just have to survive p.5

his p. 14

## **Appendix 11 - Extract of Table of Personal Experiential Themes**

### **Table of Personal Experiential Themes (PETs) for Participant 4**

#### **WHAT IT MEANS TO BE A MOTHER**

##### **Mother and only mother will do**

Only breast milk from her breast would do. Had to be the one that feeds them.

Nothing and no-one else p.41

*trying to get him to use the bottle which he didn't really like or...we... my partner didn't like that ...as well... both of them I think. So he never used the bottle in the end... all the way. And (speaking to baby) you haven't had a bottle either, have you?*

Passionately wants what is best for them and that is being breastfed and nothing and no-one else – no matter how hard it is p. 65

*the fact that she hasn't had any formula or and [1<sup>st</sup> baby's name] never had any formula and we haven't even bothered with bottles this time...um...*

*That still might be me be being a bit... a bit perfectionist and wanting the best for them. Possibly...(baby squawks) Really! (in response),... to my own detriment*

She is the only one they are reliant on. Feels the weight of responsibility of sole reliance on her for feeding but equally feels in control. p. 66

*cos I know other people, m... other friends of mine who ...haven't had problems with breastfeeding, but very happily brought in a bottle formula earlier... um...(baby vocalizes, complaining a bit?) just to l...you know... lessen the pressure on the breastfeeding parent. Um...And I haven't done that, have I...why haven't I done that? Mmm...Control? Maybe? I don't know.*

Ambivalence about baby's need for her – in some ways lovely and reassuring - in other ways finding it too much – relentless, irritating and exhausting p. 68

*So she's doing exactly what [1st child's name] did is she doesn't want to l... actually lie in her cot which is just like... an inch that way... you know it's a co-sleeper (baby vocalizes) you know...so she just wants to be next to me*

Looking after two children is too much to manage alone and has had to rely on others but not what she wanted or what first child wants – not the same as it being her p. 69

Being the only one to feed them – only breastmilk, breastfed by her will do – but then how can you ever stop? p. 85-86

*And I've lent on the childcare more than I w...was going to ...um... for both of our benefits basically...you know...er... So ... yeah! (to baby), and he also shifted nurseries, which frankly was... that was one of the harder things this time around because he doesn't like it even now and he's been doing it for three months. Half childminders, half at nursery and he hates the nursery*

Feelings of loneliness and sole responsibility – You are the only one but also you are the only one p. 87

*And I...and I think you also feel ...horribly...um...it's not necessarily that you feel ...um... there's obviously the fundamental thing that you want to feed your baby (baby vocalizes) which is the thing that panics you...(baby vocalizes) but I think it makes you feel very alone. Because...(baby creaks a bit) your partner doesn't understand it. They can't do anything about it...um...*

Just wanting to be with each other p.128

*Participant: Well, that was that big hormonal drop. Erm But it was about [1st child's name], not [baby's name]...?*

*Participant: Yeah.*

*Researcher: ... if you see what I mean...?*

*Participant: Yeah, because...um... he was...er...he was basically...erm...er...missing me and I was missing him.*

A child's desperate cry for a mother and only mother is unbearable and must be answered p. 129

*And ...er...he...and there was one point I remember when [1st child's name] erm...yelled at the ...at the middle of the night. Just "Mummy" shouted "mummy" in such a sad way that I ....literally just... even with a C section scar...just sort of bounded out of bed*

Wouldn't quite be OK to leave this baby with father – would still be being left by mother p. 129

*just sort of bounded out of bed... and left her with... with her dad you know, but ...she was asleep at the time. She wasn't... she wasn't crying. Um...but she was waking up so much at that...'cos of course, they don't know w...night and day do they at that stage?...*

Only OK because this baby was asleep - would be unaware of being left for another child – p. 129

*and left her with... with her dad you know, but ...she was asleep at the time. She wasn't... she wasn't crying. Um...but she was waking up so much at that...'cos of course, they don't know w...night and day do they at that stage?... that I was worried about if... [1st child's name] was... screaming for me*

## Appendix 12 - Extract of Table of Group Experiential Themes

Participant 1

Participant 2

Participant 3

Participant 4

### CONNECTING IS COMPLICATED

#### Doubts and disruptions in connection – mismatches and gaps

Misses earliest minutes/ hours with baby – what happens in them? p. 15

*basically the moment I heard that he's OK and his healthy that was the moment where I felt all the kind of rush of adrenaline just leaving and kind of... I... I relaxed but then the problem was that I started feeling the pain of what they were doing so that's why they decided for general anaes... anaesthetic because I was feeling everything... erm*

