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**Portfolio for Professional Doctorate in
Counselling Psychology (DPsych)**

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Submitted August 2008

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City University Declaration

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Preface

The preface will introduce the various components of the Doctoral Thesis Portfolio. The portfolio focuses on three different areas related to the topic of body image and to the practice of counselling psychology. Firstly there is an exploratory piece of research focusing on the experience of the body and body image in a particular group of women. Secondly, a case study presents a reflexive exploration of the clinical journey undertaken with a client with Binge-eating Disorder (BED). BED is an eating disorder often associated with disturbed body image, although in this particular case the focus of the work was on other areas. Finally, there is a critical review of the literature that explores Body Dysmorphic Disorder (BDD) from a counselling psychology perspective. BDD is characterised by a preoccupation with an imagined defect in appearance. An overview of each piece of work will now be presented explaining more fully the area that it covers and its aims and objectives. The preface will then be concluded with a summary of how the pieces are connected by a more personal theme.

Part 1: The research

This section consists of an original piece of research that aims to explore in-depth the lived experience of the body and body image in women in the postpartum period. The study uses semi-structured interview data gathered from a homogenous sample of eight women who have given birth to their first child. In all cases the child was less than one year old. The data is analysed using the qualitative methodology of Interpretative Phenomenological Analysis (IPA). The research focuses particularly on the influences that might impact upon the women's experience of their bodies and body image during this time. Further attention is given to the meaning and implications of bodily changes experienced by this group of women in the year after giving birth. The analysis is discussed in the light of theoretical insights gained as well as the extant empirical literature. Implications for the clinical practice of counselling psychology are identified and discussed.

Part 2: Professional practice

This section contains an example of clinical work in the form of a case study. The focus here is on the professional practice of counselling psychology. The aim of this piece is therefore to demonstrate competence in my chosen therapeutic model through showing a sound knowledge of theory and its application to practice. The study is a summary of

the main aspects of the collaborative work between client and therapist¹ over the course of 24 sessions of cognitive behavioural therapy. The client's difficulties are formulated within the model and evidence of critical reflection on clinical practice is presented. It aims to provide an account of my clinical skills, including the ability to integrate theoretical concepts with practice, and personal and professional self-awareness.

The case study presents work with a female client who has Binge-eating Disorder. This particular case was chosen as it is a good example of how a case formulation may be used to enable a shared understanding of the client's difficulties and maintaining processes. In addition to this, such a formulation can guide the application of theory to clinical practice. I found this process particularly useful in this case to assist in treatment planning and the selection of appropriate interventions. Furthermore, this particular case reflects my own process in terms of my development as a clinician.

Part 3: Critical literature review

The aim of this section is to present a systematic and critical appraisal of the literature on a topic relevant to the practice of counselling psychology. The topic chosen is that of Body Dysmorphic Disorder (BDD) from the perspective of counselling psychology. BDD is a disorder that features distortion of some element of an individual's body image, typically the face. The review explores the diagnosis, clinical features and prevalence of BDD along with comorbidities that may be associated with this condition. Clinical and subclinical BDD are considered in terms of the likelihood that counselling psychologists may well encounter either due to their estimated prevalence in the population. Finally, the literature pertaining to current psychological treatments for BDD is reviewed. Implications for counselling psychologists are highlighted throughout the review as each theme is discussed.

Thematic connection for the portfolio

The portfolio represents the culmination of three years of training both as a counselling psychologist and as a researcher. In many ways it represents a journey that I have travelled throughout this process. In keeping with this, the thematic connection that ties the pieces together is a reflection of this experience, in addition to being directly related

¹ The terms "counselling psychologist", "therapist", "psychologist" and "clinician" will be used interchangeably throughout the report.

to the content of all three pieces. The link is that of self-concept and the reconceptualisation of the self.

Body Dysmorphic Disorder is characterised by a preoccupation with an imagined defect in physical appearance. As such it could be argued to demonstrate that the ways in which we perceive ourselves are not always accurate. This raises the possibility that our self-perception and self-concept may not necessarily be fixed; it is possible that they might be fluid or flexible and that the self can be reconceptualised. In some sense this concept is central to the very idea of therapy itself: that an individual has the ability to change. On another level, the critical literature review was written at the very beginning of my journey through the doctoral research. In its original and unedited form I was struck by how it seemed to represent a different me, a student with a very different epistemological standpoint and view of science and practice to the person I am now. In its current form it represents my reconceptualisation away from my positivist roots to a new, different and more sophisticated understanding of philosophy, epistemology and ontology.

The case study details the experience of a therapeutic journey for both client and therapist. This particular piece of work was mutually significant and a parallel process is described; the client developed a stronger sense of self, realising her potential to change. I, on the other hand, gained the valuable insight that I have developed a stronger sense of myself as a cognitive behavioural therapist. This was something that had eluded me up until this point and at the time it was vital to my self-concept as I approached the end of my training and the transition to chartered counselling psychologist.

Finally, the doctoral research explores the lived experience the body and body image in a particular group of women during a transitional time in their lives. The transition to motherhood is significant for these women and the notion of self-concept emerged from their accounts as being a central aspect during this period. Both childbearing and body image emerged as having considerable impact upon their self-concept. There was clear evidence of the women reconceptualising themselves as mothers. Again I felt a parallel process whereby I am also at a significant time of transition and have developed a new sense of self as a qualitative researcher.

In this way, the portfolio represents my reconceptualisation over the last three years, both as a counselling psychologist and as a qualitative researcher.

Part 1: The research

Understanding women's experience of their bodies and body image in the postpartum year: An interpretative phenomenological analysis

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Abstract

Research into body image in women in the first year after birth is contradictory and mainly quantitative in nature. In response to these inconsistencies and the paucity of qualitative research in this area, this study has investigated the lived experience of the body and body image in women during the postpartum year. The study was conducted using semi-structured interview data analysed using the qualitative methodology of Interpretative Phenomenological Analysis (IPA). Participants were eight women, aged between 33 and 40 years of age, who have given birth to their first child. Three superordinate themes emerged from the interview data: the body, self and others; the body in cultural context; and the body as perceived and lived. The women's experience supports the notion of body image being a complex and multi-faceted construct that is firmly embedded in their lifeworld. A compelling embodied dimension also emerged from the accounts and their experience was found to be fundamentally relational in nature. Influences impacting upon the women's experience of their body and body image were also found to be complex, multifactorial and embedded in the lifeworld. Integration of the bodily changes accompanying childbearing appears to be facilitated through the women's reconceptualisation of themselves as mothers. The notion of the self emerged as an important aspect of the women's experience during this time of transition. A rich description of the women's experience of their bodies and body image in the postpartum period is therefore presented. It is argued that the study provides insights into this lived experience that may be useful for counselling psychologists when working with this group, and other women, at this important transitional stage in life.

Introduction

Body Image

The concept of body image, its nature and significance, has been examined and theorized upon by philosophers, medics and psychologists since the 1930s. Over the past 50 years, body image research, as demonstrated via the literature, has expanded significantly. The last two decades in particular were central to the modern development of body image research, with extensive exploration in the field, within a wide variety of contexts. Body image is multidimensional and has multidisciplinary relevance (Pruzinsky & Cash, 2002).

Body image plays a crucial role in human experience: it has the capacity to affect our quality of life, impacting upon our emotions, thoughts and behaviours and influencing our relationships, both intimate and otherwise. It is multidimensional and incredibly complex, with a vast array of descriptive terminology, making a definitive definition very difficult due to its many facets (Pruzinsky & Cash, 2002).

Body image is therefore operationally defined in diverse ways, depending on the precise area of interest and the objective of the researcher (Grogan, 2006). It is widely accepted, however, that body image embraces a range of behavioural, perceptual, cognitive and affective phenomena (Pruzinsky & Cash, 2002). In its simplest form, body image could be defined as referring to the internal representation that an individual has of his or her outer appearance. Body image may also be described as encompassing the perceptions, attitudes, thoughts, beliefs, feelings and behaviours related to the body (Cash, 2004).

Body image and body image concerns are important as they are an aspect of self-image, and body image disturbances have been linked to low self-esteem (Tiggeman, 1994). Research into eating disorders conducted over the last 20 years has concentrated on the association between eating behaviour and body image concerns, and has found that body dissatisfaction is a powerful risk factor for disordered eating (Thompson, Heinberg, Altabe & Tantleff-Dunn, 1999). Research into body image across the lifespan has indicated that body image concerns occur throughout development: increasingly beginning in childhood, becoming most pronounced in adolescence and young adulthood, and continuing throughout adulthood (Striegel-Moore & Franko, 2002).

Body Image in pregnancy and postpartum

Pregnancy and the postpartum period are a time when women experience significant changes in their bodies' weight and shape. It is therefore unsurprising that studies have identified considerable fluctuations in body image and greater body image concerns during these periods in some women (Heinberg & Guarda, 2002).

Pregnancy

The rapid physical changes experienced by a woman throughout pregnancy include significant increases in weight and alteration in body shape. Typically, a woman will gain 25-35 pounds or more during this nine month period. Pregnancy is therefore, unsurprisingly, a time during which women experience changes in their body image (Heinberg & Guarda, 2002).

Research thus far is mainly of a quantitative nature and presents a mixed picture regarding women's responses to these weight and shape changes. Responses range from the positive to the negative. For example, Clark and Ogden (1999) found that pregnant women were less dissatisfied with their body image than non-pregnant women. In addition, Davies and Wardle (1994) found that pregnant women were more accepting of body size compared to non-pregnant controls, with lower body dissatisfaction scores. In contrast, other researchers such as Drake, Verlhurst, Fawcett and Barger (1988) and Strang and Sullivan (1985), have suggested that women's body image becomes increasingly negative during pregnancy. Positive feelings towards body changes in pregnancy have been suggested to arise from decreased emphasis on an idealised prepregnancy body image (Clark & Ogden, 1999), lower levels of dietary restraint and a greater acceptance of body size (Davies & Wardle, 1994). It has also been suggested that this acceptance of body changes during pregnancy may be due to a woman's maternal role being associated with a reduction in pressure to achieve body shape ideals (Davies & Wardle, 1994).

Fox and Yamaguchi (1997) conducted an interesting study that investigated body image changes during pregnancy in both normal and overweight women. They used a combination of quantitative and qualitative methods and found that changes in body image were frequent in their sample of women having their first child. These changes appeared to be related to prepregnancy weight status. Women who were normal weight before pregnancy generally experienced a more negative body image during pregnancy.

This increase in negative feelings about body image was related to themes of increased weight concerns, increased self-consciousness and feeling less physically attractive. The authors hypothesize that this negative change may be due to the discrepancy between pregnant body shape and idealised body shape. Women who were overweight before pregnancy, in contrast, generally experienced a more positive body image during pregnancy. Themes that arose were a reduction in feeling self-conscious, along with a reduction in stigma and pressure to diet. The authors attribute this to reduced pressure to achieve the idealised body shape due to being pregnant. Consistent with this, Skouteris, Carr, Wertheim, Paxton and Duncombe (2005) conducted a prospective study of factors leading to body dissatisfaction during pregnancy and found that prepregnancy body image strongly predicted body image in late pregnancy.

There is an apparent scarcity of qualitative research regarding body image during pregnancy, with most studies being quantitative in nature. A qualitative study that does investigate the impact of bodily changes during pregnancy for first-time mothers-to-be, however, is that by Johnson, Burrows and Williamson (2004). It was conducted using Interpretative Phenomenological Analysis (IPA) and Foucauldian Discourse Analysis (FDA) on interview data from a sample of six participants.

The study found a complex picture of women's experience during this time that was context-dependent. Bodily changes were described as broader ranging than is usual in the literature and included issues such as disrupted physical boundaries, physical restrictions and internal sensations (Johnson et al., 2004, p.366). Three themes were identified in the IPA: the dynamic nature of body satisfaction during pregnancy, the varied impact of pregnancy on perceptions of the body and the changing boundaries surrounding the body. Three discursive constructions of bodily changes were also reported from the FDA. These were located in the wider discourse of femininity and were described as: pregnancy as transgressing dominant ideals for feminine beauty, pregnancy as legitimizing the transgression of idealized beauty and pregnancy as transgressing usual boundaries. The authors link the discursive constructions to the IPA and discuss their location in the wider discourse. Specific contexts and positionings are also considered along with the implications of both of these in terms of how the women manage their experience.

Limitations of this study include the fact that the sample was small in size and had very specific, homogenous demographics which will limit the generalisability of the findings. The authors also acknowledge that the findings are context-specific that can only reveal something of the participants' current positioning in our particular culture and for that specific group. The value of this particular study, however, is the great contribution it makes to a more detailed and in-depth understanding of women's lived experience of the impact of the dramatic bodily changes associated with pregnancy. In addition, it sheds light on how the bodily changes are constructed by these mothers-to-be, the impact of these discursive constructions upon these women and their ways-of-being, and how this shapes their experience. The use of both methodologies to investigate the interview data from these participants allows the phenomenon to be examined in ways that are different yet complementary, thus giving a much broader, deeper and more valuable picture.

