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Separated Motherhood: Exploring the experience of mothering premature twins and psychotherapeutic implications

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Abstract: The experience of giving birth prematurely presents a stressful and challenging time for new mothers, who often spend extensive time with their children in specialist intensive care hospital settings. This can impact the wellbeing of the mother and complicate the process of bonding between mother and child. Despite a high prevalence rate in the United Kingdom of prematurity in twin births, very limited research exists on the actual lived experiences of these mothers. A hermeneutic phenomenological approach is employed to explore the lifeworld experience of becoming a new mother of premature twins. It offers a lived experiential lens that highlights similarities to the contemporary research on mothers of premature singletons, as well as differences within the interpersonal dynamics between a new mother and her two babies that impact on wellbeing. The experience of three mothers of premature twins is understood as a transitional space of 'becoming' to 'being' a mother. Emotional conflict alienates them from their new motherhood and separates their sense of closeness between their babies. A fragile sense of coping contains their distress and self-efficacy is drawn from the ability to mother at least one of their twins. The validation of a separated motherhood entwines the haunting of prematurity within their separate relationships with each child. Implications of this research suggest that further exploration of the experiential context is essential to promote a wider inclusion and swift access to appropriate psychological therapies for women presenting to primary care psychological services within their perinatal period.

Keywords: Premature twins, mothers' experiences, relational, perinatal psychotherapy, phenomenology

The aim of this research was to attempt to understand what it is like to become a new mother to premature twins. What struck me initially, following a thorough review of available literature, was both the significant emotional impact on mothers being separated from their babies through the complications of prematurity and the incredibly limited availability of research on premature twins. As a Psychological Wellbeing Practitioner working within primary care in the National Health Service, United Kingdom (UK), I assess and treat adults experiencing common mental health problems often stemming from the impact of significant life events. Through my previous clinical role in secondary care services, I have also supported adults who experience significant difficulties in regulating their emotions and establishing healthy relationships as a result of problematic attachment and emotional development in childhood. From a more personal perspective, several friends and family members are mothers to premature twins, and my subjective understanding of their experience was that of a distressing period in their life. Therefore, a combination of both professional and personal curiosity motivated my interest in researching this topic.

The current national clinical guidance in the United Kingdom recognises the importance of early recognition and intervention of poor mental wellbeing for women during

pregnancy and up until their first-year post-partum. It is estimated that up to 39% of women experience mental health problems during this perinatal period (Marchesi, Ossola, Amerio, Daniel, Tonna, & De Panfilis, 2016).

Many of the women presenting to primary care services who experience symptoms of mild to moderate depression and anxiety will be referred to an Improving Access to Psychological Therapies (IAPT) service (National Institute of Health and Care Excellence, 2014). Priority assessment and swift access to treatment is a current national directive in the UK, in order to limit any potential impact of poor mental wellbeing on maternal functioning and the subsequent neurodevelopment of the child (IAPT, 2013). The majority of people accepted to IAPT services begin 'Guided Self-Help' treatment based on Cognitive Behavioural Therapy (CBT) with a low-intensity practitioner as a primary option. This is based on offering the "least invasive but most appropriate" intervention as part of a stepped care model (IAPT, 2013). The successful assessment and treatment of symptoms are determined by clinical thresholds using brief psychometric measures on the *Patient Health Questionnaire-9* (PHQ9) (Kroenke, Spitzer, & Williams, 2001) and the *Generalised Anxiety Disorder-7* (GAD7) (Spitzer, Kroenke, Williams, & Löwe, 2006). Patients who present with symptoms that do not reach the clinical threshold may potentially be declined access to the IAPT service (National Collaborating Centre for Mental Health, 2018).

However, Goodman, Prager, Goldstein and Freeman (2015) caution against using low-intensity psychological assessment and intervention as a first line approach for women in their perinatal period. Many women present with sub-threshold symptoms of anxiety and depression, yet both clinical and sub-clinical symptoms of depression can impact on maternal functioning (Weinberg, Tronick, Beeghly, Olson, Kernan, & Riley, 2001 cited in Goodman et al., 2015). Furthermore, the impact on esteem and sense of inability as a new mother is equally as problematic as a longer-term risk of depression. Whilst CBT-based intervention is effective in treating the clinical symptoms of anxiety and depression, there is limited evidence to suggest that this is sufficient to enhance the mother-child relationship and therefore the social and emotional development of the child (Beeber, Schwartz, Holditch-Davis, Canuso, Lewis, & Hall, 2013; Forman, O'Hara, Stuart, Gorman, Larsen, & Coy, 2007; Murray, Cooper, Wilson, & Romaniuk, 2003, cited in Lenze, Rogers, & Luby, 2015). However, Interpersonal and experientially focused therapies may offer a greater potential for prevention (Goodman et al., 2015; Lenze et al., 2015). The National Institute of Health and Care Excellence (NICE, 2014), recommends undertaking further research to explore the impact on new mothers' psychological wellbeing resulting from their early mother and child relationships. This suggests that further exploration of individual context is needed to consider both the ethical and clinical relevance of a standardised low-intensity psychological assessment and treatment model for women in their perinatal period.

Approximately 60,000 pre-term births occur in the UK each year with 40% of those attributed to mothers of multiple births (Office of National Statistics, 2016). The higher likelihood of physical health difficulties with premature babies can also result in multiple medical admissions and long-term monitoring that can complicate the process of bonding between mother and child (Ionio, Colombo, Brazzoduro, Mascheroni, Confalonieri, Castoldi, & Lista, 2016). Very little current data, however, is captured on the experiences of mothers of premature twin births, despite their high prevalence rate. Quantitative data is valuable in highlighting a large population of new mothers who may likely present to mental health services during their perinatal period, and this points directly to the likelihood of those mothers having complicated or traumatic births (Ionio et al., 2016). However, this data does not evidence the lived human experiences of these new mothers.