*Researcher: Gosh*

*Participant: So anyway, so I basically... they...(baby gurgle and grizzles slightly) Hey now... (talking gently to baby) got me to fall asleep and I woke up later (11.13*

Were they connecting properly? P.20

*the focus... you know the focus on the latch ...er...*

Not knowing what he wanted from her – food or comfort? P.20

*and also the fact that he seemed hungry all the time which puzzled me and I had a lot of... (baby vocalises insistently getting nearer a cry) I didn't know what to do about it because I didn't know whether I'm reading his cue's correctly. It might not be hunger it might just be that he wants to be on the boob for comfort. Do I leave him on the boob for comfort? (Baby is becoming more grizzly and more insistent) Obviously there are lots of paradigms here (murmur from baby)*

Trying so hard to connect through breastfeeding but he was just crying p. 23

*and because of that poor latch I actually my supply had decreased significantly by week 5. So actually he was probably very hungry all the time which is why he was crying all the time (laughs a bit wryly)...*

Thought there was something wrong with her - a blockage causing the pain and getting in the way of breastfeeding – not being caused by baby p. 25

*what's wrong...er... you know... so I went to the GP. I initially thought it was... obviously I started reading all the potential things that happen from milk blebs to, yeah kind of blocked milk ducts, to mastitis to I don't know... engorgement. Er, I think initially I had engorgement*

Trying so hard to make a positive connection with baby but it's not as straightforward as it seems p. 27

*but yeah I think I found it hard as, so both the pain but also the fact that it was relentless as in (Baby fusses a little, protesting at the breast) that he wanted ...a lot you know.*

*Researcher: So ... a really really hungry boy...*

*Participant: Yesh! (talking in a slightly baby voice to baby) (Baby lets out a little burp).*

*Researcher: (chuckles and speaks to the baby) That's what you think of that!*

*Participant: Just like now! That just had to... (indistinct) yeah... erm but it got better ...erm... also I started being a bit more relaxed with sidelying breastfeeding which really helped my, my back ...my back pains ... erm...yeah. (Brief pause) Umm...(there is another pause of several seconds). What else...? (24.37)*

Relief that the latch was good – they had a good connection p. 37

*you know just assessing him and testing the way he sucks and that kind of thing, um and even though she confirmed that you know the latch was good and ...you know... the... the ...what we were doing was fine, something was wrong.*

She was assured there would be a match and synchronicity with baby but there wasn't p. 40

*So maybe there's an issue with your supply so that's when basically I realised "Oh is there an issue with my supply?" I, I never knew how to assess whether I'm producing enough milk and... this is one thing... it's like everything if you read all the La Leche League you know blogs and all the kind of breastfeeding supporters they tell you that supply is never an issue as in it regulates based on the demands, right? And I had a **lot** of demand (Researcher makes listening noise) So... you know non-stop. So I didn't think supply would be an issue. I didn't... yeah. I couldn't connect the fact that he might have had a poor latch and therefore that could have been an issue.*

Breastfeeding remains difficult – it is hard to know what he wants/ needs p. 43

*you know so she said he is sucking sometimes but very rarely. (Baby grumbles a little) I knew that you know you can... in that stage... you can still kind of reverse the supply issue (baby continues to grumble and protest a bit) so I felt like there was something I could do about it. I felt optimistic but yeah...erm... yeah so I felt good about it and the next few days afterwards I*

*really focused on getting my supply up...erm... but yeah so, so I think that (baby protests a bit more insistently) Yeah, yeah, you wanna, do you wanna play? Do you wanna play? (She speaks to baby in a soft and sing song tone) I mean he could do this all day (Researcher chuckles) Erm... (exhalation as she moves) Let's try this chair again and if that doesn't work, we might have to go to the bedroom and do some er... together all three of us. Do some tummy time*

He wasn't the one that needed to recover – she did and their connection through breastfeeding did p. 45

*actually the recovery was quite, so I mean not his recovery the...(longish pause) yeah the, the im... the, the effects of the tongue tie snip I think it took about two weeks maybe to see the... to feel the difference and maybe that time for my pain to also subside and that was the only.. for me... that was the only measure of, of success because otherwise I didn't know whether it had worked on but it was when my pain subsided and he, he kept sucking and I was... and I kept breastfeeding basically.*

Idea of natural synchronicity sets an unattainable ideal – connecting and understanding baby and baby's needs is not that easy p.47