Postpartum

There is a small body of literature relating to body image in the postpartum period. The findings, however, are contradictory and therefore open to debate. Some research presents a picture of women feeling satisfied with their body image in the postpartum (e.g., Strang & Sullivan, 1985) while other studies found the opposite (e.g., Hisner, 1986). In addition to this, the relevance of participants' postpartum body image in their lives differs, with some researchers arguing that this is of greater concern and salience (e.g., Hiser, 1986) than others (e.g., Jordan, Capdevila & Johnson, 2005).

Strang and Sullivan (1985) measured 63 postpartal women's attitudes toward body image at two and six weeks postpartum in western Canada. The sample age range was from 20 to 37 years old. The Attitude to Body Image Scale (ABIS) was used as the assessment tool. This measured "the degree and direction of feelings towards one's body in the prepregnancy, pregnancy and postpartal periods" (Strang & Sullivan, 1985, p.333) using ratings of ten body parts (e.g. waist, hips) on a Likert-type scale. Content validity of the ABIS was assessed through consultation with three experts in the fields of statistics, community health nursing and maternal-child nursing, as it was a modification of Jourard and Secourd's Body Cathexis Scale (BCS: 1955). A test-retest method with a four week interval was utilised, reporting reliability coefficients (Cronbach's alpha) from 0.76 to 0.90. This indicates good reliability for this study,

particularly as the scale has only ten items (Pallant, 2003). A group of 32 non-pregnant participants were used as controls.

The researchers found that 70% of participants had a slightly positive attitude to their body image at both two and six weeks postpartum. Around 27% of the sample had a neutral attitude and 3% were found to have a negative attitude. The authors interpreted this finding as implying that postpartal women may not be so concerned about the physical appearance of their body. They did find, however, that participants felt more negative about their body image during the pregnancy and postpartum than before the pregnancy. Furthermore, the study found that participants felt more positive about their body image in the postpartum period than during the final trimester of pregnancy.

Criticisms of the study could include the fact that the pregnancy and prepregnancy data was gathered retrospectively at the second week postpartum and this may have been unreliable due to the possible inaccuracy of retrospective recall. The authors acknowledge that this may have given rise to a more positive rating of prepregnant body image than if this had been assessed before pregnancy. The testing times were also early in the postpartum period which may question the utility of the findings as the women's bodies may still be adjusting following delivery. In addition, the assessment tool used was a modification and, although the researchers made considerable efforts to check validity of content and reliability, it did not have the benefit of being fully validated and reliable.

Research by Drake et al. (1988) examined the relationship between couples' strength of identification, similarities in their patterns of change in perceived body space and global body attitude during pregnancy and the postpartum. As part of the results the authors report that, although the women's body image becomes increasingly negative during pregnancy, it changes in the postpartum period to become more positive. Twenty participant couples were tested and the women were aged between 22 and 34 years old with a mean age of 27.45 years. The measure used was the Body Attitude Scale (BAS) which is purported to measure global body attitude. This was thought to represent "the attitudinal dimension of body image" (Drake et al., 1988, p.89). Cronbach's alpha reliability coefficient was reported as ranging between 0.92 to 0.96 for the measure indicating good reliability for this sample (Pallant, 2003). The couples were tested at the third, sixth and ninth month of pregnancy and at the first and second month of the

postpartum period. Limitations of this study are the small sample size which limits generalisability, the fact that the sample was a mixture of primipara² and multipara³ and early testing points in the postpartum period.

In a more recent study, Morin, Brogan and Flavin (2002) addressed the lack of research into African American women's postpartum body image in particular, therefore focusing on possible cultural differences. This study used a sample of 42 African American women aged between 18 and 45 years old, with data collected between 24 to 48 hours after birth. The assessment instrument used was the ABIS as used by Strang and Sullivan (1985), reporting a Cronbach's alpha reliability coefficient of 0.86 with this tool for this study. This indicates good reliability with this particular sample (Pallant, 2003). In addition, a modified topographic device was used to measure perceived body space as a reflection of the perceptual component of body image, as in a study by Fawcett, Bliss-Holtz, Haas, Leventhal and Rubin (1986) and in Drake et al. (1988). Fawcett et al. (1986) reported test-retest reliability coefficients over one week of 0.64 using this instrument, thus indicating only moderate reliability (Pallant, 2003).

The researchers found that all participants in the sample had slightly positive attitudes toward their bodies immediately postpartum. This is strikingly consistent with Strang and Sullivan (1985). All 42 women also perceived themselves as larger than they really were according to the topographic device measurements of perceived and actual space occupied. The authors attribute this finding to the possibility of lax abdominal muscles contributing to the misperception of space occupied. They suggest that this may be due to the data being collected so soon after birth when muscle tone is poor. This is supported by the fact that the least positive attitude measured was that regarding the abdomen.

Limitations of the study include the limited sample size and lack of generalisability of results due to its specialised nature. The proximity of testing to delivery could also be argued to limit the utility of the results. In addition, the strikingly similar slightly positive results reported in both of the investigations could be an artefact due to the use of the modified ABIS. Both studies reported good reliability for this assessment tool, but there may nonetheless be a possibility that the validity was questionable. As these

² Primipara are women who have had only one child

³ Multipara are women who have had more than one child

studies both reported positive body image postpartum, and they used the same modified assessment tool, it is pertinent to draw the reader's attention to these points. Moreover, this result would be expected, further questioning its utility, given that the women would have certainly been smaller in size immediately following delivery. It is possible that the size difference may have held increased salience for these women given the proximity of testing to delivery.

Interestingly, a point raised by Morin et al. (2002) is that family and friends make an important contribution to African American women's body image through their reactions and responses, however, a measure of this was not incorporated into their research. It is in fact unusual to find research into postpartum body image that considers other influential factors.

Other research suggests that women in the postpartal period tend to experience a more negative body image. Hisner (1986) conducted a study investigating the concerns of 20 multipara aged between 18 and 35 years during the second postpartum week. The study used a 62 item card-sort tool and the authors suggest that the frequency of sorting specific items indicates areas of concern for the mothers. Eighty percent of the women sorted a concern around meeting the needs of the family. Seventy five percent of the mothers sorted a concern about their weight and 70% listed shape of figure and return of figure to normal (prepregnant figure) as a concern. This suggests that body image and weight concerns were prevalent within this sample. Limitations of the study acknowledged by the author include a lack of generalisability due to the small sample size and sample specificity. In addition, the degree of concern reported was subject to individual interpretation of the card-sort items and was therefore subjective.

Stein and Fairburn (1996) examined changes in women's eating habits and attitudes in the six months postpartum. Their sample consisted of 92 participants, with a mean age of 26.6 years old, taken from the general population in Oxford, UK. It consisted of primigravid females (i.e., pregnant for the first time), so that they had no prior experience of the weight and shape changes associated with pregnancy and postpartum. The assessment tool utilised was the Eating Disorder Examination (EDE). This is reported by the researchers to be a well validated and established interview assessment tool containing measures regarding concerns about eating, shape and weight. The advantages of this study are therefore that it is prospective rather than retrospective,

conducted using a community cohort and that it was confined to primigravid women who were assessed at both three and six months postpartum. A disadvantage is again the relatively small sample size that may limit the generalisability of the findings.

Although their study focused on eating disorder psychopathology, the researchers also report that the level of concern over shape manifestly increased to a peak at three months postpartum, and then decreased significantly in the subsequent three months. Concern regarding weight, however, continued to rise over the six month postpartal period to well above prepregnancy levels. The findings show that, between three and six months postpartum, the women's weight reduced considerably. However, at six months postpartum, weight was still greater than prepregnancy. The authors attribute the continued rise in weight concern to this enduring overall weight gain. They report many women commenting that they were astonished at the extent of the enduring weight gain and changes in body shape, and had not expected them to be so persistent.

Another investigation that has contributed to knowledge in this area is that of Wood Baker, Carter, Cohen and Brownell (1999). They investigated global and specific components of eating attitudes and behaviours in pregnancy and at four months postpartum. In doing so, the researchers also assessed weight and shape satisfaction at these points. The sample was comprised of 90 women with a mean age of 30.4 years. Forty five percent of the women were having their first child. Two measures were used: the first was the Eating Attitudes Test (EAT), a 26-item self-report measure used to identify eating disturbances in a non-clinical population. Cronbach's alpha was reported as ranging from 0.77 to 0.82, indicating good reliability in this particular study (Pallant, 2003), and criterion validity (eating disorders versus controls) was reported as acceptable. This measure was administered during pregnancy and at four months postpartum. The other measure used was a Satisfaction and Dieting Scale which was administered only at the second testing. This inquired about current postpartum weight, dieting behaviour and weight and shape satisfaction as well as retrospectively assessing these features in prepregnancy and pregnancy. Weight and shape satisfaction were rated on a Likert-type scale.

The study found that participants' body mass index (BMI) at four months postpartum was significantly higher than the prepregnancy BMI. In addition, participants were more satisfied with their weight and shape during pregnancy than postpartum. Seventy

percent of participants were trying to lose weight postpartum. The authors argue that the greater satisfaction with weight and shape during pregnancy may arise due to a different response to weight gain during this period. The new maternal role may allow women to prioritise appearance and body image less, and bodily changes and weight gain may be considered a sign of infant growth and maternal nurturance, making them more acceptable. In addition, societal expectations may be relaxed, making weight gain more acceptable. Less satisfaction with weight and shape in the postpartum period may reflect the fact that women can no longer justify the added weight from the pregnancy. They can no longer attribute the weight and shape changes to the positive aspects of supporting the pregnancy, and the authors contend that this may have contributed to the large percentage of participants trying to lose weight postpartum. In addition, they note that women who self-identify as dieting prior to pregnancy may be more likely to experience dissatisfaction with their bodies postpartally.

Limitations of this study include the retrospective reporting of weight and shape measures from prepregnancy and pregnancy that may be unreliable, a lack of generalisability of the findings due to the relatively small sample size and a high rate of attrition between the two assessments. Furthermore, the assessment tool for Satisfaction and Dieting was not an established measure but was a Likert-type scale with no indication of reliability or validity stated by the authors.

Other related research investigates weight and weight concerns specifically, as opposed to body image itself. For example, Jenkin and Tiggemann (1997) conducted a study investigating the psychological effects of weight retained after pregnancy. They obtained self-report data at four weeks before birth and four weeks after birth from a sample of 92 primiparous women with a mean age of 25.6 years. The information gathered at both points included weight as well as responses to a body weight and shape satisfaction scale, a self-esteem measure and a measure of depressive affect. Body weight and shape satisfaction was measured on a five point Likert-type scale that was not a recognized measure. Established measures were used, however, to assess self-esteem and depressive affect. The researchers reported reliability coefficients of 0.86 and 0.75 respectively for the sample, indicating good reliability on these measures (Pallant, 2003).

As might be expected, the researchers found that the women weighed more and were less satisfied with their weight and shape at four weeks postpartum than before becoming pregnant. Perhaps of more interest is that weight was found to be related to psychological well-being: increased weight was associated with decreased body satisfaction and higher depressive affect. Interestingly, while the study primarily focused on weight the authors report that it was clear that the women “were very disappointed with their postnatal shapes” (Jenkin & Tiggeman, 1997, p.96). In addition, some of the participants commented on other changes not related to weight and shape that they found upsetting, for example, loose skin and stretch marks. Limitations of this study include a lack of generalisability due to the small sample size, as well as the relatively short postpartum testing period of four weeks. Furthermore, the scale used to assess body weight and shape satisfaction was not an established measure, and therefore had no evidence of reliability or validity.

An investigation into the extent to which women experience weight-related distress in the early months after childbirth was conducted by Walker (1998). The study also examined the association of weight-related distress with several other variables, one of which was body image dissatisfaction. The sample consisted of 227 women with a mean age of 29.8 years, at a range of 2.5 to 6 months postpartum. Content analysis was used to categorise women’s written accounts of their feelings towards their weight. This gave rise to a continuum of feelings, views and reactions to the question: “In your own words, how do you feel about your weight at this time? (Describe as best you can)” (Walker, 1998, p.33). The Weight Feelings Coding System used was developed in a pilot study. The researcher reported an intracoder kappa of 0.82, with over 5% coded by a second coder, with an intercoder kappa of 0.80. Cohen’s kappa indicates a measure of agreement between codings and coders, with the reported statistics indicating a good degree of reliability (Howell, 2002). The measure for body image dissatisfaction was the Body Cathexis Scale (BCS; Jourard & Secourd, 1955). This measures attitudes to one’s body along a dimension of satisfaction-dissatisfaction, based on feelings regarding 29 body parts (e.g. waist, hips). A reliability of 0.83 for females was reported for the BCS by Jourard and Secourd (1955), and Walker (1998) reported a good internal consistency reliability of 0.91 (Pallant, 2003).

The study found that 43% of participants were somewhat satisfied with their weight, while 40% were mildly dissatisfied and 8% experienced weight-related distress. Seven

percent of participants were postponing weight management due to breastfeeding, 1% were underweight and 1% had missing responses. An association between feelings about weight, body image dissatisfaction and lifestyle was also discovered: the more dissatisfied or distressed about weight, the greater the body image dissatisfaction and the less healthy the lifestyle. Walker (1998) interprets these findings as illustrating that 50% of participants experience unfavourable feelings regarding their weight, however, it could also be interpreted that 83% convey little or no concern (Jordan et al., 2005). These findings are therefore subject to interpretation.