Qualitative Literature Review

A review of contemporary phenomenological studies on Northern European women with premature babies highlights multi-dimensional aspects of experience that may impact on the wellbeing of both the mother and the potential development of the child (see Table 1). All the studies reviewed undertook semi structured/guided interviews. Each study began their data capture during or shortly after admission to the Neonatal Intensive Care Unit (NICU).

Study	Methodology	Main Findings
Arnold, Sawyer, Rabe, Abbott, Gyte, Duley & Ayers (2013)	Inductive systematic thematic analysis Participants: 32 mothers	The main themes suggest anxiety about mothers meeting their babies for the first time within a hospital setting. It highlights individual experiences of embodiment and the importance of touch in facilitating bonding
Hagen, Iversen & Svindseth (2016)	Phenomenology inspired by Giorgi Participants: 8 mothers	Coping was more difficult when the women had prior experiences of complicated birth. Mothers benefited from feeling heard by medical staff. For those feeling a lack of agency, there was a sense of alienation and difficulty with bonding.
Hall & Brinchmann, (2009)	Phenomenology inspired by van Manen Participants: 5 mothers	Lifeworld themes are drawn from the mothers" experience of spaces and the change in tone and embodiment when transferring between these spaces.
Hall, Kronborg, Aagaard & Brinchmann (2012)	Phenomenology inspired by van Manen Participants: 5 mothers	Three primary themes were elicited depicting a journey from the uncertainty of new motherhood, establishing their new motherhood in a "hospital world" and the mothers entering a new journey upon homecoming. (continued on p.3)

(continued from p.2) Erlandsson & Fagerberg (2005)	Phenomenology inspired by Giorgi Participants: 6 mothers	Mothers were distressed by separation from their babies even for short periods of time. They felt a strong need to be close and this was hindered by staff and organisation. The effects of separation during hospitalisation continued even after homecoming.
Værland, Vevatne & Brinchmann (2018)	Phenomenology inspired by van Manen Participants: 9 mothers	Mothers longed to be close to their babies but the restrictions of physical health post-partum inhibited the process of bonding. The new mothers strived to "act as a mother should".

Table 1 Summary of qualitative research about the postpartum experience

Four overarching themes from the lived experiences of becoming a new mother of a premature baby were elicited from the literature. Each theme is discussed below with consideration to the intrinsic interweaving and interaction between them, through the theoretical concept of "lifeworld" dimensions (Husserl, 1939/1970 cited in Stenner & Lazard, 2016 p.320). A distinct gap within the literature relating specifically to the individual experiences of mothers of premature twins, highlights significant limitations in capturing the impact on both the wellbeing of the mother and the future development of the child when using basic measurements that lack interpersonal and relational contexts.

Awareness of Body and Self

Arguably, one of the most tangible experiences of pregnancy is the physical body. From the roundness of the stomach to the movement of the child within. For mothers of premature babies there is a sense of loss and adjustment to unexpected and sudden changes, alongside fatigue, illness and pain from surgery and infection (Erlandsson & Fagerberg, 2005; Hall et al., 2012; Vaerland et al., 2018). Physical contact between mother and baby is also very important in facilitating bonding (Arnold et al., 2013; Hall et al., 2012; Erlandsson & Fagerberg, 2005; Hall & Brinchmann, 2009; Hagen et al., 2016; Vaerland et al., 2018). However, some mothers avoided touching their babies for fear of transmitting infection to their child (Hall et al., 2012). In contrast, a mother of premature twins avoided touching her babies because she could not decide which child to touch first (Arnold et al., 2013). This describes the physical awareness of the body and sense of touch as being significant in the self-awareness of being a mother and therefore potentially inhibiting of the bonding process.

Connections and Disconnections of Space

Erlandsson and Fagerberg (2005) argue that travelling between the spaces of home and the Neonatal Intensive Care Unit (NICU) disconnects mothers from their sense of 'being a mother', particularly for those recovering from ill health (Vaerland et al., 2018). Suggesting, that being between these spaces is divergent from their expectations of motherhood. However, the interpretive approach of Erlandsson and Fagerberg (2005), offers limited discussion in respect of reflexivity, therefore limiting transparency within the findings. Although, the physical barriers of ventilated incubation on the NICU created a similar sense of detachment because the baby belongs to the hospital (Hall et al., 2012; Hall & Brinchmann, 2009; Vaerland et al., 2018). This elicits a sense of this space of medical care creating confusion for the mothers' role as a non-medical care-giver. However, Arnold et al. (2013) reports that a mother of premature twins felt an instant bond with both of her babies on the NICU. In contrast, Hall et al. (2012) and Hall and Brinchmann (2009) describe the more intimate and nurturing space within the hospital of the quiet-caring room, that created space 'to be' a mother. Suggesting an interweaving of places, material objects and bodily awareness of emotion. Although, some women avoided intimate spaces in case their baby died (Arnold et al., 2013). This elicits a sense of individual experiences of being within a temporary space of life and death (Hall et al., 2012), that both connects and disconnects the self-identity of 'being a mother'. However, nuances may exist within the very limited inclusion of the experience of mothers of premature twins.