*I can see how the breastfeeding community; the supporting community, they are trying to remove (baby continues to make similar noises) all the mental barriers to continuing breastfeeding by saying things like you know about the supply on demand and the fact that "well you should never worry about the*

*supplies... you know it's always adjusting but I also think... for example with the supply, I do think there's almost like a normal limit to it. A natural limit to how quickly my, my breast can produce a certain amount of milk in a given time. So even though technically I could produce an infinite amount it takes time (Researcher makes listening noise) and it might be that the rate at which he's getting hungry and he needs more is bigger so his needs might be always bigger than the natural capacity of my breasts even if I'm producing all the time ...if that makes sense?*

There is a mismatch between her and baby – what she can provide and what he needs p. 48

*I never went ...well ... I actually did in January ...I did do a month of exclusive breastfeeding but I feel like there's a lot of pressure on mothers especially when there is this mismatch between...*

A gap, something missing between the moment of the baby at birth and the baby in the crib p. 54

*Erm and yeah...I...again, someone had left him in a towel while I was under... erm... so you know it was er...*

**It's difficult – needing to take a break**

Hard to stay connected with baby – mind can get in the way p. 42

*So I'm thinking maybe I'm overthinking it ...but I'm thinking that he feels there's no milk let down (Researcher makes listening noise) or that my muscles are being contracted from me using my phone and that's how he knows that I'm on the phone. Anyway, I use it to almost as a mindfulness prompt to just be in the moment (Researcher makes chuckling noise) and enjoy the... the bonding ...er... connection.*

Painful to be trying so hard to connect/ understand baby but not to be able to – giving up and needing to take a break/ disconnect p. 44

*Do some tummy time (I feel slightly uncomfortable about that prospect)  
(42.41) Erm, ....I'm trying not to turn the TV on 'cause that's like last, last resort*

It's hard work to communicate/ understand communications – not always straightforward and sometimes too difficult and need to disconnect /take a break p.49

*Speaking to baby in soft and kindly voice) What, what's wrong? (She tries to put him on the breast) What? No, no more? You're getting tired yes.  
Um...yeah I... the problem was it actually didn't work so he started losing weight. (Baby continues to grumble) Erm, so now... we're back (smiling and speaking to baby) . Let's er.. let's move to the other room and maybe need to take a bit of a break.*

Give me a break! No time allowed for recovery P. 54

*So I started apologising towards her for ...for ...bursting into tears ...erm...and I said, "Oh you know, probably I'm just tired... and you know... I don't even know what time it is. I was just ...you know... sent here... you know....I just ... I just... you know... just take it easy basically (exhalation with a little laugh) Erm... so, so yeah so, so I think in terms of like my first support... experie..*

Weaning is a matter of practicality and feasibility – emotional aspects complicate matters and are harder to think about. If it gets difficult will wean.  
P. 63

*obviously now it's getting ... now it's easy and ... you know...um.. ..yeah, now I'm definitely minded to continue for as long as I would say feasible, meaning you know as long as he doesn't bite me with his future teeth; and as long as basically it doesn't get to a point where yeah... it's er... more complicated.*

### **Separating is difficult**

Wanting interview to continue p. 50

*Participant: We can try to put him on tummy time.*

*Researcher: We're actually you know what, we are almost at an hour. Would*

*you?*

*Recording ends and resumes a few minutes later having decided to continue in the main sitting room, given that we have nearly finished. She will put him down for a nap afterwards.*

Hard to disconnect having connected - separation anxiety – being left alone again and in need of comfort p. 66

*Yeah. Yeah... And, he's approaching the anxiety, whatever it's called, the separation anxiety so we're going to need the boob for that yes... yes... (speaking to baby).*

*Researcher: Thank you very much*

*Participant: You're welcome.*

*Researcher: Thank you.*

### **Care means being connected**

They were there when on hand whenever needed

*Yeah...erm... but...and... I did have midwife in me every time like they...they...they were really nice about it. They said, so erm, whenever I was gonna to breastfeed my baby that I should just call them for them like to*

*observe or help me if I needed to. Um, yeah, they were there every single time.*

Things really started working when her baby was sick – knew baby needed her and could take what she had to offer p. 36

*And I think following ...the surgery, that was the first I was actually like able to feed her ...like nurse her... fu...lly. It was still really a struggle. And I think it took another four weeks for her to fully like learn how to ...*

*Researcher: Latch?*

*Participant: Yeah, yeah, and all of that. Like...the...it.. I...I... because she got sick when she was six weeks old. And I remember that was the point when she like started ...nursing more efficiently, and I actually felt like okay, like, this is working.*