Limitations of this particular study include a lack of generalisability due to sample demographics as the women were mainly white and well-educated. In addition, the author acknowledges that contextual factors in women's lives, such as partner support or partner preferences regarding weight and body shape, may influence dissatisfaction during this period however these factors were not investigated. Finally, although the measure used to assess body image dissatisfaction showed good reliability in this study it is of note that it was established in 1955 and was therefore over 40 years old at the time of the study.

Devine, Bove and Olsen (2000) investigated women's experiences of pregnancy and postpartum weight changes in a different manner. They used a longitudinal design, conducting multiple detailed qualitative interviews with 36 women throughout pregnancy and the first postpartum year. They also examined the strategies that the women used to deal with these weight changes, along with patterns in their attitudes and these strategies across this period. The sample was diverse with participants varying in age, being between 18 and 41 years old, and in educational level, employment status, prepregnancy weight, infant feeding intention and parity. Semi-structured interviews were conducted at mid-pregnancy, six weeks postpartum and 12 months postpartum. In addition, each participant gave a telephone interview at six months postpartum.

The interview data were analysed qualitatively using techniques adapted from the constant comparative method (Glaser & Strauss, 1985). The authors present a comprehensive overview of the procedure in the report. A predominant theme emerged from the data as underlying the women's experiences of the weight changes in this period. This theme was one of stable trajectories in the women's orientation to body weight and their physical activity and dietary practices. Four different trajectories were

identified that were characterised by differences in the women's orientations towards these factors: "relaxed maintenance" (n=4), "exercise" (n=10), "determined" (n=11) and "unhurried" (n=5) (Devine et al., 2000, p.570).

The authors found that 33 of the 36 women's trajectories remained the same as they had intended for the postpartum year and were closely aligned to their weight at 12 months postpartum. From this the authors conclude that prepregnancy orientations towards body weight appeared to be the principal influence on the women's postpartum attitudes to weight, patterns of physical activity and diet. These prepregnancy orientations therefore ultimately contributed to postpartum weight outcomes. From this they go on to suggest that these trajectories "demonstrated a striking pattern of continuity and momentum in behaviours and attitudes across a major life transition" (Devine et al., 2000, p.577). They further conclude that for most of the women, in terms of influence on postpartum attitudes and behaviours, the direction created by prior weight and lifestyle strategies was apparently more robust than transitional events. The authors also note that participants had differing expectations and goals regarding weight changes in pregnancy and that multiple life transitions, such as moving, marrying, changing employment or employment status as well as giving birth, appeared to be associated with divergence from a stable trajectory. Such multiple transitions are suggested to increase the tension between managing family roles and diet and exercise practices, thus encouraging divergence from a stable trajectory.

The value of this longitudinal qualitative approach is that it has increased our understanding of how life course trajectories in weight-orientation and lifestyle strategies may function as processes that shape responses to life transitions including the transition to motherhood. This perspective provides valuable insights into both continuity and change in health-related attitudes and behaviours. In addition, the findings suggest that prepregnancy weight-orientation may be a more useful predictor of postpartum weight retention than prepregnancy weight itself. This allows the authors to identify which groups of women may be at risk for retaining weight postpartum and provide guidance on what approach may be best for weight management throughout this period depending on the weight orientation of the particular individual.

One clear advantage of this longitudinal qualitative design using multiple interviews is that it provides the opportunity to gather more in-depth data. This is due to the

development of greater trust and rapport with participants as well as the extended timeframe allowing for a fuller picture of weight orientation and trajectories to be developed. Limitations include the demographics as the sample again consisted of predominantly white, well-educated women with “adequate resources” which the authors feel may have acted as a buffer from some of the demands of motherhood (Devine et al., 2000, p.579). This will limit the generalisability of the findings to other ethnic and socioeconomic groups who may experience different challenges. Finally, the self-report information about prepregnancy strategies and attitudes was gathered retrospectively and so may be questionable. The authors also acknowledge that starting the study earlier than in mid-pregnancy may have provided further information regarding changes in weight and attitudes that may have been useful.

A more recent study that investigates postpartum body image using yet another methodology is that of Jordan et al. (2005). They used Q methodology to explore how a sample of 20 women, who had given birth in the previous three years, expressed their postpartum concerns and to identify patterns (called narratives in the study) across these concerns. The statements in the Q pack were derived from statements collected from literature, media and mothers known to the researchers. From this pool of material a questionnaire was formulated and administered in a pilot study to ten mothers chosen for diversity. From this, 60 final statements were identified that were relevant to the concerns of new mothers and used in the main study.

From the analysis of the Q sorts, six narratives were identified that were interpreted by the researchers as illustrating the chief constructions or understandings within the study and our culture. The narratives identified were labelled: family centred, stressed, happy mothers, missing personal space, supportive family and mother/child oriented. The authors interpret the family centred narrative as suggesting dissatisfaction with appearance due to the placement of body image related items at the negative extreme. However, this is within the context of happiness derived from the family, as while the negative end of the sort is defined by body image, the positive end is defined by the greater importance of the family and children. The authors interpret the stressed narrative as revealing an unhappiness with bodily and other changes. This factor is therefore argued to reflect a more general unhappiness rather than exclusively with the body. In the other narratives listed, body image was interpreted as possibly playing a role in some, but not prioritised as a main concern for any.

The authors conclude from this that body image is of variable importance to mothers, and that other issues and concerns come to the fore in the postpartum period. The advantage and great value of this study is that these findings are considered in the light of contextual issues as the narratives adopted by a woman will depend on the context of her individual life. In addition, the use of a Q sort provides a refreshing alternative to the predominantly quantitative approach found in much of the extant literature. This methodology aims to tap into shared cultural understandings of the topic in question and as such provides both a broader and much richer picture than is possible with psychometric measures (Stainton-Rogers, 1995).

What might be of additional interest, however, is demographic information regarding the participants for both the pilot and main study. The sampling strategy is consistent with the methodology and the mothers were “chosen for their diversity” (Jordan et al., 2005, p.23). The authors also acknowledge that the findings of the study cannot be generalised to the general population. It would, nonetheless, be interesting to have information regarding demographics in order to qualify this diversity and place the findings in context when they are considered alongside other research conducted in this area. In addition to this, the mothers performing the Q sort may well have given birth up to three years prior to the study. This raises the question of reflexive changes in participants’ retrospective interpretation of the postpartum period. In other words, their view of how that period was for them may have changed over time and on reflection.

The most recent research into postpartum body image is a prospective study conducted by Rallis, Skouteris, Wertheim and Paxton (2007). This study longitudinally investigated body image changes and possible predictors of body image the postpartum year using quantitative methods. They investigated a sample of 79 women from Melbourne, Australia. Participants completed questionnaires at five points throughout their pregnancy and postpartum year. These points were between 16 to 32 weeks and 32 to 39 weeks of their pregnancy and at six weeks, six months and 12 months postpartum. A wide variety of measures were used that investigated body dissatisfaction, physical comparison tendencies, general well-being and dietary restraint. All scales employed in the study were well established and the authors report good previous and current reliability and validity data.

The results indicate that body concerns are heightened in the postpartum year, with women feeling fatter and less strong and fit. Participants also reported a greater difference between their ideal size and perceived current size than before pregnancy. In addition to this, weight and shape were more salient in the postpartum than in late pregnancy for this sample. The authors attribute this finding to late pregnancy allowing a relaxing of standards relating to the idealised figure, thus giving respite from body image concerns as suggested by Davies and Wardle (1994). They propose that this effect is no longer present in the postpartum.

Concerns about feeling fat were reported to be greater in the postpartum than prior to pregnancy. The women reported feeling most fat at six months postpartum despite actually weighing less at this point than at six weeks postpartum. The authors conclude that this may be related to participants no longer being able to accept a fuller figure as they can no longer consider such a figure in the light of the recent pregnancy or birth. Ideal body size was found to remain stable throughout the postpartum, however, the difference between ideal and current figure ratings decreased through all three postpartum testing points. The authors note that this decrease was accounted for through reported body size decreasing over the postpartum year and ideals reverting to those similar to pre-pregnancy rather than adjusting to a more realistic level as they are shown to in pregnancy (Skouteris et al., 2005).

The study also found, somewhat unsurprisingly, that the strongest predictor of body image in the postpartum year was prior body image. In addition to this, psychological factors comprising of depressive symptoms, greater physical comparison tendencies and dieting tendencies were found to predict body dissatisfaction at one year postpartum. These findings support previous research in adolescents and non-pregnant and pregnant women (Heinberg & Thompson, 1992; Schutz, Paxton & Wertheim, 2002; Skouteris et al., 2005). The authors therefore suggest that these factors are closely related to body image and that women at different life stages are subject to their influence (Tiggeman, 2004).

The main limitation of this study is the small sample size which limits generalisability of the findings, particularly given that it uses quantitative methods. In addition, the demographics of the group are not reported beyond the fact that the sample was “mainly tertiary educated and in married (or de facto) relationships” (Rallis et al., 2007, p.100).

The authors note that the sample was drawn from a previous study and that demographic details are available in Skouteris et al. (2005). It could be argued, however, that as only 61.7% of the original sample participated in the current study the demographic details, and in particular those such as age, may be somewhat different and as such should be reported in the current paper. Along these lines, the authors also acknowledge the possibility of selection and volunteer biases since the women participating in this study originally volunteered for the study by Skouteris et al. (2005) into body image in pregnancy.

Finally, a qualitative study using a sample of 21 women with differing levels of eating disorder psychopathology was published by Patel, Lee, Wheatcroft, Barnes and Stein in 2005. The study investigated how these women perceived and coped with changes in eating, body shape and weight in the postpartum year and how these changes influenced the women's identities as mothers. Participants completed a modified diagnostic questionnaire to screen for eating disorder psychopathology (EDE-Q. Eating Disorder Examination – Questionnaire. Fairburn & Beglin, 1994) and then completed a face-to-face clinical and diagnostic interview (EDE: Eating Disorder Examination. Fairburn & Cooper, 1993) in their own home somewhere between 2 and 6 months postpartum. The women were categorized according to their results on the diagnostic questionnaire as either eating disordered (n=6) or at risk of eating disorder (n=9), or put into a comparison group who had very low scores (n=6). Full demographic details were gathered with all participants being reported as “similar in all characteristics” (Patel et al., 2005, p.350), in a stable relationship and with ages ranging from 28 to 43 years old.

A thematic content analysis was conducted on the women's responses to the structured interview and their additional comments. Overall, the mothers in all three groups reported a negative reaction to bodily changes and weight gain in the postpartum regardless of their eating disorder status, supporting previous research reviewed (e.g., Hisner, 1986). Five themes were identified from the interview data: loss of the prepregnancy self, life transitions, feeding relationship with the infant, relationship with family members and role within wider society.

The authors conclude that the themes can be understood as a restructuring of identity on various levels, with the first theme, the loss of the prepregnancy self, being most strongly related to body image. The authors suggest that the mothers' acceptance of

their postpartum bodies can be considered as a loss which requires a process of adjustment. They report that the stage the women were at in this process was related to their eating disorder status. They found that women without evidence of an eating disorder found it easier to adjust to their postpartum bodies than those with an eating disorder who were more likely to be distressed about bodily changes.

The second theme relates to how the three groups coped with earlier life transitions. This appeared to be a significant indicator of how they managed the transition to motherhood. All participants reported previous concerns relating to body image but those who were able to resolve these difficulties using support seemed to cope better with the current transition. Participants' spontaneous reports regarding breastfeeding gave rise to the third theme. The authors suggest this theme reveals the mothers' experience of their babies' dependence on them for nutrition. Of note here was that eating-disordered mothers found this dependency uncomfortable and described their perceptions about breastfeeding predominantly in relation to their own worries relating to weight reduction. Body image was not a feature of the remaining themes relating to relationships with family members and the mothers' new role in society.

The primary limitation of this particular study is that a structured diagnostic interview was used rather than a specifically designed semi-structured interview. The latter format would have been more suitable, being more flexible. This may have given rise to more detailed and focused information being gathered from participants. Despite this, however, the authors comment that they were "surprised at the richness of information gathered from the mothers' spontaneous comments" (Patel et al., 2005, p.362). Nonetheless this still begs the question of whether the qualitative analysis was conducted in a rather post hoc way on data that emerged as being in some way suitable rather than the study being planned as qualitative from the outset.

A further limitation is the limited demographics of the small sample which were mainly middle class women drawn from the same area in London and using the same services. This is likely to limit the generalisability of the findings. Finally, the women were only interviewed once and it may have been interesting to gather data more longitudinally in order to shed light on how their views may have changed over the postpartum year. Despite these limitations, however, it is of note that this is the only qualitative study into postpartum body image that has been conducted to date and as such it provides

interesting insights into this particular group of women's lived experience during this period.