Emotional Irregularity of Time

Time was also particularly relevant in relation to the experiences of both body and space. For example, conflicting emotions arose from the interruption of pregnancy, feelings of loss, guilt and fear around the premature thrust from the safety of their womb into a world of sickness and medicine (Hall et al., 2012; Hall & Brinchmann, 2009). This generated a sense of responsibility and loss of control over their baby hurtling into danger, whilst trying to slam the metaphorical failing brakes on time. In contrast, the anticipation of meeting their child created a sense of willing time to speed up, for the development of the child to be rapid, because they are too small and not ready (Arnold et al., 2013), (Erlandsson & Fagerberg, 2005; Hall & Brinchmann, 2009), sensing time as being both short and long (Hall et al., 2012). Mothers also longed for time to be 'suspended' to allow space to process their feelings and thoughts (Hall & Brinchmann, 2009). This elicits a turbulent sense of conflict between a visceral fear of uncertainty and embodied sense of loss and gain that is woven through an awareness of irregular and unstable time.

Longing and Belonging of Social Closeness and Distance

The experiences of social relationships more broadly, feature heavily within the literature. The lack of privacy on the NICU led to mothers feeling that they could not have intimate space with their baby (Arnold et al., 2013; Erlandsson & Fagerberg,

2005; Hall et al., 2012; Hall & Brinchmann, 2009; Hagen et al., 2016; Vaerland et al., 2018). On the other hand, the temporary relationships with other mothers provided support through shared understanding, but also elicited feelings of anxiety when comparing the progress of their baby (Hall & Brinchmann, 2009; Hagen et al., 2016). This highlighted the need for agency within the pull and push of social relationships because: "neighbours are good, but you need a hedge" (Hall & Brinchmann, 2009 p. 132). The relationships with medical staff were also important to 'being a mother', bringing a sense of achievement and hope as well as disempowerment and fear of getting it wrong, that created reluctance to speak up about the care of their babies (Hagen et al., 2016; Erlandsson & Fagerberg, 2005; Hall et al., 2012; Vaerland et al., 2018). However, Hagen et al. (2016) researched from within their field of expertise as neonatal nursing staff with a focus on the impact of clinical interactions within the hospital, suggesting the potential of biases within their findings. Whereas, Hall et al. (2012) and Hall and Brinchmann (2009) offer concrete descriptions of bracketing and their approach to describing the phenomena is independent of hospital staff, providing a greater transparency within the analysis and a focus on eliciting the essence of the lived experience. However, both interpretive and descriptive phenomenological approaches consider that many of the mothers encountered difficulties during the transition from hospital to home, feeling unsupported, fatigued and having to learn to grow into their role as a mother (Erlandsson & Fagerberg, 2005; Hall et al., 2012). This suggests, that the experience of spaces, awareness of closeness, distance and temporality of social relationships is interwoven within the sense of the physical body and self-identity of 'being a mother', as described through their lifeworld.

The contemporary literature offers insights from differing qualitative approaches suggesting that the experience of becoming a new mother of a premature baby is an interweaving of lifeworld dimensions. However, there was limited inclusion of the experience of new mothers of premature twins during the transition of hospital to home, despite the suggestion of nuances from those of mothers of singletons (Arnold et al., 2013). This forms the basis for this phenomenological study.

An increased likelihood of prematurity in mothers of twins (ONS, 2016), and the degree of stress experienced by mothers of premature babies may have significant implications on both their own emotional wellbeing and the emotional development of their children (NICE, 2014). The idiographic complexities drawn from these experiences further broadens the argument for atypical presentation of common mental health problems in terms of clinical thresholds, when compared to standardised brief psychometric measures. Furthermore, a distinct lack of data concerning the lived experiences of mothers of multiples, the potential for problematic bonding resulting from the complications of prematurity and a longer-term risk of depression, suggests that this is a current concern for UK health and social care provision. Therefore, to build on the prior descriptive research of Hall et al. (2012) and Hall & Brinchmann (2009), this research project set out to ask: What is the lived experience of becoming a new mother of premature twins?

Method

Design

A hermeneutic phenomenological methodology was adopted loosely following the approach of van Manen (1990), to open up possible meanings and capture the way the mothers experienced being a mother of premature twins. Hermeneutic [interpretative] phenomenology [study of lived experience] challenges a researcher to help people articulate their lived world. The main theoretical concepts within this research draw on *lifeworld* dimensions (Husserl, 1939/1970 cited in Stenner & Lazard, 2016 p.320), and the existential philosophy of *Dasein* [the human experience of being in the world] (Heidegger, 1927/1996). Here the focus is capturing how the person's world is experienced and how it is concretely lived in an embodied, relational, and contextual way. While all phenomenologists prize rich description, hermeneutic variants also acknowledge the inevitable role of interpretation (van Manen, 1997, 2014). As Heidegger (1927/1996) asserts, the act of description always involves prior interpretation; it's the precondition of all understanding. As part of the phenomenological process, I attempted to engage the '*Epoché*' and 'reduction' [the suspension of preconception or assumption], taking up an attitude of openness and wonder (van Manen, 2011). My aim was to engage a radical, reflective attentiveness to the way in which the participants experience their world (Finlay, 2008).

> The wonder of that thing takes us in, and renders us momentarily speechless ... From this moment of wonder, a question may emerge that addresses us and that is addressed by us. It should animate one's questioning of the meaning of some aspect of lived experience. It also should challenge the researcher to write in such a way that the reader of the phenomenological text is similarly stirred to the same sense of wondering attentiveness to the topic under investigation. (van Manen, 2011)

Participants

Recruitment of participants was purposive, specific to mothers aged 18-45 whose first experience of motherhood was premature twins. This was carried out via direct telephone

contact as the participants were known to me. Two are just personal acquaintances; the other I have a closer relationship with (see Table 2.) However, no participant is known to the other. All participants were in relationships with the father of their twins throughout the transitional period described. No participant was encouraged to seek psychological support by their care teams during their perinatal period. Equally, no participant was involved with mental health services whilst taking part in this research. Participation was voluntary and informed consent was gained prior to data collection. This included the right to withdraw all or partial elements of their participation and the limitations to withdrawal of consent following dissemination of the findings. Pseudonyms (both mothers' and children's names) have been used to ensure anonymity.