It felt so different when finally, she could breastfeed baby properly . p. 38

*when she was six weeks old and that's when I ...well ...when I'm sure like she's... she properly learned how to latch and how to...well, nurse and I felt a difference too. And it became more... I don't know...erm (pause)...*

*I...er...er...s...s...sorry! (laughs) (Researcher makes listening noise)*

*...erm...not sure how to ...er...it...it just... it just...er... felt like it was working.*

Baby learnt to connect with her and to be looked after by her p.38

*Erm...she got ...she got sick when she was six weeks old and that's when I ...well ...when I'm sure like she's... she properly learned how to latch and how to...well, nurse and I felt a difference too. And it became more... I don't know...erm*

Struggling to connect and then finally making the connection – fitting together  
- things clicking! p. 39

*Researcher: More ordinary?*

*Participant: Yes, Yes, sorry. Yeah. Yeah. Yes,*

*Researcher: Like it was just sort of... it ...it was a thing that you did, as opposed to...j... I dunno...*

*Participant: Yeah, yeah. No, like, yeah, that's funny. Yeah, I...maybe ...we just became*

*Researcher: it clicked? (interrupting a bit)*

*Participant: Yes, yes. That's what it clicked. Thank you! (both laugh) Yeah.*

## **Disconnection**

Staying connected is difficult when things get emotionally painful p.12

*he had to go to work as soon as we came back home, which was really annoying. (Researcher makes acknowledging noise) Er. Yeah! (with some finality)*

*Researcher: Can you remember....well can you remember that night...that night before the night you called? Can you remember?*

*Participant: Er when we were sat in hospital? Or? Or... when we?*

*Researcher: Well, I suppose both..the hospital. Well I was thinking about that...particularly that...*

Disconnection between her body and her mind p.19

*But I was...I was struggling like ...to...to eat that. Like it...it...it tasted like chalk... like I was ... like I was hungry but I just I couldn't eat. I wasn't like...like.....I wasn't feeling hungry but I...I... I was hungry, if that makes sense.*

## **A. ISOLATION, REJECTION AND DISCONNECTION**

Being given a baby from nowhere leaves a feeling of disconnection and shock – a grounding process missed out? p.22

*But the caesarean went really well. It kind of ...it was...sss... utterly bizarre... like I couldn't picture being handed a ...baby and so when I (laughs) ... put this baby on me I was just like "Oh my word! A human baby"*

Communicating and connecting with others should feel helpful but doesn't – adds pressure and intensifies the anxiety p. 69

*all those external communications were about um... latching as well, which didn't help I don't think but also may have helped in other ways.*

## Fears of irretrievable damage

It is worrying to think about the possible impact of the birth not going to plan – uncertainty - has irretrievable damage been done? P.23

*And ... yeah, they ... as much as they could, they respected the kind of desire we had to kind of skin to skin straightaway and those kinds of things. And I really liked we had a nurse in recovery who was really sweet and very excited and... immediately like tried a lot to help us latch the baby which... kind of wasn't what I was picturing*

Fear that things will never feel any different and of irretrievable damage to baby p. 43

*Um...(sigh) but yeah...I think it was just such a...a difficult...I think at least three weeks and I just remember googling a lot like "Baby Blues, how long do they last?" Like what is normal? Because I was very, very, very worried that I'd develop ...like... postnatal depression or ...it...I...I... I didn't know. Huh. Yeah, I was very, very, very stressed about that...um...*

Devastating worries that irretrievable damage had been done to her bond with baby. Perhaps still difficult to connect with baby p. 59

*But a lot of worry, I was very, very worried that I'd kind of messed up my bond and that...I'd kind of ...those... first few weeks had led to like me and [baby's name] not being securely bonded (this feels very painful for the researcher to hear) and kind of , I gu...I guess it must have felt like irreparable damage had been done, that could never be undone (this feels devastating and researcher wants to reassure her and attempts to with her facial expression)*

Things are not alright – she has caused irreparable damage p. 60

*worrying about those first few weeks and kind of... not having done enough skin to skin ...not having done enough latching attempts and just not have spent enough time to...with her for the first two weeks especially. Erm... and it was interesting because in pregnancy ... I'd done so much of the kind of school of thought on ... how great skin to skin is and all those things that I just had it kind of certain in my mind that ... there was some kind of seismic things happening in those first two weeks that I'd kind of... couldn't undo.*

*Um...so, it was interesting, even though kind of ...we'd got through that period... we'd established the breastfeeding, there was still this kind of feeling that "Actually. No. You've ...you've not... it's not a problem that's just solved. Ac...actually, you've kind of done something that can't be undone"...*