While more recent researchers such as Devine et al. (2000), Jordan et al. (2005) and Patel et al. (2005) adopt different approaches, it can be seen that the majority of published literature regarding body image in the postpartum period is quantitative in nature. Another feature that immediately stands out is the relative age of much of the research with only five studies being conducted in this decade (See Devine et al., 2000; Jordan et al., 2005; Morin et al., 2002; Patel et al., 2005 and Rallis et al., 2007). The review demonstrates that the findings in this collection of studies could be described as disparate and contradictory. There are a number of criticisms that can be put forward: much of the comparison data for pregnancy and prepregnancy was retrospectively gathered giving rise to questions regarding its accuracy. Direct comparisons are also difficult to make due to different measures being used throughout and a number of the studies use measures that have not been validated. Most of the studies have small sample sizes considering they are conducted using quantitative methods and populations are widely different thus limiting generalisability. Furthermore, the women in the studies were either primipara or multipara or a mixture of both and the time at which participants were tested during the postpartum period varies enormously from study to study, both of which further limit comparability. Finally, it could be argued that testing times that are very close to the time of delivery may limit the utility of the data as the women would still be experiencing changes associated with the immediate aftermath of the birthing process.

Although there is a small amount of mixed research using both quantitative and qualitative methodologies, the more recent study using the Q sort and the qualitative studies published by Devine et al. (2000) and Patel et al. (2005), the author would alert the reader to the lack of purely qualitative research in this area. This suggests that there is a need for further studies of this nature, in order to explore more deeply the lived experience of women during this period and the meaning that it holds for them. Research thus far also concentrates almost solely upon weight and shape concerns, with minimal focus upon other bodily changes that might arise during the postpartum period.

In addition, the author has noticed a paucity of research into influences that may exert themselves on women's perception of their body image in the postpartum year. Other

well documented influences on body image and body image concerns in other groups such as adolescents include the media (Tiggeman, 2002) and both familial (Kearney-Cooke, 2002) and interpersonal influences (Tantleff-Dunn & Gokee, 2002). Research indicates that the media are a persuasive influence in the development and maintenance of body image. Evidence demonstrates that, subject to individual differences, even brief exposure to idealized media images can have negative effects upon mood and body satisfaction in the short-term (Tiggemann, 2002). An increased understanding of whether the media has an impact upon women's body image in the postpartum period would therefore be of relevance in today's media saturated society.

Furthermore, an increasing amount of research indicates that interpersonal factors impact body image: an individual's perception of opinions and feedback from family, peers, romantic partners or even strangers can exert a considerable influence on body image (Tantleff-Dunn & Gokee, 2002). Body image has also been demonstrated to be influenced by social comparison of oneself to others, with greater levels of comparison relating to greater body dissatisfaction (Tantleff-Dunn & Gokee, 2002). An increased understanding of how interpersonal relationships and social comparison fit into women's experience of their body image in the postpartum would therefore also be of interest.

Other contexts

As the importance of context is highlighted in a number of the studies reviewed (see for example Jordan et al., 2005), and both the methodology and the author's stance regarding the current study emphasise the person-in-context, a brief review of other contexts that may be found at this time will be put forward.

Body image and contingent self-esteem (CSE)

Patrick, Neighbors and Knee (2004) remind us that, as early as William James in 1890, theories of the self have proposed that our sense of self is shaped by interpersonal encounters and feedback from significant people in our lives. A sense of self and self-esteem are principal features of our subjective experience and quality of life (Crocker & Woolfe, 2001). Contingent self-esteem reflects the extent to which positive self-worth is conditional or contingent on matching some standard or meeting some criteria such as social approval or appearance (Bergstrom, Neighbors & Lewis, 2004; Crocker & Woolfe, 2001; Patrick et al., 2004). Thus those who are high in CSE may base their self-

worth on evaluative standards such as physical appearance. Contingencies of self-worth therefore refer to the domains in which an individual believes they must achieve or succeed in order to be worthwhile (Crocker, 2002). Body image or appearance could be one such contingency of self-worth for some individuals.

The implications of CSE are far reaching in many areas. That which is pertinent to the current study is the role of CSE in relation to body image and appearance. Research has shown that CSE is in all probability a significant mediator for body image perceptions and misperceptions (Bergstrom et al., 2004). For example, studies by Geller, Johnston and Madsen (1997) and Geller et al. (1998) have demonstrated lower global self-esteem, lower body esteem and a greater risk of disordered eating in individuals who evaluate their self-worth as contingent on weight and shape. Other research by Bergstrom et al. (2004) found that women tended to misperceive what the opposite sex finds physically attractive and this was associated with negative consequences such as disordered eating in those participants with greater appearance-related contingent self-worth. Further to this, Patrick et al. (2004) showed that women who based their self-worth on contingencies, and had a lower level of perceived attractiveness, found appearance-related social comparisons more distressing than women whose self-worth was not contingent. The potential implications of these findings are that body image concerns may originate from CSE, particularly those arising from social comparison and the internalisation of the slim ideal that is projected in Western culture.

It could be argued that those individuals with a greater investment in their appearance may be at increased risk of experiencing self-worth that is to some degree contingent on their body image and appearance. Thus, if an individual's self-worth is contingent on their physical appearance, body image concerns may have an effect on psychological well-being, leading to poorer global self-esteem and even depression or disordered eating (Geller, Johnston & Madsen, 1997). There is therefore a complex interplay between self-esteem and body image. The way a woman feels about herself, her self-esteem, may influence how she perceives her body and may in turn be impacted by body image concerns (Tiggeman, 1994). The possibility therefore remains that a great degree of weight gain and physical changes postpartum may give rise to appearance concerns for some individuals. This in turn could impact upon self-esteem and even give rise to depressive symptoms or disordered eating (Geller, Johnston & Madsen, 1997).

Crocker (2002) argues that external contingencies of self-worth such as appearance require continual validation from others. They are therefore unreliable, fragile and have high costs as they are constantly vulnerable to threat and demand incessantly that the individual earn the approval of another. The impact of this on a day-to-day basis may include spending a considerable amount of time on appearance related behaviours such as grooming or exercising. Her study showed that the relentless pursuit of appearance related contingencies of self-worth was associated with negative outcomes. These may include stress, vulnerability and maladaptive coping which could in turn include disordered eating or substance abuse. In addition, instability of self-esteem over time has been shown to increase vulnerability to depression (Crocker, 2002; Kernis et al. 1998, Roberts & Gotlib, 1997; Roberts & Kassel, 1997) thus implying that the pursuit of a fragile contingency of self-worth could contribute to such a vulnerability in some individuals. In these instances, a move away from contingencies of self-worth associated with appearance and body image would be desirable in those individuals who demonstrate such a strategy for maintaining their self-esteem.

The transition to motherhood

Becoming a mother represents an important life transition for a woman and engenders substantial changes in her life including those of a significant personal, social and biological nature (Smith, 1991, 1999). These changes may involve a diverse range of areas such as relationships and lifestyle, as well as changes in role and many other new challenges, all of which may create a need to restructure or even reconstruct an individual's identity or self-concept (Lewis & Nicolson, 1998; Salmela-Aro, Nurmi, Saiato & Halmesmaki, 2000; Smith, 1991, 1994). These challenges must be negotiated in order to move toward an integrated maternal identity (Shelton & Johnson, 2006) or a reconstructed self (Smith, 1991, 1994). The transition to motherhood is therefore a process that may well be tricky and stressful for some individuals due to its demands.

The transition to motherhood and self-concept

Self-concept refers to thoughts and feelings about the self (Swann, Chang-Schneider & Larsen McClarty, 2007). In the 1970s Shavelson, Hubner and Stanton (1976) developed a multidimensional, hierarchical model of self-concept that fundamentally impacted successive research (Marsh, Trautwein, Ludtke, Koller & Baumert, 2006). The model suggests that at the apex of the hierarchy is global self-concept, a construct that is also

sometimes described as self-esteem. Differentiated beneath this are multiple and separate dimensions of self-concept such as physical, social and emotional self-concepts. Thus in the literature the terms global self-concept and self-esteem are used interchangeably and may be distinguished from more domain-specific dimensions of self-concept (Marsh et al., 2006).

The conceptualisation of specific domains of self-concept may enhance understanding of the complexity of the self in different contexts and help predict behaviours (Marsh et al., 2006). The relevance of this to clinicians is that it may give an indication of the possible influence and impact of clinical interventions. In addition, research has demonstrated that specific facets of self-concept have significant effects on subsequent performance in areas such as academia and are shaped by context, environment and life events (Marsh et al., 2006).

In the transition to motherhood, various self-concept or identity effects are described (Bailey, 1999; Lewis & Nicolson, 1998; Salmela-Aro et al., 2000; Smith, 1991, 1994, 1999). Smith (1991) published a single qualitative case study following one woman through pregnancy and the transition to motherhood. The study used interpretative phenomenological analysis (IPA) and focused on the changes that occurred in the participant's accounts of her identity. Smith (1991) found that this particular woman experienced a complex and dynamic process of identity transformation throughout this time of transition. In his 1994 paper, Smith qualitatively examined "the notion of self-reconstruction" (1994, p.371) using IPA to compare current and retrospective accounts of personal identity from four women going through the transition to motherhood. The women were interviewed at four points: at about three, six and nine months pregnant and at five months after the birth of their first child. In addition to the semi-structured interview data, the participants kept diaries that were used as material for the study. Smith argues that the women's narratives suggest the telling of "reconstructive stories" (1994, p.390) of this period of transition. In other words, these women slightly alter their accounts of pregnancy following the birth of their child in order to build self-enhancing narratives of, for example, personal growth or continuity. This allows them to present a particular view of the self to both themselves and others.

In yet another paper relating to this period, Smith (1999) presents a theoretical model outlining how aspects of a woman's sense of self or identity may be transformed during

the transition to motherhood. The model is derived from the interview data obtained from the four women found in Smith (1994) along with repertory grids constructed at each visit. This study, however, explores the participants' personal accounts of this transitional period in order to establish whether it has significant effects on their sense of self or identity. Smith (1999) found that pregnancy acted as psychological preparation for mothering and that the women typically replaced the public world of work and wider social context with the more personal and intimate world of family. The data also support the notion of the relational self in that the participants' increased social contact with significant others seems to facilitate an enhanced awareness of their sense of self "being relationally defined" (Smith, 1999, p.295). Finally, Smith (1999) found that in the postpartum the women were adjusting to the presence of the infant and turning their attention to their own life projects again. In some participants the transition to motherhood appeared to facilitate a transformation in those plans.

Another study published by Bailey in 1999 describes changes to self-identity in the transition to motherhood. This paper is a discourse analysis of 30 semi-structured interviews conducted with middle-class white women aged between 25 to 38 and in the third trimester of their first pregnancy. Bailey (1999) found that although her participants experienced a continuous sense of self, this was nonetheless altered along a number of different dimensions. She describes the women's awareness of different aspects of themselves as increasing throughout the transition to motherhood. It is suggested that this might be interpreted as the women being "refracted by the prism of pregnancy rather than altered fundamentally" (Bailey, 1999, p.350) thus revealing hitherto concealed facets of the self. Six key dimensions of this awareness or changing experience of the self are identified in the report and include self identity and mothering identity, the body and the self, the working person, practices for the self, the relational sense of self and the experience of space and time.

The transition to motherhood and postpartum depression

Despite the birth of a first child being a positive experience for many individuals (Green & Kaftersios, 1997) the postpartum period may feature a complex mix of emotions that are associated with the transition to motherhood (Fleming, Ruble, Flett & Van Wagner, 1990; Lewis & Nicholson, 1998; Nicholson, 1999). The first few postpartum months can be stressful and new mothers may feel inadequate, vulnerable and depressed. This may be as a result of the material realities of being a new mother, such as feeling tired and

the loss of a former lifestyle due to the demands of the baby, as well the discrepancy between the myth of motherhood and the actual reality (Choi, Henshaw, Baker & Tree, 2005). Popular versions of motherhood as non-problematic, happy and joyous may be at odds to the individual's experience of what is essentially a difficult time involving change, loss, readjustment and negative as well as positive elements. This may result in disappointed expectations of motherhood as a fulfilling and happy experience (Lewis & Nicolson, 1998).

There is therefore a risk of postpartum depression or less severe, but nonetheless debilitating, postpartum dysphoria resulting in irritability, tearfulness and feelings of inadequacy (Fleming et al., 1990) following the birth of a child. In fact, Nicolson argues that "some degree of postpartum depression should be considered the rule rather than the exception" (1999, p.176) due to the inevitable losses, such as autonomy and sense of self for example, that are experienced throughout the transition to motherhood. Any postpartum reaction, however, will be influenced by an individual's history, personality, experience and associated meanings. In addition to this, the social desirability of responding to motherhood in a positive way may make women less inclined to acknowledge feeling differently, even to themselves.

In this vein, Choi et al. (2005) remind us of the feminist perspective that women may be reluctant to reveal feelings of inadequacy arising from conflict between the ideological myth of motherhood that is perpetuated in society and its actual reality. In admitting these feelings, and that they are finding it hard to cope as the dominant discourse of femininity dictates they should, new mothers may feel that they have failed as a woman. Motherhood is still central to female identity despite the fact that women in modern society are defined by much more (Nicolson, 1999). Women may therefore conceal difficulties coping or feelings of depression in order to maintain a facade that is in line with the dominant ideology of motherhood and femininity (Choi et al., 2005).