Participant	Gestational weeks	Days hospitalised (twins)
Amy	34	19
Zara	29	90
Kate	30	15

Table 2 Demographic information about the participants

Data Collection

Descriptions of lived experience, from which underlying patterns and structures of meaning are drawn (van Manen, 1997), were derived from one semi-structured interview from each participant. The interviews were conducted in locations that were convenient for the participants due to childcare needs. Amy and Kate were interviewed in their homes for approximately 50 minutes and 45 minutes respectively. Zara was interviewed for 80 minutes in a private area of a coffee shop. Time was taken to talk through the informed consent, sensitively and honestly answering their questions before they agreed to the research and signed a consent form. Three main questions were asked in all three interviews aimed at prominent memories of specific time frames and all remaining questions were guided by the experiences described. For example: "Can you describe your strongest memory of when you first touched your babies on the NICU"? Socratic questioning was used where emotive description arose: "Can you tell me a little more about that...what was that like"? Verbal and non-verbal communication was used throughout that employed warmth, empathy and respect for the participants. For example: "It's ok [softly]" (Amy)..."it really sounds important" (Zara)... "that sounds difficult...take your time" (Kate). Towards the end of the interview each mother was asked to give a brief summary of their positive experiences of being a mother in order to positively ground them. A copy of the debriefing information was given after the interview was concluded. All data was recorded on an unused iPhone 5 and an iPad as a back-up device. Both devices are password protected to ensure data protection and confidentiality.

Data Analysis

Initially, listening to the recordings several times allowed me to openly immerse myself within the participant narratives and note the initial sense of their experience (Finlay, 2014). The recorded data was then transcribed verbatim onto separate word documents with all personal information omitted. Prominent words, phrases and context were also noted during this time. The formal systematic reading of the transcripts and application of the *Epoché* then began. Finlay (2008, p.1), describes this process as: "a tango in which the researcher twists and glides through a series of improvised steps". The initial phase of the "dialectical dance" (Finlay, 2008, p.3), was to re-read each transcript with "fresh eyes", iteratively highlighting points of both individual variation and commonality within their contexts that were specific to mothering premature twins and chunking the overall sense of the descriptions. The transformation from descriptive components into more general meaningful themes was done by colour-coding and annotating the descriptions. I then stood back from the data for several days to return once again to re-read and repeat the process and allow the themes to evolve. Finlay (2008, p.29) suggests, that researchers should: "remain focused on the phenomenon being studied while both reining in and reflexively interrogating their own understandings". Such interrogation was done through using reflective journal notes, whilst imaginatively comparing my understanding of the implicit meanings drawn from the text and contrasting these meanings within the concrete examples of the participant's contextual description.

Analysis of these findings was then undertaken within the concept of the lifeworld. Van Manen (1990) refers to lifeworld themes as 'existentials', those which are particularly helpful in the reflective process of researching human experiences of lived space, body, time and relationships. Instead of offering a clear-cut and tidy end product, the lifeworld needs to be shown in its full ambiguity, irreducibility, contingency, mystery and ultimate indeterminacy (van Manen, 2011, cited in Finlay, 2014).

My attention to attempting to loosely follow van Manen's approach found expression in the writing up phase where I attempted to create an evocative text using language which captures some of the intensity and tone of the mothers' experience. A phenomenological text is most successful, van Manen (1990) argues, when readers feel directly addressed by it:

> Textual emotion, textual understanding can bring an otherwise sober-minded person (the reader but also the author) to tears and to a more deeply understood worldly engagement (1990, p. 129).

Ethical Considerations

This research was part of my undergraduate psychology honours degree with the Open University (United Kingdom) and received formal ethical approval and followed the guidelines set out by the British Psychological Society. To minimise any psychological distress from this potentially emotive subject, participants were recruited at 3+years postpartum, with no loss of pregnancy or born child and no signs or symptoms of Post-traumatic Stress Disorder as classified by the ICD-10 (World Health Organisation, 1993). My role as a researcher aside from my personal and professional life was discussed with participants and it was mutually agreed that they would only share information they were comfortable with. Breaks could be taken where needed and information was given on how they could access emotional support afterwards should they need to. A colleague of mine, who is a psychology graduate, practitioner, and a mother of a premature baby agreed to participate in a pilot interview. This was to employ ethical scientific integrity by preventing a genuine participant's contribution being devalued, as their data was not likely to be used in the final report.

Results

Three overarching themes emerged: *Conflict*: A twin motherhood in jeopardy; *Containment*: The conjuring of becoming a mother; *Balance*: A haunted motherhood in transition. These themes were drawn from the overall sense of the descriptions that depict a transitional experience from 'becoming' a new mother to 'being' a mother of premature twins. The findings will now be described below.