Now she keeps worries that not securely bonded far away in her mind – unthinkable and unbearable p. 61

*Which is very strange, like now looking back on it, it seems quite bizarre, because ... I think it probably ...was fine (different intonation). Um...it started to get to a point.... she started smiling really early, which is lovely.*

Regret at what might have been – something irretrievably lost p. 63

*Um...42:26 I guess what I'll never know (slight break in voice) is if breastfeeding was established fine on day one and she didn't have the tongue tie (coughs) ... I'll never know kind of how I'd have felt in those first few weeks.*

### **Rejected with no place**

There is no room or place for her – ignored and rejected. P.14

*we had to meet with a consultant and she was saying it's essential that you ...um... have another ultrasound to check everything's okay... essentially to check on the placenta, but then... they couldn't fit (elongated) me in for like five days and then the Ultrasound Department said "Actually you've passed 42 weeks now so we don't...erm.. we won't see you" (researcher feels shared outrage and frustration)*

Fathers have a role – but what is it? p.20

*that point and thought we'll make the plans for like my dad to pick up the dog from the vet (laughs wryly)*

The unspeakable awfulness and intensity of trying to connect and not being able to feed or comfort her – the offer of breast causing baby distress p.29

*acute stress of it kind of set in on ... probably the first night we had [baby's name] at home. I think ...probably what was happening... was that I was just continually trying to get her on the breast. and she just couldn't. She was just kind of ...opening her mouth a little bit and not really going on. And then getting really, really, upset. And it got to the extent (voice starting to break) like... early days... kind of every time we tilted her into the position to like latch, she'd just scream and scream and scream. And... newborns don't have the loudest cry but it's quite an intense (researcher makes affirmative sound) cry...erm.. to have and...(inhales deeply)...*

Her breast might be so easily replaced and rejected for ever. p. 36

*because she's likely to... go better from finger to breast (sound of baby crying from the other room) rather than bottle to breast. The idea was that we try and avoid the bottle for as long as possible. Just in case...um, it causes confusion and we don't then establish...um (sound of baby crying from the other room) ... breastfeeding*

**Lost connection with partner**

The connection is between father and baby not her and baby – she is left out with only role to produce milk which he will feed to baby leaving her with none of the satisfaction p.31

*It was this kind of ...bleak scene of [partner's name]... [partner's name]... in the bed, my partner erm... with the 'next to me'... like cot on his side ...because I had always pictured I would go on that side but then obviously with the caesarian (researcher makes acknowledging sound) I couldn't climb in and out ...erm...with [baby's name] next to him and then me on the other side kind of...s...se.. sat up because I had the caesarian I couldn't lie down. And... I was kind of hand expressing into syringes as he fed them to [baby's name].*

Partner's connection with baby, bringing him satisfaction and elation leaves her excluded and on her own, feeding her feelings of rejection, inadequacy and disconnection p. 38

*I internally was feeling (baby still grumbling a bit)..ssh...ssshhh (baby still grumbling a bit but settling).. there you go... um.. 24:11 I was feeling... completely lost and kind of... I think devastated and kind of (baby making noise at breast still not settled) just completely inadequate...like I cannot look after this baby, like... I can't meet her needs. That, that was the thing that was just playing... like "I can't meet this baby's needs. I can't..." contradict ...like juxtaposed for [partner's name] who was on like Cloud Nine - unbelievably*

*just full of love, full of joy (baby makes contented noises) And every time (voice starts to break again) I didn't want to like stop him saying those things. Every time he like "God, I'm just so happy. I love her so much". I was just like, "Oh my God!" ... like it just made me feel so much worse. Um...because I could just see it in him (speaking with great emotion) a... it was just joyful. And I think interestingly, because we set up finger feeding...erm...He beca...kind of... became the expert in that so suddenly the kind of vision I had of like me doing all the feeding, became [partner's name] doing all the feeding. Well, this just wasn't what I was expecting (baby makes [contented] noises)*

A felt shift away from his care of her towards baby, excluding her and leaving her feeling rejected and left by both p. 63

*... I felt like it wasn't... he is just amazing at talking to her and being on her level. And he speaks to her in [REDACTED] ... so they had... it felt like they had this really good bond. Um...and it just kind of ... played into all my anxiety that I wasn't doing that and I couldn't do that.*

As well as trauma and exhaustion of birth and feelings of failure she was getting the feelings of exclusion and having to sort out external things (like pumping the milk) that perhaps usually are managed by the father in support of maternal dyad. P.76