Mauthner (1999) proposes yet another theory of postpartum depression that is relational. She argues that women may experience a wide variety of negative emotional responses to motherhood which may range from feelings of low mood to feelings of depression. Some women however, for a combination of individual, interpersonal and cultural reasons, may find it more difficult than others to accept, acknowledge and disclose these feelings. This may particularly occur if they feel that they do not have supportive

relationships within which to do this. In this case, the individual may withdraw into silence and their feelings may deteriorate into those of postpartum depression. Mauthner therefore highlights the importance of an “accepting relational context” (1999, p.158) for new mothers whereby they are encouraged to express their feelings early on in a supportive and non-judgemental environment in order to prevent postpartum depression. She also raises the importance of creating cultural and social contexts where the range of feelings experienced by mothers, including ambivalence, distress and depression, are both “accepted and acceptable” (Mauthner, 1999, p.158).

Body image and the sociocultural perspective

A sociocultural perspective focuses on the way that values and behaviour of the individual are shaped by cultural values. From this perspective, culture defines what is perceived as attractive in terms of body image and an individual’s self-perception of their body image will be in relation to these cultural definitions. Such self-evaluations may be adversely affected if cultural values relating to body image are internalised to serve as personal ideals and there is a discrepancy between the internalised ideal and the individual’s self-evaluation. This may give rise to body dissatisfaction (Jackson, 2002).

It has been widely suggested that cultural norms for appearance, including thinness, play a leading role in women’s normative discontent with their bodies (Rodin et al., 1985; Thompson et al., 1999). The cultural ideal of what is attractive in women has also been shown to have become increasingly slim (Wiseman, Gray, Mosimann & Ahrens, 1992). Models and celebrities have been put forward as powerful examples of cultural norms for appearance and slimness in society. It has been suggested that women believe they will be judged according to cultural norms thus increasing the salience and relevance of images of individuals who reflect these norms (Strahan, Wilson, Cressman & Buote, 2006).

The majority of research investigating the effect of the media on body image has been related to the sociocultural model of disordered eating. This model connects cultural trends in the media that promote the slim ideal with an internalisation of this ideal. This in turn leads to body dissatisfaction, subsequent negative affect and dieting, and may culminate in disordered eating (Bradford & Petrie, 2008). Grabe, Ward and Shibley Hyde (2008) conducted a meta-analysis of a vast corpus of studies investigating the relationship between media exposure, body dissatisfaction, internalisation of the thin

ideal and eating behaviours and beliefs. The meta-analysis suggests that exposure to mass media promoting the thin ideal is robustly related to women's generalised dissatisfaction with their bodies, internalisation of the thin ideal and more frequent eating disordered behaviours. This overall finding, however, is not consistent across all the research included in the meta-analysis. In addition, not all women experience dissatisfaction with their bodies despite exposure to mass media suggesting that media influence does not invariably lead to internalisation of the thin ideal and dissatisfaction (Grabe et al., 2008).

Various factors have been identified as mediating the relationship between media exposure to the thin ideal and negative self-directed effects. These include social comparison processes and body image self-discrepancy (Bessenoff, 2006). Body image self-discrepancy is where an individual has a discrepancy between an internalised body ideal and their subjective evaluation of their own body. This process has been shown to moderate the likelihood of making social comparisons to media promoting the slim ideal (Bessenoff, 2006). Self-discrepancy has been shown to be associated with emotional distress (Higgins, 1987, 1989) which may increase vulnerability to social comparison processing of media images, therefore activating the pathway from sociocultural pressures to meet the slim ideal to body dissatisfaction and even disordered eating (Bradford & Petrie, 2008).

Body image and interpersonal influences

As with self-concept, our body image is shaped by our interpersonal encounters such as relationships, how we see ourselves in comparison to others and feedback we receive from them (Tantleff-Dunn & Gokee, 2002). A growing body of literature suggests that we are profoundly impacted by others' opinions and there is evidence supporting the view that explicit and implicit messages regarding appearance have a significant effect on the development and maintenance of an individual's body image (Thompson et al., 1999). These messages may come from a wide range of individuals including parents, siblings, peers, partners and even strangers. As body image development is a lifelong process, it will therefore be influenced by significant individuals playing central roles at different times in our lives. Who these people are will depend on where we are in our life span (Tantleff-Dunn & Gokee, 2002).

It has thus been generally assumed that a woman's sexual partner may contribute to her satisfaction or dissatisfaction with her body and could be the source of body image concerns (Ogden & Taylor, 2000). The majority of research in the area of intimate relationships and body image has therefore tended to investigate their effect on body dissatisfaction due to its association with disordered eating. Relationship quality has been proposed to be a factor in body satisfaction (Friedman, Dixon, Brownell, Whisman & Wilfley, 1999) and levels of dieting (Markey, Markey & Birch, 2001), as supportive intimate relationships have been suggested to provide a psychological buffer against societal pressures to maintain the thin ideal (Boyes, Fletcher & Latner, 2007). Relationship satisfaction for both partners may therefore be an important factor in body image concerns. Furthermore, having a partner that is depressed has been associated with women being less satisfied with their bodies and engaging in higher levels of unhealthy dieting. This relationship may also be reciprocal, with women's body dissatisfaction having deleterious effects on their partners' mood (Boyes et al., 2007).

Body image, postpartum sexuality and breastfeeding

The postpartum period is therefore a time characterised by intense biological, social and psychological changes. These changes may also impact upon woman's sexuality (Bitzer & Alder, 2000). Changes in sexuality are relevant as they may impact women's psychological well-being, intimate relationships and quality of life (Pauls, Occhino & Dryfhout, 2007). The complex interaction of changes experienced through the postpartum and the process of adjustment to these may well influence sexual interest and behaviour. In addition to hormonal changes, chronic fatigue due to irregular sleep patterns and physical exhaustion due to the demands of the infant and breastfeeding may give rise to lowered sexual function (Bitzer & Alder, 2000). Although it is generally assumed that women may also have to contend with body image concerns during this period, and that this may affect sexual functioning, a study by Pauls et al. (2007) did not find that body image was a significant predictor of sexual dysfunction in the postpartum period.

LaMarre, Paterson and Gorzalka (2003) argue that the literature regarding postpartum sexual functioning and breastfeeding can be broadly divided into early and late studies. They report that early studies from the 1960s to the 1980s tend to be methodologically flawed as they are retrospective in design and use small sample sizes. They suggest that these and other design flaws render this research "virtually uninterpretable" (LaMarre et

al., 2003, p.156). Over the last two decades, however, other research has been conducted using prospective designs with larger sample sizes. These indicate that breastfeeding is associated with a greater reduction in sexual functioning than bottle-feeding. More specifically, duration of breastfeeding has been linked with sexual dysfunction. Longer duration is associated with delayed resumption of intercourse, lower desire and enjoyment and greater dyspareunia (vaginal pain on intercourse). These effects may be mediated by hormone levels but other likely contributing factors, such as mood and fatigue for example, have not been fully elucidated (LaMarre et al., 2003).

Other factors that may contribute to sexual difficulties while breastfeeding could include the woman's needs for intimacy being met by the baby, milk ejection during intercourse being off-putting, fatigue and hormone levels reducing libido and relationship difficulties associated with the transition to parenthood (Jackson, 2000; LaMarre et al., 2003). It is of note that few women with postpartum sexual problems tend to report them or seek help (LaMarre et al., 2003; Rowland, Foxcroft, Hopman & Patel, 2005). Many women who do engage in psychosexual therapy later relate the onset of their problems to this time (LaMarre et al., 2003). Sexual difficulties may give rise to distress, decreased quality of life, decreased physical and mental well-being and impaired relationship functioning (Bitzer & Alder, 2000; LaMarre et al., 2003). On the whole, however, it is reported that sexual relations tend to return to pre-pregnancy levels by one year postpartum regardless of the feeding method (LaMarre et al., 2003).

Research aims

The aim of the study is therefore to explore in depth the lived experience of the body and body image in women in the postpartum period. Particular attention is given to the influences hypothesised to impact upon their experience of body image. Further attention is given to the meaning and implications of the bodily changes experienced by women in the year after giving birth.

Research questions

- How does this group of women experience their bodies and body image in the year after birth?

- How does this group of women experience the influences that may impact upon their experience of their bodies and body image?
- How does this group of women experience the changes in their bodies that have resulted from pregnancy and childbirth?

Rationale for adopting a qualitative research paradigm

As the review of the literature demonstrates, research thus far into body image in the postpartum period is contradictory and dominated by a quantitative approach. This type of approach is generally concerned with quantification and the identification of cause-effect relationships (Smith, 2003; Willig, 2001). On the other hand, qualitative approaches are concerned with how the individual experiences events and makes sense of the world through exploring, describing and interpreting personal and social experiences (Smith, 2003; Willig, 2001).

Gleeson and Frith note that despite body image being described as complex and multifaceted it is actually simplistically assumed to be “a reified, relatively fixed schema which exerts influence on people’s behaviour” (2006, p.80) in the majority of quantitative research. They argue that this fixed and basic notion of body image may limit its usefulness as a construct, precluding broader research questions. In addition to this, the assumption that body image is a fixed and enduring construct with parameters that can be measured has led to it largely being investigated quantitatively as a one-dimensional concept. Furthermore, such an approach posits that body image is internal to the individual and that participants are objectively reporting details about an internal image they hold. From this assumption springs yet another assumption that differences in the way individuals respond to psychological measures denote real differences in their perception or evaluation of their bodies (Gleeson & Frith, 2006).

These assumptions are problematic for a number of reasons; firstly, although research has attempted to attend to social context, outside influences such as the media are therefore theorized to act on the individual in a causal way, influencing the internally held model. This simplistic view neglects the complexity and diversity of individual experience and how participants use their understandings of their bodies in day-to-day life and in their interpersonal interactions; in other words, how they make sense of their embodied experience. It also rejects the idea that an individual may engage with external influences in a discerning and dialogic way (Gleeson & Frith, 2006). In terms

of lived experience, this approach to body image as a static mental representation therefore disregards the complexity and embedded nature of body image in the individual's lifeworld. In this sense, much quantitative research ignores the intricate nature of how people perceive and evaluate their bodies in a socio-cultural context and give meaning to their embodied experience (Gleeson & Frith, 2006).

A qualitative approach was therefore adopted for the current study in order to remain consistent with the research aims and consider the context and complexity of women's experience of their bodies and body image during the postpartum period. It is hoped that the use of a qualitative approach that is experiential and reflexive will better capture the intricate and dynamic concept of body image rather than a "reified, static and schema driven" construct (Gleeson & Frith, 2006, p.88). In this way the study hopes to provide more meaningful insights into this area for this group.

In addition to these methodological and epistemological considerations, as a counselling psychologist the author felt naturally drawn to the qualitative paradigm. The general fit of this mode of enquiry with a professional interest in the client's subjective experiences was intuitively appealing. Moreover, the data collection methods utilised tend to involve close interpersonal contact with participants, for example using face-to-face interviews. Interactions such as these are central to the practice of counselling psychology (Ponterotto, Kuriakose & Granovskaya, 2008), therefore a firm base for the required skills had already been developed as a result of the author's training in this discipline.

Rationale for adopting Interpretative Phenomenological Analysis (IPA)

When considering the methodological approach most suitable to address the research aims, several options were investigated along with IPA. These included grounded theory methods and discourse analytic approaches. IPA, however, was considered to have the best fit with the aims of the research as it is concerned with the detailed and flexible examination of individual lived experience, how individuals make sense of that experience and the meaning it may hold for the individual (Chapman & Smith, 2002; Eatough & Smith, 2008).

Grounded theory methods were considered as an alternative. They emphasize the building of inductive theories that are directly grounded in the data and are suited to studying individual or interpersonal processes and experiences (Charmaz, 2003).

Amongst discourse analytic approaches, discursive psychology (DP) emphasizes the performative qualities of language moving beyond content and examining its action orientation. It tends to examine how participants use discourse and the effects of this, looking at what people do with language and how they might claim or achieve something in a particular interaction such as an interview (Willig, 2008).

Given that the research concerns the complexity of lived experience, it was decided that neither of these two approaches were a better fit than IPA. The aim was to develop a more interpretative and contextual account of the phenomenon than grounded theory methods would allow. IPA also offers a more flexible framework in terms of method. The constructionist position of DP and its primary concern with language use was felt to possibly be restrictive; the central focus of the current study is primarily experience and as such includes context, affect and cognition as well as language. IPA differs from DP in its take on the status of cognition. DP does not link verbal reports to underlying cognitions and instead tries to illuminate the interactive tasks these verbal reports are used to perform, how these tasks are accomplished and the linguistic resources drawn on to do this. In contrast, IPA is concerned with understanding what the individual thinks or believes about the subject under discussion (Chapman & Smith, 2002). A further discussion of this may be found in the overview of IPA located in the methodology section. DP, however, may well have given an interesting insight into how the women use language to construct their experience of body image and bodily changes in the postpartum period and to negotiate and manage their interests in the interview (Willig, 2008).