Conflict: A twin motherhood in jeopardy

The first experiences of the life supporting environment of the Neonatal Intensive Care Unit (NICU), provoke anxiety about "getting it wrong": "You don't know what you can touch and what you can't" (Amy). The perception of vulnerability also creates a reluctance to be close: "They are so fragile that you think that they are going to break if you touch them" (Zara), as well as frustration: "It's like Christmas as a kid... only not being able to play with your toys" (Kate). For Amy, the unexpected prematurity of motherhood within this space of illness and uncertainty, creates a conflict within the self as a new mother. This elicits a sense of detachment from her babies:

> It was like I was in a goldfish bowl and I was just looking through at this family that were just meeting their kids for the first time, like they weren't really mine... they were mine, but...they weren't, I was just sort of looking in. (Amy)

Touching their babies for the first time entwines this sense of space with a perceived vulnerability between their babies. A dilemma erupts within the self as a new mother between protecting the fragility of one baby and feeling guilty for neglecting the perceived strength of the other:

> When I touched Milo...the bond was stronger... [he] was all skin and bones...whereas, Rose was quite strong... I remember them coming home and thinking, God, how can I think that! (Amy)

> Your focus would go to the one that was really sick... so much focus had been on Jack, I remember feeling...like I had neglected Tom, like I had let him down somehow. (Zara)

> Lucy was a lot smaller than Ben which meant everyone gave her attention… "aww, she is so small"… but Ben was really poorly…even though one was smaller... I felt he needed protecting more. (Kate)

For Zara, her experiences of other neonates on the NICU brought about relief that *her* babies "didn't look like liver" (Zara). However, her encounter with another mother whose baby did not survive becomes internalised. The interweaving of shared space and premature motherhood reflects on the self, empathising through her own visceral sense of 'what if'. An imagined dilemma of loving one baby and losing the other:

> The space where this baby had been, was just empty and the baby had died...I remember just being absolutely heart-broken... that might be me... how do you focus on just one baby after that? (Zara)

Being rapidly thrown into the prematurity of motherhood and a space of the not right now, but at any moment (Heidegger, 1927/1996), alienates them from their sense of mothering. The entwining of space and others polarises their perception and the wholeness of pregnancy is now separated by a sense of guilt that weighs heavily on a fragile becoming of a twin motherhood in jeopardy.

Containment: The conjuring of becoming a mother

Immediately after the birth, the mothers did not see their babies for several hours and they longed to be close: "I didn't want them to be on their own... they had been inside me for so long, I just wanted them with me" (Amy). Despite the knowledge that they would receive specialised care: "I wanted someone who belonged to them to be with them" (Zara), "I wanted somebody that loved them...that really cared about them to be with them" (Kate). This was particularly significant for Zara, whose twins were in separate hospitals at one point:

"Whoever you were with, you were just feeling guilty about the other" (Zara). The bridging of the distance between the hospitals through close family, meant that: "I was alright with that" (Zara). Whilst the mother's experiences remain unstable, their sense of caring for each baby through their family system as an extension of the self, contains their need to be close.

Despite the babies still being attached to life supporting medical equipment, moving from the NICU into a private room contains their vulnerability:

> You could actually be mum and dad [others can] come into our little world and see what we have created [and we're no longer] on show with everybody looking at you and judging you (Amy).

> The nurses let me stay in a self-contained flat on the ward... it felt like I had got them... even though I wasn't home (Kate).

For Zara, her sense of containment was a "really homely" neonatal ward where "having two incubators together, meant that even if I was focussing on one, I wasn't that far away from the other" (Zara). When her twins were finally able to come home, she felt: "a feeling of loss... leaving this little bubble of the ward... my safe place" (Zara). The sense of safety represented by these spaces provides a degree of emotional containment, a slither of shielding from their self-awareness of vulnerability. An empowering space that fosters resilience.

The influence of 'breast is best' within the NICU saturates their sense of success and failure as a new mother: [expressing breast milk] "was one thing that I could control, it was my thing... if I couldn't produce milk... I have failed" (Zara). Two of the mother's encounter difficulties when they begin to feed and care for their babies during skin to skin contact. The sense of ability with one child contains their feelings of inability with the other and the initial strength of closeness to the more fragile baby jumps to the healthier baby:

> Rose was the loud screaming one all the time... everything was easier [she was] chunkier and it didn't matter as much. (Amy)

> Having another child that you could do those things with, the one that was doing a bit better, helped! You could still do something for someone even if you couldn't do it for them both. (Zara)

Zara also perceives that the healthier baby helps the sicker child: "It was like being together actually helped them!" For Kate, a sense of claiming her babies from the care of the hospital staff elicits self-efficacy:

> All I did was sit and look at them in the incubators for hours and hours through the day. I did all their cares as much as I could... I wouldn't let the ward staff feed them or change them. (Kate)

This sense of containment draws on their self-projection towards becoming a mother through their tools-at-hand. Utilising their 'being-with' of family relationships and their 'being-in' of safe space, promotes resilience against their anxieties (Heidegger, 1927/1996). The intentionality of doing something for someone when lacking control, elicits a sense of self-protection against their fragile beginnings of motherhood and drawn on what is available, and is tactically changed to create the illusion that something is happening (Heidegger, 1927/1996). A tangible conjuring of becoming a mother.

***Balance*: A haunted motherhood in transition**

Bringing the children home brings about a brief transitional period. From the conflict of feeling unsupported: "It's too hard, I can't do it" (Amy). To the containment of being able to mother: "feeling content because they were with me" (Kate). The containment of internal conflict evolves through time, now grounded within a conscious assurance of the present, a balancing within the self as a mother: "it's buy one get one free... we have a ready-made family" (Zara).

For Zara, the support of the district nurse "kind of weaned us off". Being freed from the barriers of incubation within the privacy of home, she attempts to overwrite her vulnerability of the past: "We are very cuddly... almost like I was compensating for the time when I couldn't do that". Although residual effects of the conflict between protection and neglect remain, her containment shifts to habituation as her young children continue to be hospitalised: "It's just completely different because... the other one is with [family]... [and] they will be fine... as long as they're with [family] I am alright". Her faded sense of separation provides room for assurance that she is able to care for both children. This validates her being of twin motherhood.