*Like I dunno, I just felt...kind of more... misunderstood... not ...I just felt like "No one understands",... and again... just such a juxtaposition for our experiences because I was feeling like this like symbol of failure with this finger feeding if we do it in public, whereas [partner's name] kind of loved finger feeding because he had no anticipation that he'd get to do any feeding early doors*

He was getting something better than he expected, something that should have been hers - she was getting something so much worse p. 76

*just such a juxtaposition for our experiences because I was feeling like this like symbol of failure with this finger feeding if we do it in public, whereas [partner's name] kind of loved finger feeding because he had no anticipation that he'd get to do any feeding early doors. So suddenly he could do all this feeding. He loved it. He was really good at it. [Baby's name] would kind of gaze at him, and they'd have this bonding experience. So, he was really keen to do it out because he had... it was kind of lovely for him. It was this great thing and he'd get to do it... out and about wherever they were. So, we kind of had this really different experience in terms of feeding when we're out which I found quite tough.*

Had lost sensitive and usually emotionally attuned partner to baby with the additional cost of not establishing her own bond with baby p. 77

*Like I dunno, I just felt...kind of more... misunderstood... not ...I just felt like "No one understands",... and again... just such a juxtaposition for our experiences because I was feeling like this like symbol of failure with this finger feeding if we do it in public, whereas [partner's name] kind of loved finger feeding because he had no anticipation that he'd get to do any feeding early doors. So suddenly he could do all this feeding. He loved it. He was really good at it*

*And... even though [partner's name] I think ...he's very kind of sensitive and very kind of attuned to how I'm feeling ...*

### **Difficulties connecting with baby**

We were both wanted and were trying to connect through breastfeeding and I thought we were but that hope was misplaced p.24

*And (sigh) kind of a few times in that period she kind of at least tried to get on (researcher makes listening noise)... she had her mouth around my breast at least and so... kind of I think I had this like...f.. false reassurance in those first 12 hours that everything was gonna be okay with breastfeeding, because I had been really nervous about it and I think especially having a caesarean...*

Producing, producing but without the satisfaction of connection of feeding baby at the breast and baby taking in her milk p.30

*we started to use the colostrum from the freezer. 18:26 And I think that probably went within 24 hours – we'd used all of that. Um...and I was advised by [midwife's name], our midwife early doors to ...start getting more colostrum out and just keep... start hand-expressing. So I...I was really pleased that I had done that before because I think it would have been really stressful to try and learn that and work out how to do it. But erm... yeah, definitely, the first night probably the second as well. It was this kind of ...bleak scene of [partner's name]... [partner's name]... in the bed, my partner erm... with the 'next to me'... like cot on his side ...because I had always pictured I would go on that side but then obviously with the caesarian (researcher makes acknowledging sound) I couldn't climb in and out ...erm...with [baby's name] next to him and then me on the other side kind of...s...se.. sat up because I had the caesarian I couldn't lie down. And... I was kind of hand expressing into syringes as he fed them to [baby's name]. And I'd be...constantly be "Like how many... how many on your side?" And he'd say like "two or three or four or five" and I'd be like "Okay. I can't sleep now. I've got to keep going. Keep going..."*

So far away from high of initial feelings of connection with baby and sense of achievement and power in their successful production of a healthy baby – both a mother and a partner p.33-4

*And after a while of faffing around [partner's name] fell asleep in the hospital chair and [baby's name] was in the little crib. And I was just wired ...like wide awake...beaming smile, like "I can't believe we've done this!" and every time*

*[partner's name] likes tired because he was really uncomfy on his chair, I'd be like, "Do you want a cushion? Do you want a pillow?" and he was like "Why'd you just so awake?" (laughs) "Yeah, and he said the next day, "You were just so wired last night!" and I was. I just couldn't... fathom, that we'd done this. And I think as the stress had gone on...um... of that period when we were really overdue I kept on just saying like...my faith in the fact that we're gonna take a healthy baby home is going down and down and down. So, to have this healthy baby which is miraculous. Like ...I'm like, "Oh my God, we've actually done it". So, I kind of went from that like high ...and of course hormonal as well... that high um...to this...just this feeling of like "Oh my God, I can't do this. I'm completely stuck and I can't feed my baby" (hard to speak because of the emotion and takes a deep breath to gather herself). (Pause of several seconds)*

So frustrating and upsetting when trying to connect and bodies won't do what they're supposed to do p.37