Another alternative that was given serious consideration was Foucauldian discourse analysis (FDA). FDA is another discourse analytic approach (Willig, 2008), however, it differs from DP in that it is less concerned with interpersonal communication and more with the role of language in the constitution of social and psychological life (Willig, 2003, 2008). It may have been interesting to examine the women's discursive constructions in order to evaluate the constraints and opportunities in operation for them and what kinds of ways-of-being are made available to them as a result. This approach could have allowed an in-depth investigation into the relationship between the dominant discourses of appearance and femininity in society and how the women think and feel about their bodies and body image (Willig, 2003, 2008). Although FDA appealed, it is

also a constructionist approach and as such did not seem to fulfil the emphasis on lived experience that the author was seeking.

The appeal of IPA was therefore in its distinct focus on lived experience and sense making as well as its unique contribution to psychology; it has been widely used in health psychology as well as in clinical and counselling psychology (Eatough & Smith, 2008; Smith, 2004). IPA is also well supported with detailed procedural descriptions (Langdrige, 2007; Smith & Dunworth, 2003; Smith, Jarman & Osborn, 1999; Smith & Osborn, 2008) which were appealing to a newcomer to qualitative research methods. Furthermore, IPA also offers and encourages flexibility in adapting and developing the method to the researcher's own way of working and the particular topic of investigation (Smith, 2004; Smith & Osborn, 2008). The author was also drawn to the broad philosophical underpinnings and epistemology of this approach (Smith, 2004). A further discussion of these aspects can be found in the sections regarding the overview of IPA and epistemological standpoint located in the methodology section.

Another factor that contributed to the choice of IPA is the active "community" associated with the methodology. This involves a website and on-line discussion group, a yearly conference and monthly meetings with a regional research group all of which provide the opportunity to get involved in a wider discourse regarding IPA and access support from other researchers. This was immensely appealing and these aspects have been invaluable, with the author having made full use of all these opportunities to discuss and validate the study.

Compatibility of IPA and counselling psychology

In addition to the compatibility of IPA with the aims of the research, the author would argue that IPA is highly compatible with counselling psychology. Counselling psychology in the UK is relatively recent in origin but is recognised as a contemporary version of an older tradition originating with Wilhelm Wundt and William James who held an interest in consciousness and subjective experience (Strawbridge & Woolfe, 2003). Counselling psychology has therefore developed from these thinkers and others such as Maslow, Rogers and May, who established the discipline's humanistic value base and focused on understanding the subjective world of the self and other (Strawbridge & Woolfe, 2003).

The German philosopher William Dilthey first linked the notion of human science with the understanding of experience and played an influential role in the development of research into subjective experience, meaning, culture and human consciousness (Rennie,1994). Both Wundt and Dilthy argued that a true human science could only be based on the analysis and interpretation of meaning (McLeod, 2003; Rennie, 1994); counselling psychology is rooted in this human science perspective (Strawbridge & Woolfe, 2003) as are qualitative research methods including IPA. There are therefore many parallels between the philosophy and practice of counselling psychology and IPA.

In its definition of counselling psychology found in the Professional Practice Guidelines (British Psychological Society, 2000), the Division of Counselling Psychology emphasizes a number of points that parallel the exploratory principles of IPA. The definition highlights the importance of subjective and intersubjective experience and meanings, along with the empathic engagement of the psychologist with the world of the client. Counselling psychologists are encouraged to accept and respect the subjective accounts of the client as meaningful and valid in their own terms and “elucidate, interpret and negotiate between perceptions and world views but not assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing” (British Psychological Society, 2000, p.2). The definition also encourages the prioritisation of practice-based research, therefore implying a bottom-up approach to generating knowledge.

It can be seen therefore that there are striking parallels between the Division’s definition and the aims and objectives of IPA which seeks to understand and give voice to the participant’s concerns, make sense of the participant’s account and contextualise it from a psychological perspective (Larkin, Watts & Clifton, 2006). IPA is also a truly bottom-up approach to generating knowledge and thus intuitively appealed to the author as a practitioner who is interested in clients’ experiences in the context of their lifeworld.

Personal reflexivity⁴

In this section I aim to explain my position in relation to the research. I will give some background information regarding how I came to choose the topic and will attempt to outline the assumptions that I held at the beginning of the process.

⁴ The sections on reflexivity found throughout the report will be written in the first person in order to address the reader directly.

Whilst considering a topic on which to write my doctorate, I was faced with the inevitable challenge of trying to find something that would be engaging enough for me to sustain such a large piece of work spanning effectively more than two years, that would be interesting enough for someone else to want to read it, and that had relevance for counselling psychology. I struck upon the idea of investigating some aspect of body image and in my consideration of this particular area of research, I came to realise how important my body image actually is to me as an individual. In addition to this, I came to understand that this had been at the very edge of my awareness, lurking as something I had not really acknowledged as being that significant.

On reflection, I now realise how my attitude and my concerns regarding my body image insidiously pervade my everyday life, a background murmur that I tend to ignore but nonetheless subtly influences me on a daily basis. I suppose that I have always just accepted my negative feelings towards my body image as par for the course. I've never known any different, so they are "normal" to me. I realised that I was indeed one of the many women in our society who have, to some degree or other, a normative discontent regarding their body image (Rodin, Silberstein & Striegel-Moore, 1985).

During the course of a pregnancy, major transformations will occur to a woman's body. In pregnancy and the postpartum period, many women are reported as not being prepared for the extent of these changes and for the fact that the body rarely returns immediately to its prepregnancy shape and weight (Jenkin & Tiggeman, 1997; Patel et al., 2005; Stein & Fairburn, 1996). I am a woman of childbearing age, and in fact I'm actually approaching the end of this period in my life, being in my late thirties. I have not had a child and at this stage I'm not sure if I will have a child, however I do spend a considerable amount of time ruminating on how it might be to experience such radical changes in my body should I become pregnant, not least because I have observed a large proportion of my peers go through this very experience over the last decade or so.

For this reason, I became interested in the changes in body image occurring throughout this transitional stage in a woman's life. In particular, the postpartum period fascinated me due to the recent explosion in media interest in "celebrity mothers". I am not an avid reader of gossip magazines, however even I have noticed in myself a heightened awareness of reporting on the ability of celebrity mums to apparently regain their

pregnancy figure with astounding rapidity. This has led me to wonder if women in the postpartum period notice this material too, and whether this has an impact upon them and their body image.

I decided to use a sample of older women aged between 30 to 45 years old. This is partly because of my own age, but also because this group of women, who have often delayed starting a family due to their careers, have been very much in the public eye for this very reason. There has been much recent media attention regarding the risks involved in delaying childbearing, such as problems with infertility and miscarriage. I therefore felt that they might be a relevant group to investigate, as well as holding a personal interest for me as they are both “same” and “other”.

My starting point at the beginning of the research process was that I assumed that these women would be dissatisfied with their postpartum bodies and the changes resulting from childbearing. When I reflected on the origin of my assumptions, I realised that the general notion in society seems to be that body image is a “potentially problematic entity” (Gleeson & Frith, 2006, p.81) that may or may not influence an individual’s behaviours and mental health in an adverse way. For example, media coverage focuses on eating disorders, the size zero debate has been prominent for a number of years and concern regarding young girls susceptibility to images presented in advertising and by fashion models abounds. This type of coverage automatically assumes that body image may be dysfunctional (Gleeson & Frith, 2006).

Furthermore, the literature on body image generally tends to focus on the negative; there is a predominant focus upon dissatisfaction due to its association with eating disorders. Even the literature pertaining to the postpartum period tends to negate any positive aspects with the focus again being on the negative. In addition to this, my own attitude to my body image and my lack of experience of childbearing led me to blindly assume that most women would find the dramatic changes, and therefore any residual effects from these, a negative experience.

The aim of outlining these assumptions is not to attempt to be unbiased or objective, rather they are to situate myself and my attitude at the beginning of the research process. I hope to make evident the motivations and interests that I have introduced into the research (Gough, 2003). I tried to be as reflexive as I could regarding my starting point

in order that I might, as far as possible, engage with the participants' accounts in a fresh and open manner (Finlay, 2008). In this spirit, other sections describing ongoing aspects of the reflexive process will be found throughout the report. This is so that the reader may develop an understanding of the processes that have contributed to the study. I hope that this will provide insights into how subjective and intersubjective factors have influenced the research, thus increasing its integrity and trustworthiness (Maso, 2003).

Methodology and Procedures⁵

Methodology

Research Design

The study employed a qualitative methodology using semi-structured interview data gathered from a homogenous, small sample. The data were analysed using Interpretative Phenomenological Analysis (IPA).

Overview of IPA methodology and philosophical underpinnings

IPA was developed by Jonathan Smith in the mid-1990s. His fundamental rationale for IPA was a return in psychology to the neglected area of subjective experience and personal accounts as first espoused by William James in the late 1800s. He therefore wanted to articulate “a qualitative approach to psychology which was grounded in psychology” (Eatough & Smith, 2008, p.180). It has been used widely in applied psychology, most notably in health psychology, but also in counselling, clinical, social and organisational psychology (Smith, 2004).

IPA is a phenomenological approach whose main aim is a detailed exploration of how individuals make sense of their personal and social worlds. This includes the meanings that particular experiences, events or states hold for the individual (Smith & Osborn, 2008). IPA’s commitment to the examination of an individual’s lived experience, the meaning of the experience to them and their sense-making of it relates to its theoretical underpinnings of both phenomenology and hermeneutics (Eatough & Smith, 2008; Smith & Osborn, 2008).

The phenomenological aspect of IPA is concerned with the in-depth investigation and illumination of an individual’s lived experience using systematic procedures, therefore building a detailed account. This, however, is not a purely descriptive attitude in the Husserlian sense, as with Giorgi’s phenomenological psychology (Giorgi & Giorgi, 2003). It also draws on hermeneutic phenomenology associated with Gadamer (1990) and Heidegger (1962/2004) and therefore gives emphasis to the interpretative features of analysis. Moreover, this interpretation should arise from close attention to the phenomenon rather than being brought in from another source (Eatough & Smith, 2008).

⁵ This chapter is written in the first person in order to address the reader directly and illustrate the unfolding nature of the research process including reflexivity.

Heidegger's proposition of individuals' being-in-the-world is central to IPA's take on phenomenology and entails a rejection of the Cartesian divide of mind/body, subject/object and therefore person/world. It is the starting point for IPA which acknowledges the unique intersubjective experiences of the individual that are inevitably embodied and also emphasises the existence of social, historical and contextual influences on the lifeworld (Eatough & Smith, 2008).

IPA acknowledges that an individual's experience cannot be accessed directly and that the best we can do is examine their experiential reality; in other words, that we might do our best to understand an experience by investigating how it is experienced and given meaning by an individual (Eatough & Smith, 2008; Smith, 1996).

IPA is also influenced by hermeneutics, the theory of interpretation, and within this there are potentially different interpretative stances available to the researcher. IPA tends to blend empathic hermeneutics with questioning hermeneutics, meaning that it endeavours to understand what it is like for the participant whilst asking critical questions of the textual account. The particular combination used will depend on the study and a richer analysis is likely to involve both (Smith & Osborn, 2008).

In tandem with this aspect of interpretation, IPA also acknowledges that the research process is dynamic with the researcher playing an active role. Another reason why it is not possible to access another individual's personal world directly or completely is that this depends on and is complicated by the researcher's own viewpoint. IPA therefore represents a double hermeneutic with the researcher trying to make sense of the participant trying to make sense of their experience (Smith & Osborn, 2008).

IPA has a strong commitment to idiography as opposed to the nomothetic approach underpinning the majority of psychological research. It focuses on the particular rather than the universal and has a concern with understanding the meaning of individual life rather than attempting to establish universal and causal laws (Eatough & Smith, 2008). The methodology argues that through this attention to the particular and the detail of the individual's lifeworld we can connect with significant themes that are central to the lives of us all, thus taking us nearer to the universal (Eatough & Smith, 2008; Smith, 2004).

IPA is therefore interested in the variability and diversity of human experience, looking for the convergences and divergences in a set of accounts. It relies on the close analysis of individual accounts case-by-case to establish a better understanding of a phenomenon. Once the single case analysis is complete, a cross case analysis may be performed that is fine-grained and highlights the similarities and differences in experience along with the different nuances and textures within the accounts (Eatough & Smith, 2008; Smith, 2004). Once this in-depth analysis of cases is complete the results will be discussed in relation to existing theory and psychological literature (Smith, 2004).

A controversial aspect of IPA that certainly warrants discussion in this arena is the ongoing debate around its concerns with cognition. Criticism has been levelled at IPA's use of this term and whether the study of cognitions can genuinely be phenomenological and in line with phenomenological philosophy's rejection of the Cartesian divide (Langdridge, 2007; Willig, 2001).

Eatough and Smith (2008), however, respond to this and are very clear regarding their conceptualisation of the term. They dispute the widely accepted idea that cognitions can only be conceptualised as isolated and discrete processes managing sensory input, as they are in cognitive psychology, and argue instead that they are an aspect of being-in-the-world. They construe cognition as an aspect of lived experience, as meaning making itself, believing that this is a central aspect of human existence. This, they argue, was the original intention of the cognitive movement away from behaviourism in the mid-twentieth century. The original conceptualisation of cognitive psychology was in fact concerned with meaning and meaning making before it turned into the science of information processing (Smith, 2004; Smith & Osborn, 2008).