For Amy, the embodied wholeness of pregnancy is now divided by an intersubjective sense of closeness and distance between each twin as they grow. Her conflict between success and failure still echoes but is entwined with an interchangeable "pounding love" for each child that is activated through a reciprocal validation of motherhood. She describes a [not level but consistently back and forth] transaction between each child and balance results from the familiarity of this shared but separated love:

> I've never had a stage where they've both just been level. I have days where I am stronger to one or the other all of the time. Milo just looks up at me and said "mummy I wuv

> you"... ooof, you've just got me...Rose comes running with her arms open... and wants a cuddle... but Milo hangs back... doesn't want to speak to me... then I get the pounding love for Rose... It changes. (Amy)

Kate recalls the first few months after bringing her babies home: "I remember just sat holding them whilst I was sat in the window and had this feeling of just complete contentment". She enters a new world of containment:

> Sometimes I wouldn't come downstairs... we would just be upstairs locked away in the bedroom, it was a small space and more confined for just me and them... coming downstairs it opened it all up... I liked the bedroom... the smallness... my own small world. (Kate)

Although there is an established sense of balance: "my life began when I had children", there is also grief around adjusting to the loss of this temporal space where "I can make their bottles and put their nice fluffy blankets on them." Her being of twin motherhood through knowing her children is complicated by differences born of her initial perceptions on the NICU:

> I miss them as babies, but they start to want to sit up and then grow up. Although Lucy is still the smaller one, she shines... *a performer*... whereas Ben is more quiet, so I suppose I still have that soft spot for Ben... I don't want him to feel as though he isn't as loved. (Kate)

This entwining of the separation and connection of past conflict and the supportive structures of containment, in the process of having been, become present (Heidegger, 1927/1996). Their embodied validation of motherhood, barriers the haunting of failure, neglect and loss within their temporal *being* of *becoming* a mother of premature twins.

Discussion

Emotional conflict arises through the interweaving of space, touch and others on the NICU which elicits a sense of detachment as a mother. The perceived vulnerability and strength between their babies, separates their sense of closeness and is embodied as guilt. A need to be close is contained by supportive family relationships, safe spaces promote resilience, and their sense of doing something for someone elicits self-efficacy in becoming a mother. Their validation and familiarity of separated mothering becomes grounded through time, entwined with a haunting of their past conflict of prematurity, balancing their *being* of twin motherhood within their experiential present. These findings echo much of the similarities to the current research on the experiences of mothers of premature singletons. However, there are significant differences that involves the transition from mothers caring for two premature babies through to the development of their interaction with each twin as they grow.

Evaluation of Method

The premise for the theme of *Conflict* was 'Becoming a new mother' and draws initially on the overwhelming emotional impact of being thrown into a new and unfamiliar lifeworld. Whilst similar experiences of 'getting it wrong', detachment from their babies and longing to be close are described in Hall et al. (2012); Hall & Brinchmann (2009); Vaerland et al. (2018), the comparison of vulnerability between two babies jeopardises their sense of twin motherhood. Mixed methods research using large data sets of parents of multiples, suggest that a mother's perceptions of their twins affect their initial feelings (Goldberg, Perrotta, Minde & Corter, 1986 cited in Holditch-Davis & Roberts, 1999). Furthermore, mothers are often drawn to the smaller child (Holditch-Davis & Roberts, 1999). However, this research elucidates a more complex sense of embodied conflict between protection and neglect, as opposed to being drawn to one child and this impacts on their sense of becoming a mother. While focused on individual experiences, this research provides a rich experiential validity, situated within the concrete description of the mothers pre-reflective lived context and therefore elicits a deep human understanding of the phenomenon.

The theme of *Containment* draws on the combined elements of the lifeworld that support resilience in becoming a mother. Although similar experiences of coping through others, spaces, willing and agency were described in Erlandsson & Fagerberg (2005); Hagen et al. (2016); Hall et al. (2012); Vaerland et al. (2018), the ability to care for at least one of their children is also protective. Goldberg et al. (1986, cited Holditch-Davis & Roberts, 1999) suggest that the increased stress of having twins when one baby is sicker than the other leads to the mother preferring the easier/healthier child. However, the rich description gained through the phenomenological reduction probes multi-dimensional aspects of the lifeworld. This elicits a sense of caring for at least one child as protective to a fragile sense of esteem through their ability to mother, as opposed to a sense of preference. Therefore, a strength of this phenomenological method was the opportunity to elicit an individual sense of covert emotional functionality within their experiences. Furthermore, the higher prevalence rates of neonatal illness in premature babies (Ionio et al., 2016), also suggests that lifeworld description may offer a reliable context on which to further consider the findings of quantitative studies on mothers of multiples.

Finally, the theme of *Balance* draws on the habituation of growing into their role as a mother and supports earlier

research by Erlandsson and Fagerberg (2005) and Hall et al. (2012). However, this differs through the sense of separated-ness of being a mother to two babies, entwined with a haunting of a prior sense of self that is complicated by prematurity. Goldberg et al. (1986, cited Holditch-Davis & Roberts, 1999) claims that there are no general interactional differences between mothers of multiples and their children compared to mothers of singletons. Although, some mothers of twins feel closer to one of the children and this can be interchangeable (Minde, Corter, Goldberg, & Jeffers, 1990 cited in Holditch-Davis & Roberts, 1999). Whilst the description of shared but separated love is congruent with aspects of this prior research, the strength of the phenomenological approach here, is the highlighting of idiographic complexities [related to individual cases] within the dyadic transactions between a mother and each of her premature twins. Therefore, without understanding the individual relational contexts that may affect mothers of premature twins, there is a significant potential for clinicians to lack recognition of emotional and psychological distress in these new mothers.

Strengths and Limitations

During the interview process, I felt distinctly conflicted between my personal and professional roles at times, due to concerns that the participants would feel uncomfortable in sharing their honest experiences. However, drawing on the listening skills from my professional training, such as eye contact, open body language and subtle gestures, helped to establish a sense of mutual psychological safety through which to sensitively explore their descriptions.