*(speaking to baby as she tries to settle her to the breast) Hello. Hi. You hungry? You want some food? (baby crying). (Baby still fussing). I see, I see how hungry you are...I see that...hello...thank you...come on then.... (Dad leaves. Baby starts to settle to the breast but can't quite). You're a bit schnuffly too...oh baby...there you go...??? my hair (baby clutching it?) Um (baby still not settled)... shall we wait for the milk to come in?...yeah...coming through now?...well done. Erm... (baby still grumbling a bit)...there you*

*go...shh..shhh (holding and stroking baby's head in a calming way)... (baby still grumbling a bit)... You got hungry, didn't you?... Yeah?... (baby still grumbling a bit)... I know... it's ok...(something indistinct). (Sigh). I... I ...yeah, there we go...(I get the impression she has now let down)*

[Difficulties getting baby to latch]

Baby didn't need her – she wouldn't be missed. She wouldn't miss her baby?  
They could separate fine p.42 to 43

*And I just remember being so sad that day, like...kind of my vision was always that first session. It'd be really tricky for me to leave [baby's name] and... it will be difficult but actually... I was like she'll actually .. she's like... "She'll be absolutely fine" because [partner's name] was meeting her needs and that I think was really difficult (voice breaking) ...*

Worries that body wouldn't produce enough milk were unfounded – she had more than enough milk but she still couldn't feed her baby p. 52

*. I'd be worried in pregnancy about not having enough milk because I've got quite small breasts, but it hadn't been an issue. I had kind of loads of milk... I was leaking all the time. But also, I was just... I was just so stressed;*

Ongoing worries about bond with baby and that baby more securely bonded with father p. 61

*... I think it probably ...was fine (different intonation). Um...it started to get to a point.... she started smiling really early, which is lovely. But she'd often only smile for [partner's name], my partner (inhales) and that just kind of fell into this narrative in my mind that actually, "No, she doesn't...You're not bonded" and... it was interesting (voice strained), I Googled it ...like "baby smiling at more at dad" kind of thing, as I'm sure (laughs) lots of people do. And I felt ...when I Googled it... it was basically saying your baby will smile at the person who's their... most securely bonded to. So again, I'm thinking, "Yes, I've messed this up. This is...this is gonna be terrible".*

Her friend saw a union with baby and she saw a confirmation of her lack of significance and connection p. 62

*Interestingly, my friend had a baby 10 weeks later, a very close friend. And just a few weeks ago, she said ...oh erm... my baby's like smiling more at her dad. And I was like, "Oh, yeah, definitely that ...we had that" and she was like, "Yeah, but luckily, I Googled it and it ...straightaway Google said that essentially she like sees me as like an extension of herself. And like...(coughs) so that's why ...like she just sees you as like part of her". And so that really reassured me and I was like, "Oh, I didn't get those results! That would have been really helpful for me in those first few weeks" (laughs as she speaks and researcher joins).*

No link in baby's mind between breast and milk and to her as a feeding mother p.85

*and she didn't understand that that's where you've got milk. So we were just never getting to the point where she was kind of ...feeding wrong...which I think a lot of women have when they're kind of latched ... but kind of incorrectly because of the tongue tie and they get some damage. I didn't have that. I just didn't have the latching, if that makes sense?*

### **Feelings that cannot be shared**

Unspeakable worries that not bonded – turned to Google rather than a person  
p.61

*But she'd often only smile for [partner's name], my partner (inhales) and that just kind of fell into this narrative in my mind that actually, "No, she doesn't...You're not bonded" and... it was interesting (voice strained), I Googled it ...like "baby smiling at more at dad" kind of thing, as I'm sure (laughs) lots of people do. And I felt ...when I Googled it... it was basically saying your baby will smile at the person who's their... most securely bonded to. So again, I'm thinking, "Yes, I've messed this up. This is...this is gonna be terrible".*

### **Not wanting to be seen**

Not wanting to be seen at all costs p.73

*... I was so paranoid that they were ... I knew there was a break during the group and I thought that all the mums would just see me and I was really... Yeah, I was a bit of a mess. I was very tearful (voice breaking and on the edge of tears*

Feeling ashamed feeding in public p. 81

*Erm, so it's been kind of this journey of ...what feeding in public feels like. And obviously, early days, it felt quite ... kind of mortifying. And then ...s... I just felt more and more comfortable as time has gone on. And I still have this feeling that yeah, I'm not feeding in this 100% pure conventional way because I'm using the shields but also... I'm very much fine with that now and I'm fine with kind of ...people seeing that in public*