In this way, therefore, IPA focuses on all facets of lived experience including beliefs and values, wishes and desires, feelings and motivations and how these may manifest themselves, or not, in behaviour and action (Eatough & Smith, 2008). IPA therefore looks to offer an alternative understanding of human cognition that relates to meaning and how this comes into being in the context of individual lifeworlds (Eatough, 2007).

Epistemological standpoint

IPA does not claim a distinctive epistemological position, but describes itself as “part of a stable of closely connected approaches which share a commitment to the exploration of personal lived experience” (Smith, 2004, p.41). It was developed from a broad base of theoretical influences and its unique epistemological openness resulting from this breadth was certainly an aspect which attracted me to the methodology. Its influences include phenomenology (see Moran, 2000), symbolic interactionism (see Blumer, 1969), social cognition (Smith, 1996) and social constructionism (see Burr, 2003) some of which have been discussed above and some of which I will discuss here as I elaborate the standpoint from which this research was undertaken.

My standpoint draws heavily on that of Virginia Eatough (Eatough & Smith, 2006b) and it is to a brief summary of this that I now turn. This particular approach to IPA could be described as lightly social constructionist in that it agrees that sociocultural and historical processes are central to our experience, our understanding of our lives and the stories we recount about this. It also holds that language is important in this and that our sense of self is at least partly emergent from the process of communication between individuals. It is more aligned to symbolic interactionism, however, rather than the poststructuralist influence of discursive psychology. It wishes to consider the “empirical realities of people’s lived experience and their sense of self” (Eatough & Smith, 2008, p.184) rather than just focus upon the lifeworld as a linguistic and discursive construction. This is the position I have adopted in my approach to this study.

IPA emphasizes subjective meaning making and a view that the individual is inextricably caught up in a reality that they participate in. This position, which I also hold for the current study, is aligned with symbolic interactionism and sees the individual as constituting their social worlds and developing their sense of self through intersubjective interpretative activity (Eatough & Smith, 2008).

In line with discursive approaches (Willig, 2003), this approach to IPA also appreciates that talk is action orientated and that the language of an individual’s culture may influence and limit reality. This is not the full picture, however, of what an individual is doing when they recount their life stories (Eatough & Smith, 2006b, 2008). I espouse this particular stance, positing that people find personal relevance and ongoing significance when they tell their life stories, and this is why events in an individual’s life

are important (Eatough & Smith, 2006b). People do perform actions, such as justifying and persuading for example, when they recount personal events but they also instil these events with meaning so that they can connect past, present and future lived experiences (Eatough & Smith, 2006b). This is much more than drawing on “a culturally available stock of meanings” (Eatough & Smith, 2008, p.185). This standpoint therefore maintains that there is more at stake when people talk than simply action orientation although it acknowledges that this is part of what people do.

This particular approach to IPA also shares some common ground with FDA in examining how an individual’s world is discursively constructed and how these constructions are implicated in influencing and constraining their experience. However, while this type of IPA acknowledges multiple influences such as cultural and historical situatedness, including discourses, it privileges and gives a central role to experience (Eatough & Smith, 2006b). Eatough and Smith (2006b) argue that thinking about an interview as simply telling us about how a person talks about a particular experience is an incomplete account of what is happening. They propose that there is an ongoing stability and significance for an individual that spans accounts, thoughts and actions and transcends a localised interaction such as an interview. This is the stance that I have adopted for this study and in this way I have incorporated into my analysis some examination of how personal and cultural discourses, or frameworks of meaning, interconnect and are lived and experienced by the participant (Eatough & Smith, 2006b).

IPA can therefore be seen to be a bridge between discursive psychology and mainstream social cognition research (Smith, 1996). It has a clear focus on experience without applying any closed a priori theoretical assumptions on what might be learned from participants. Because of this IPA can make cautious inferences regarding affective, discursive and cognitive phenomena.

My epistemological stance rejects the dualistic separation of subject and object and therefore the individual from the world, espousing the Heideggerian view of the person-in-context. By this I mean that we are inevitably beings-in-the-world always situated amid and involved with some sort of meaningful context (Larkin, Watts & Clifton, 2006).

IPA is an experiential approach and is phenomenological. As such it accepts that language reflects the experiences of, and the meanings attached to, particular events and situations by participants (Lyons & Coyle, 2007). Accessing this experience is not straightforward, however, and depends on and is complicated by the need for interpretation by both the participant and the researcher (Smith, 1996). I acknowledge therefore that it is impossible to fully access the participant's lifeworld. From this perspective I have focused on the person-in-context, striving to use participants' accounts to reveal a glimpse of their engagement with and relatedness to the phenomenon in question. I have aimed to illuminate how they understand and make sense of that experience in the context of their history, culture and environment.

My position could therefore be described as somewhere between critical realism and contextual constructivism (Jaeger & Rosnow, 1988; Madill, Jordan & Shirley, 2000).

Reflexivity

The notion of reflexivity is vital to the qualitative paradigm as it rejects the idea that a researcher can remain detached and impartial from their subject matter thus providing a truly objective view. It is therefore vital that researchers reflect upon their own position in relation to the phenomenon in question in order to consider how they may have shaped and influenced both the process of the research and the findings (Willig, 2001).

Willig describes two types of reflexivity: personal and epistemological. Personal reflexivity involves reflecting on how "our own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research" (2001, p.10). Epistemological reflexivity, on the other hand, is more about reflecting upon our assumptions about knowledge and what we can know (epistemology) as well as our assumptions about the world (ontology) and how these might have influenced the research and our findings.

In terms of personal reflexivity, I acknowledge that it is impossible not to be implicated in the research process, and that my own view of the world and the nature of my interaction with the participants have influenced both data collection and analysis. In this way, I recognize that the analysis is my interpretation of the participants' experience, and that an awareness of my contribution to the construction of meaning from the data is vital (Willig, 2001).

Thus I have considered my own standpoint while conducting the study and as a result have been aware of and critically examined my reflexivity and influence upon the research throughout the process. I have endeavoured to include these reflections in the report. Moreover, in terms of epistemological reflexivity, I trust that the reader will find evidence of full reflection upon these aspects in the earlier sections.

In addition to personal and epistemological reflexivity, I have also discussed various methodological considerations. Examples of methodological reflexivity can be found throughout the report. These include a discussion of other qualitative methods considered in order to answer the research question and how these methods might have given rise to a different understanding of the phenomenon and reflections on the process of interviewing and of analysing the data.

Validity

Along with a proliferation in the use of qualitative research methods in psychology over the last two decades, a lively debate regarding quality and validity has also been flourishing (See Elliott, Fischer & Rennie, 1999; Reicher, 2000; Elliott, Fischer & Rennie, 2000; Yardley, 2000). The wide diversity of qualitative research methods and associated epistemologies has given rise to broadly different traditions and procedures. This diversity, while allowing qualitative research methods to offer a complementary set of investigative procedures to the more traditional quantitative approach, has ultimately increased the difficulty of demonstrating value and validity for these methodologies (Yardley, 2000).

The ongoing debate has focused around the desire for convergence on a well-defined and unitary set of criteria by which qualitative research may be evaluated. However, it has also been argued that one set of criteria can never cover the extensive range of methodological and epistemological standpoints within the qualitative paradigm. This suggests that common procedures and standards for validity are incompatible with qualitative research methods (Meyrick, 2006; Yardley, 2000).

As the debate has progressed, however, some consensus has been reached regarding guidelines that are useful as a set of suggestions for good practice. These allow qualitative researchers to show that their studies are rigorous and reliable within the

paradigm. There is a caveat, however, in that simply following guidelines will not necessarily guarantee good research and these guidelines are therefore not a set of rules to be followed slavishly (Yardley, 2008) but must be used thoughtfully and tailored to the methodology. They may also be influenced by the epistemological standpoint from which the researcher is working. The guidelines for evaluating validity suggested by Yardley (2008) and Meyrick (2006) are argued to be sufficiently flexible to cover a wide range of methodological approaches and it is in line with these guidelines that I aim to demonstrate the validity of the current study.

The first core principle is sensitivity to context. This may cover a number of issues, the first being that the study is sensitive to the context of existing theory and research in the development of the research topic and question (Yardley, 2008). This study aims to demonstrate that a question has been formulated to address a gap in the current research regarding women's body image across the lifespan. It therefore focuses on a particular time in the lifespan and a topical group of women. A thorough literature review can be found in chapter one that demonstrates clearly the rationale and development of the research questions.

A second issue is that of sensitivity to the perspective and socio-cultural context of participants (Yardley, 2008). This may impact participants' willingness to contribute to a study and whether they feel able to express themselves freely. The researcher's characteristics and the setting in which the research is carried out, for example, may influence participants and, as a consequence, the data gathered.

Participants were interviewed in their own homes in order to maximise accessibility and to ensure that the women felt entirely comfortable throughout the interview process and could conveniently feed and change their babies should they need to. In addition, the interviews were carried out by the researcher herself who is a woman of similar age and socio-cultural background to the participants. It was hoped that these factors might encourage the women to give an open and frank account of their experience, but have also required consideration regarding issues of reflexivity that will be discussed later.

Furthermore, the interview schedule (see appendix E) was constructed in an open-ended manner and used flexibly in the interviews themselves in order to encourage participants

to convey what was important to them regarding the topic with minimal influence from the researcher.

The issue of sensitivity was also considered at the analysis and writing up stage with reflection upon and due consideration being given to the content of the women's views and how these were expressed. In an effort to show sensitivity to the data I have endeavoured to suggest alternative interpretations throughout and pay heed to the complexities of the women's accounts. The reader may decide if these aims are demonstrated in the report and have been achieved to some measure.

A third issue is that of commitment and rigour (Yardley, 2008). This may involve several aspects, the first of which is a demonstration of sufficient depth and insight in terms of the analysis. Even though I have endeavoured to engage with the women's narratives extensively, assessment of the study on this criterion will ultimately lie with the reader. Another aspect of this issue is that of the sample. I have attempted to convey sufficient detail regarding sampling techniques and a coherent rationale for the choice of sample (Meyrick, 2006) therefore demonstrating that it is purposive and homogenous in nature and thus appropriate and representative of the group chosen for the study.

The fourth issue for consideration is that of coherence and transparency. Coherence may be described as being between the design of the study and the analysis and presentation of the data; it relates to how much the study makes sense as a consistent whole (Yardley, 2008). I have been mindful of this throughout the research process but again the reader will ultimately be the judge of this aspect.

Transparency relates to how clearly the reader can see exactly what has been done and why (Yardley, 2008). Once again I have endeavoured to make the aims of the research and research questions clear and have also provided a comprehensive, explicit and detailed description of the design and procedures employed in the research process that is fully referenced to a body of literature. The reader can therefore make a judgement on the appropriateness of the methodology and how systematically the process of analysis was conducted (Meyrick, 2006).

Attention has also been paid to reporting the divergent experiences that contradict the emerging patterns of themes within the women's accounts (Meyrick, 2006). It is hoped

that this demonstrates a complementary process of “disconfirming case analysis” (Yardley, 2008, p.242) that will assure the reader that I have taken all the data into account and not simply presented that which fits with my perspective.

Moreover, the entire process is supported by a full paper trail. The paper trail can provide evidence linking the raw data to the final report and each step of the analytic process may be traced in detail. Through this process I hope to further demonstrate rigour and transparency (Meyrick, 2006; Yardley, 2008).

In addition, transparency is enhanced through reflexivity. This is an explicit consideration regarding the researcher’s impact upon the study in a variety of ways (Yardley, 2008) and, as mentioned above I have endeavoured to demonstrate due reflexivity throughout the report. In particular I have clearly stated my epistemological stance and defined the exact nature of my proximity to the data through acknowledging how my own experience has shaped the findings throughout (Meyrick, 2006).

The final issue that will be taken into account when considering the validity of the current study is that of impact and importance (Yardley, 2008). The current study focuses on the meaning, context and complexity of this group of women’s lived experience of their bodies and body image and as such has generated a rich, contextual and interpretative description of their subjective experience. I hope that this might lead to a better understanding of this particular group of women for counselling psychologists in terms of their process and that this might therefore enhance clinical practice. Ultimately I hope that this will encourage a deeper and more meaningful connection, and possibly a heightened level of empathy, when working with this group of clients and will therefore lead to some practical application in a clinical sense.

Procedures

Sampling and Participants

Participants were eight women aged between 33 and 40 years of age, who had given birth to their first child (i.e., primipara), and who had English as their first language. The literature suggests that body image concerns of first-time mothers are greater than for those with more than one child (Devine et al., 2000; Stein & Fairburn, 1996). The sample, therefore, was primiparous so that the women interviewed had no prior

experience of the bodily changes that accompany pregnancy and postpartum. It was also purposive and homogenous.

The study focuses on “older first-time mothers” as population statistics show that in England and Wales there has been a trend towards later childbearing over the last two decades. This is demonstrated by an increase in fertility rates (number of live births per thousand women) for women in their thirties and forties and a decrease in fertility rates for women in their twenties or younger. For example, in 2004 the fertility rate for women aged 30 to 34 overtook that of women aged 25 to 29 for the first time. This age group of 30 to 34 subsequently had the highest fertility rate for both 2005 and 2006 and look set to do the same for 2007 (UK Office of National Statistics, 2006).