Also, the reflexivity within this research is multi-dimensional. Firstly, I am male with no children of my own, I had assumed at the outset of this research that this would help me to stand back in some way as a more neutral observer, allowing the themes to emerge as a natural process. However, I also have my own personal relationships with each participant and their children, hearing the first-hand accounts of their experiences connected with me at a deep and unexpected emotional level, providing a very different context to my own lived experience of the memories they described. This made me more alert to the potential of my own emotional impact on the selection of data contributing to each theme.

Finally, I work as a professional low-intensity practitioner within an IAPT service, as I worked through the data, I began to recognise many similarities in both the language and descriptions of their emotional distress to those described by patients seen in my clinical role. This influenced the direction of my research from simply describing experience, to how these experiences are situated within a wider psychotherapeutic context.

This all posed several challenges for successful bracketing. During the analysis I noted in a reflective journal where there was temptation to frame their descriptions within my own experiential dimensions, whilst also reflecting on where new understanding was found. My own memories of one of the mothers interacting with her twins on the NICU shortly after the birth, are now surreal and promote a sense of guilt for not recognising her emotional conflict during that time. Furthermore, the depth of analysis during the review of recent literature also had the potential to overshadow my openness to hearing the participants with new ears. Whilst the data analysis did generate some commonalities with the recent literature, the immersion within the unfamiliar newness of their lived experiences provided a lens to *see* differently.

The interview with Zara could have been better controlled at times due to my becoming absorbed in her story. This generated lengthy description of events and reflective rather than pre-reflective accounts on occasion. Whilst providing a situated context, it also raised ethical consideration around the verbal contracting to discussing specific memories across the timeline. In addition, mothers can feel ashamed when acknowledging differences in feelings towards their children (Bryan, 2003). On reflection, the depth of questioning around their interactions with each twin was driven by a research interest. Therefore, the potential impact on the wellbeing of participants in future research is also a concern for ethical consideration.

It also needs to be recognised that this was a small-scale undergraduate project. I was learning how to do phenomenology and I am a relative novice when it comes to research. Whilst I believe I have managed to capture some lifeworld dimensions in an in-depth and appropriately phenomenological way, the findings remain partial, tentative, emergent and still open to further work. It could be argued that my use of loosely engaging van Manen's approach did not do justice to his ideas. A researcher with more experience and expertise would engage more specifically with hermeneutic phenomenological methodology and philosophy.

Recommendations for Further Research

Whilst this small sample of British mothers has drawn out rich and valuable experience, a larger and more diverse sample size would likely produce broader data on which to compare and clarify the emergent themes. Using a mixed participant sample of new mothers who present with both clinical and sub-clinical symptoms on the *PHQ-9* and *GAD-7* may also provide a deeper understanding of commonalities and differences that may be impacted by the choice of psychotherapeutic assessment and intervention. This may also enhance further qualitative and quantitative approaches in this field.

Professional Implications

The implications of these findings offer reflection on the complex difficulties that impact on the emotional and psychological wellbeing of new mothers of premature twins. These difficulties undoubtedly complicate their early interactions with each baby. Their relationships and environments that support resilience stem from an entwining of multiple lifeworld dimensions that are implicitly layered within the fabric of these mothers' experiences. These complex textures are woven through their dyadic transactions, creating unique contexts that impact on their sense of esteem and bonding with each child. Therefore, new mothers experiencing emotional distress stemming from a separated motherhood may present with atypical symptoms on standardised psychometric measures of anxiety and depression, and currently risk being excluded from primary care services. Using standardised low-intensity assessment for new mothers of multiples without being informed by individual contexts, may also limit new mothers from being directed towards appropriate treatment modalities, leading to ineffective outcomes. Initial assessments by clinicians trained in relational and interpersonal therapies that are informed by the experiential contexts of mothers of multiple births, may be better positioned to explore the complexities that affect wellbeing. Further research focussing on the interpersonal contexts of these mothers may generate new understandings of complexity and difference that inform future policy and practice.

Conclusion

The sense of experience drawn from this research shows something of the experiential context for mothers of premature twins presenting to primary care psychological services within their perinatal period. Emotional conflict arises from their new motherhood creating an emotional detachment that alienates them from their babies. Their fragile sense of coping is drawn from safe spaces, supportive relationships, and the conjuring of agency from being able to care for at least one baby. Haunted by the emotional conflict of premature birth within the familiarity of a new but separated motherhood, their validation of mothering stems from the familiarity of their individual and complex relationships with each twin. These experiences generate a unique lens through which to view contexts that may differ from those of mothers of premature singletons through the bracketing of preconception and assumption. It provides a signposting for further exploration of individual contexts where relational and interpersonal psychotherapeutic approaches may promote more inclusive and appropriate access to psychological wellbeing interventions for women in their perinatal period.

References

Arnold, L., Sawyer, A., Rabe, H., Abbott, J., Gyte, G., Duley, L., & Ayers, S. (2013). Parents' first moments with their very preterm babies: A qualitative study. *BMJ Open 3*(4), 1-8. Retrieved from http://bmjopen.bmj.com/content/3/4/e002487

Bryan, E. (2003). The impact of multiple preterm births on the family. *International Journal of Obstetrics and Gynaecology, 110,* 24–28.

Erlandsson, K., & Fagerberg, I. (2005). Mothers' lived experiences of co-care and part-care after birth, and their strong desire to be close to their baby. *Journal of Midwifery*, *21*(2), 131-138.