## **A. THE COMPLICATIONS OF COMING TOGETHER AND COMING APART**

### **Feelings of easy togetherness**

Hoping for an easy baby but she didn't get one p. 16

*And then....um... and she latched... much better than [1st child's name], [1st child's name] didn't latch at all. Like he just kept on slipping off ...kept on slipping off. So, he didn't have any... milk at all...um... from me...even when I*

*got nipple shields ... and everything...um...So, I ... because I knew all about that I thought "Oh! Amazing" maybe (researcher makes listening noise) we...I've got a baby that actually you know the...you hear people "Oh! I didn't have any problems at all!" You just ...internally slightly seethe (grimaces in playful way). Erm... it's like people who say "Oh, yes, she sleeps eight...eight hours a night!". (Researcher chuckles) 06:20 Erm...so...erm (still chuckling a bit)... "Brilliant!" (Researcher chuckles) Erm...yeah...so...erm, I thought it was okay. But actually, even in the recovery bit from the C section, she was making one of my nipples bleed...*

Baby soothed by being held and comforted and then much easier to be with and to feel loving towards her p. 43

*Participant: And you'd have to r...rock her in that position and ...[finely known?] and all that kind of... and then she'd be okay. (Talking to baby) Um...so... yes, we're talking about you! (baby looking and smiling at her)*

*Researcher: Mmmm (appreciatively)*

*Participant: Yeah (baby makes echoing noise which sounds like 'yeah') Yeah! Are you copying my voice, or am I copying your voice... who knows? (baby vocalizes several times to which participant responds each time) Yeah! ... (researcher chuckles) Yeah!*

Easy miracle baby vs. difficult IVF baby p. 58

*Erm...so in fact...and then like ...this little one was an IVF baby ... the f...[1<sup>st</sup> baby's name] . [1<sup>st</sup> baby's name] was a ...was a bit of a miracle (change of tone) Hey! But by that... but... this one...um...point we were trying to ...for this one I had a miscarriage mostly I think because of my age.*

First baby was a lovely cuddly baby in a way that this baby is not p. 62

*Um...(toy jangles) And it was... what he ...he does...he does... Even now he's a very cuddly boy, you know...which is what we all like, isn't it? Hey? Yeah (to baby?)*

Feeling more certain of connection and of loving feelings in both directions with first baby than with second baby. He needs and wants her in a way she's not so sure this baby does p. 62

*had I not been breastfeeding him (researcher makes listening noise), you know, when he was about ... he was almost two. Um...(toy jangles) And it was... what he ...he does...he does... Even now he's a very cuddly boy, you know...which is what we all like, isn't it? Hey? Yeah (to baby?)*

Arrival of this baby spelled the end of simplicity of complete togetherness with first baby – a terrible loss – misses that so much p. 131

*and I remember thinking "Oh my God... this is... I've missed this" of lying down (researcher makes listening noise) ... because we used to also lie down*

*with him to fall asleep ...now since she was born, we sit in the same room to him ...with him as he falls asleep. It's partly so I can...s... breastfeed because now I do...*

### **Feelings of difficult togetherness**

Nothing went wrong with the 2<sup>nd</sup> birth but still didn't feel great – not relaxed  
p. 15

*So, they did... they...so, I was in hospital for two...days before the...sort of...then suddenly his heartbeat went very high and I ... we had to be rushed into theatre. So, this one was a lot more... she was a lot more...um...er...s...a lot...yeah, semi-relaxed.*

Although things are better still finds it difficult with this baby – hard to feel settled and relaxed p. 26

*So to feel that you then... can't cons...and then you know, she...she would be...she would do this, and then some ...you know, when she couldn't have any milk. So it then...it...to... adding a screaming baby, which I think I don't know biologically makes your ...nerves jangle... even if you're feeling relaxed.*

Connecting together with this protesting baby is difficult –frustrating – hard to get a flow p. 35

*Oh! Is that what we needed to do? (researcher chuckles a bit half-heartedly, even disingenuously?) Hey?... did you have to have a little....(baby lets out a cry) Do you want some more?... Okay...um... (Researcher feels annoyance with all the interruptions when transcribing) (baby starts feeding) So...er... so all of that really informed me (baby lets out sharp cry) just trying to get as prepared as possible. So, I don't think (baby lets out sharp cries)... I was ... I wasn't as...as low or as panicky as I was with [1<sup>st</sup> baby's name]...um (sounds of baby feeding) And I...I had more support around ... although I had more responsibility because [1st child's name] was around too, obviously. But um...because (sounds of baby feeding)*