Finlay, L. (2008). A dance between the reduction and reflexivity: Explicating the "phenomenological psychological attitude". *Journal of Phenomenological Psychology, 39,* 1-32. Retrieved from http://booksandjournals.brillonline.com.libezproxy.open.ac.uk/content/journals/10.1163/156916208x311601

Finlay, L. (2014). Engaging phenomenological analysis. *Qualitative Research in Psychology, 11*(2), 121-141.

Goldberg, S., Perrotta, M., Minde, K., & Corter, M. (1986). Maternal behavior and attachment in low-birth-weight twins and singletons. *Child Development, 57,* 34-46.

Goodman, J.H., Prager, J., Goldstein, R., & Freeman, M. (2015). Perinatal dyadic psychotherapy for postpartum depression: A randomized controlled pilot trial. *Arch Womens Mental Health, 18,* 493-506.

Hagen, I.H., Iversen, V.C., & Svindseth, M.F. (2016). Differences and similarities between mothers and fathers of premature children: A qualitative study of parents" coping experiences in a neonatal intensive care unit. *BMC pediatrics, 16*(1), 631-639.

Hall, E.O.C., & Brinchmann, B.S. (2009). Mothers of preterm infants: Experiences of space, tone and transfer in the neonatal care unit. *Journal of Neonatal Nursing, 15,* 129-136.

Hall, E.O.C., Kronborg, H., Aagaard, H., & Brinchmann, B. S. (2012). The journey towards motherhood after a very preterm birth: Mothers" experiences in hospital and after home-coming. *Journal of Neonatal Nursing, 19,* 109-113.

Heidegger, M. (1996). *Being and time: A translation of Sein und Zeit.* (J. Stambaugh, Trans.). Albany, State University of New York Press. (Original work published 1927).

Holditch-Davis, D., Roberts, D., & Sandelowski, M. (1999). Early parental interactions with and perceptions of multiple birth infants. *Journal of Advanced Nursing*, *30*(1), 200-210.

Improving access to psychological therapies (2013). Perinatal positive practice guide. *Department of Health*, 1-14. Retrieved from https://www.uea.ac.uk/documents/246046/11919343/perinatal-positive-practice-guide-2013.pdf/aa054d07-2e0d-4942-a21f-38fba2cbcceb

Ionio, C., Colombo, C., Brazzoduro, V., Mascheroni, E., Confalonieri, E., Castoldi, F., & Lista, G. (2016). Mothers and fathers in NICU: The impact of preterm birth on parental distress. *Europe's Journal of Psychology*, *12*(4), 604–621.

Kroenke K., Spitzer R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, *16*(9), 606-613.

Langdridge, D. (2016). Why focus on experience? Introducing phenomenological psychology. In H. Ness., H. Kaye., P. Stenner (Ed.), *Investigating Psychology 3* (pp. 347-388). Milton Keynes, UK: Open University Press.

Marchesi, C., Ossola, P., Amerio, A., Daniel, B.D., Tonna, M., & De Panfilis, C. (2016). Clinical management of perinatal anxiety disorders: A systematic review. *Journal of Affective Disorders, 190,* 543-550.

Minde, K., Corter, C., Goldberg, S., & Jeffers, D. (1990). Maternal preference between premature twins up to age four. *Journal of the American Academy of Child & Adolescent Psychiatry*, *29*(3), 367-374.

National Collaborating Centre for Mental Health (2018). *The Improving Access to Psychological Therapies Manual*, 1-73. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2018/06/the-iapt-manual.pdf

National Institute of Health and Care Excellence (2014). *Clinical Guideline 192. Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance*. Retrieved from https://www.nice.org.uk/guidance/cg192

Office of National Statistics (2016). *Births in England and Wales by Characteristics of Birth.* Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthcharacteristicsinenglandandwales

Lenze, S, N., Rodgers, J., & Luby, J. (2015). A pilot, exploratory report on dyadic interpersonal psychotherapy for perinatal depression. *Arch Womens Mental Health, 18*, 485-491.

Spitzer, R, L., Kroenke, K., Williams, J, B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Arch Intern Med, 10,* 1097-1092.

Stenner, P., & Lazard, L. (2016). Why use text-based qualitative methodologies? The phenomenology and social construction of jealousy. In H. Ness., H. Kaye., & P. Stenner (Eds.), *Investigating Psychology 3* (pp. 299-346). Milton Keynes, UK: Open University Press.

Værland, I.E., Vevatne, K., & Brinchmann, B.S. (2018). Mothers' experiences of having a premature infant due to pre-eclampsia. *Scandinavian Journal of Caring Sciences, 32,* 527-534.

van Manen, M. (1990). *Researching lived experience. Human science for an action sensitive pedagogy*. Albany: State University of New York Press.

van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy* (2nd edition). London: The Althouse Press.

van Manen, M. (2011). *The heuristic reduction: Wonder*. Retrieved from https://www.phenomenologyonline.com/inquiry/methodology/reductio/heuristic-reduction/

van Manen, M. (2014). *Phenomenology of practice*. California, CA: Left Coast Press.

World Health Organisation. (1993). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines.* Geneva: World Health Organisation.

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James Spiers spent his early career working in the banking and retail industry and began a part-time undergraduate psychology degree with the Open University (UK) in 2013. In 2015, he became a full-time recovery worker for the NHS within specialist inpatient and community mental health services. In 2017 he completed a post-graduate certificate in low intensity psychological interventions with the University of Sheffield, UK and graduated from the Open University in 2018. He currently works as a qualified Psychological Wellbeing Practitioner within the Sheffield Health and Social Care NHS Foundation Trust, treating common mental health problems with Cognitive Behavioural Therapy based interventions. James has a special interest in working with socially diverse and marginalised communities to promote inclusive access to mental healthcare.