In the decade since 1996 women aged 35 to 39 have also shown increased fertility rates, showing a 43 percent increase in live births per thousand women. Fertility rates for women aged 40 and over have also been increasing for the last twenty years. In 2006 the fertility rate for women aged 40 to 44 was more than double that of 1986. Birth rates for women aged 40 and over are at their highest rate in forty years (UK Office of National Statistics, 2007). In contrast, women under 20 are experiencing their lowest fertility rates for 50 years, indicating that the teenage birth rate has fallen. Fertility rates for women under 25 have also fallen in the last decade, as have those for women between 25 and 29 years old (UK Office for National Statistics, 2006).

These population statistics clearly demonstrate the growing trend towards later childbearing and this topic has been the subject of much recent media attention. This is due to the possible complications during pregnancy that older mothers may experience, as well as the increased demand for IVF treatment by couples wanting to start a family later in life who are experiencing problems conceiving. I therefore felt that this group of women aged between 30 and 45 years were a topical group to investigate within the current context.

According to the principles of IPA, eight participants were recruited for the main sample (Smith & Osborn, 2008) with one additional participant recruited solely for use in a pilot interview. Participants were recruited through contact with local branches of the National Childbirth Trust (NCT) in London. The NCT is the leading countrywide

charitable organisation for pregnancy, birth and parenting and runs courses for parents both before and after birth that are led by NCT trained workers.

The trend toward later childbearing is reputed to be highest among women with higher educational qualifications as they increasingly postpone childbearing to pursue their careers. As life expectancies have increased in the Western world, a woman in her thirties may now be considered to be in her prime. More and more educated women are now choosing to delay motherhood until well into their thirties when they feel more ready to start a family having already had good career and leisure opportunities. This, coupled with increased maturity, may mean that these women feel better equipped to cope with the emotional and financial demands of having a baby.

This common speculation is supported by an empirical study conducted by the Population and Demography Division of the Office of National Statistics (Rendall & Smallwood, 2003). The report investigated the association between women's attainment of higher education qualifications and childbearing. It used data from a longitudinal survey of women born in the 1950s who are consequently the group of women that have most recently completed their reproductive lives. The findings are therefore an estimate but nonetheless concluded that attaining higher educational status is associated with delayed first childbearing.

The sample was drawn from the NCT for these reasons as I was aware that this organisation appeals mainly to educated, middle class women of older age groups who can afford to engage in fee paying antenatal and postnatal courses to support them through the childbearing experience.

Unfortunately the NCT could not provide specific demographic information relating to its service users in order to support this assumption prior to recruitment. A report regarding access to maternity information and support published by the organisation in 2000, however, does note that "older white women from the upper end of the socio-economic spectrum were more likely to have heard of and used NCT services" (Singh & Newburn, 2000, p.50). This implied that the NCT is a valid source of older, more educated mothers. In order to validate the sample further in this respect, demographic details relating to educational status were gathered prior to interviewing (see demographic form in Appendix A).

Contact was established with Hackney and Islington NCT, where the postnatal group coordinator offered to assist in the recruitment of participants through email dissemination of information about the study to group members. Recruitment material that was passed on to potential participants included the information sheet and flyer that can be found in Appendix B and C respectively. Both materials had ethical approval for use from the University as part of the proposal for the study. Five participants contacted the researcher as a result of this and were recruited for the study.

Contact was also established with another local branch of the NCT, the Birth Education Network for Central London. The coordinator of this group invited the researcher to attend a postnatal group meeting and present the project to the mothers. From this meeting a further four participants were recruited. The presentation was based on the information sheet found in Appendix B which was also used as material to be taken away by the mothers for reference.

Situating the sample

Brief details of each participant's circumstances in a thumbnail sketch can be found in Appendix D. The purpose of these is to contextualise the women's experience as a notable feature that emerged from the transcripts was how each woman's interview was dominated and coloured by their individual experience. Demographic details that are directly relevant to the study can be found in Table 1 below.

Table 1. Participants' demographic details.

Participant	Age	Number of children	Age of child at time of interview	Type of birth	Breastfeeding	Educational attainment	Ethnicity	Marital status
Amanda ⁶	40	1	6 months	Vaginal	Stopped	Postgraduate degree	White British	Co-habiting
Emily	37	1	3 months	Vaginal	Yes	Degree	White British	Married
Helena	39	2 (twins)	4 months	Caesarean section	No	Postgraduate degree	White British	Co-habiting
Sarah	34	1	4 months	Vaginal	Yes	Degree	White British	Married
Olivia	40	1	7 months	Vaginal	Yes	Degree	White British	Co-habiting (previously divorced)
Claudia	33	1	6 months	Vaginal	Yes	Postgraduate degree	White British	Married
Eva	40	1	5 months	Vaginal	Yes	Degree	White British	Co-habiting
Anna	35	1	4 months	Vaginal	Yes	Postgraduate degree	White British	Married

⁶ All names have been changed to preserve anonymity

Interview procedure

The data were collected through semi-structured interviews conducted by the researcher at the participants' homes at a time convenient to the participants. Safety precautions involved initial telephone contact with each participant, followed by a safety procedure. A friend or relative of mine was notified of the participant's details and contacted by telephone immediately prior to entering the address and on leaving at the end of the interview. In this way they might be satisfied that nothing untoward had occurred.

Semi-structured interviews allowed me to engage the participants in a dialogue. Initial questions were modified depending on participants' responses, and the format therefore provided the freedom and flexibility to explore novel and unexpected issues as and when they arose (Smith & Osborn, 2008).

Informed consent was obtained from all participants for both participation in the research and for the recording of the interview (see the section on ethical considerations). Prior to conducting the interview, demographic information was collected using the form that can be found in Appendix A. There are several critiques of the demographic form, and the information gathered from it, that may be usefully made here. The point at which this form was designed was very early in the research process. I must admit some naivety at this stage and, although the form was carefully considered at the time, on reflection I feel that it is somewhat lacking. Firstly some of the original wording could have been more appropriate. For example, the question "have you returned to work?" may have been more appropriately posed as "have you returned to paid employment?" It is possible that the former may have been interpreted by some as devaluing mothering as not being "work" whereas the latter clearly distinguishes paid employment. It should be noted, however, that none of the mothers in the sample interpreted this question in a negative way and all feedback regarding interviewing materials was very positive.

I decided at the time to gather demographic data that included some idea of educational attainment in order to establish whether participants fit the description of "older mothers" as discussed in the earlier section on sampling and participants. In addition, I asked about current relationship status, although I neglected to establish the duration or quality of this which, on reflection and in the light of the analysis, would have been useful demographic information to further contextualise the women's experience.

Information gathered about the mode of delivery and whether or not the participants were breastfeeding was also hoped to provide more contextual information about the women's individual experience of their bodies and body image. In actual fact these issues spontaneously arose in the interviews as they emerged as being integral to each individual's experience and it is therefore questionable as to whether it was absolutely necessary or useful to include them on the demographic form.

Finally, the demographic form also requested information regarding height and weight. At the time of creating the form I included such information in order to possibly calculate Body Mass Indices (BMI) for participants. I feel now that this clearly reflects my positivist stance at the start of the process. I expected at that time that I would want to establish some "objective measure" of the participants BMI from this information. As the research progressed, however, I came to realise and understand that, as a result of a radical shift in my understanding of epistemology, my stance and my interest in subjective experience, this type of "objective measure" was not actually relevant after all. In fact, on reflection, it would have been far more useful to gather data pertaining to the length and quality of the women's relationships in order to further contextualise their experience within their lifeworld.

The interview schedule that provided a framework for the semi-structured interviews can be found in Appendix E. Consistent with the aims of IPA, the schedule did not dictate the direction of the interview; rather it was used flexibly as a reminder and to guide the interview. This allowed the participants maximum opportunity to talk freely about their experiences, including unanticipated areas (Smith & Osborn, 2008), and I also remained free to follow the participants' lead and follow up their concerns and priorities at a deeper level (Smith & Dunworth, 2003).

The interview schedule was constructed following consideration of a range of issues that I wanted to cover. The review of the relevant literature provided inspiration and ideas as to which topics might be addressed. I aimed at the time to be specific enough with my questions to encourage the participant to talk about the topic but also to be as general and open-ended as possible in order to encourage the participant to respond freely and to minimise my own influence on their response (Smith & Dunworth, 2003; Smith & Osborn, 2008). This was a delicate balance which I am not entirely sure that I

achieved. A critique of the interview schedule and suggestions for improvement may therefore be found below.

Time was taken at the beginning of the interview to develop a rapport with the participant by using several “warm up” questions regarding the pregnancy and birth. The order in which the questions were raised on the schedule was decided according to what seemed a logical sequence in the moment with more sensitive questions being left until later in the interview when the participant had relaxed (Smith & Dunworth, 2003).

Participants demonstrated a range of styles of responding with around half freely discussing their thoughts and experiences around all areas of the schedule with very little input from me and the other half requiring more use of the schedule and prompting. Pacing was vital in order to allow participants enough time to give full and complete answers (Smith & Dunworth, 2003).

As with the demographic form, the schedule was constructed very early in the research process and, once again, I feel that it reflects my naivety at this point in my development as a qualitative researcher. With the benefit of hindsight, and a greater understanding of qualitative interviewing, I now feel that the questions are too closed and directive, despite doing my best at the time to remain open ended. The impact of this may have been that the data were in turn restricted according to the questions asked and that participants were largely respondents rather than really telling their stories. I would certainly write quite a different schedule now and would aim for a more mutually exploratory journey. In order to achieve this I would start by being clearer with participants at the outset that the aim of the interview is a mutual exploration of their experience. I would be more explicit regarding my wish that they talk freely and bring their experience to life for me and that they are the experiential expert. To this end I would also take some time to dispel any preconceptions they may have about the interview or me being the expert as I am in the position of the interviewer.

Through asking very general introductory questions such as “what does the term body image mean to you?” I would hope to enable the participant to set the scene and provide the main dimensions or parameters of the phenomenon as it is for them. Initial questions such as this aim to prompt the participant to raise aspects that are important or significant to them, thus setting the dimensions of the topic early on. Following this I

would encourage the participant to share concrete, situated details from their lifeworld, rather than generalities, through more specific questions like: “Can you tell me about a time since the birth of your baby when your body came to your attention in some way?” or “can you tell me about a time when you were happy or unhappy with your body?” followed by “can you describe how you feel about your body now in relation to that time?”. I would use more direct questions, as on the present interview schedule, later in the process as it would be more appropriate to be directive once the participant has set the broad dimensions of the phenomenon as it is for them.

On reflection therefore, although the interview schedule used to gather the data for the current study leaves a lot to be desired, it still enabled the garnering of rich and nuanced data. I suspect, however, that this may have been rather more by luck than design and I feel fortunate that the women participating in the study were on the whole very articulate and thoughtful, and seemed to be reflecting in the moment without much prompting from me.

The interviews lasted between approximately 45 and 90 minutes depending on the participant. They were recorded with participants’ consent on a Sony Digital Voice Recorder. The participants were verbally debriefed at the end of the interview, and were given written debriefing information (see the section on ethical considerations). The interview recordings were transferred to CD-R and stored in a locked cabinet at the researcher’s home. They will be destroyed when the research and assessment are fully completed.

I conducted a pilot study with three participants in addition to the main study using six participants. The purpose of the pilot was to pre-test the interview schedule, with particular focus on the wording and order of the questions. The pilot also provided an opportunity to gauge participants’ responses to the questions, receive input regarding content and allow technical rehearsal and troubleshooting.

The three pilot interviews were conducted over a period of three weeks. Each was transcribed by the researcher and a preliminary analysis was conducted in order to ascertain whether the interview schedule was giving rise to data of a rich enough nature. The subsequent interviews were then conducted in succession over a further three weeks. These were transcribed in succession over the following three months.

I would like to note at this point that following the initial analysis of the three pilot interviews I decided to use two of the pilots as data for the main study. This was due to the rich nature of the data from these interviews. Identical procedures regarding the entire interview process were used for these two pilots and the main interviews. In addition, the interview schedule was not altered subsequent to the two pilots used as data for the main study. In light of all ethical and methodological considerations being the same, and the richness of the data obtained in these two pilot interviews, I have chosen to include the transcripts in the main body of data.

Ethical considerations

The proposal for this study was granted full ethical approval at the Department of Psychology of City University. The ethics release form may be found in Appendix F. In addition, I gave full and due consideration to the ethical implications of the proposed research, in accordance with the British Psychological Society Code of Conduct, Ethical Principles and Guidelines (2005).

Recruitment at the proposed organisations was subject to approval from both the Department of Psychology and the relevant parties from the local branches of the NCT. Those mothers who expressed an interest in participating were given a written information sheet (see Appendix B) in order to furnish them with details about the project aims and what participation involved so that they might give informed consent.

Informed consent was obtained once I had the opportunity to establish face-to-face that the participant fully understood the information provided, and involved the signing of the consent form appended (see Appendix G). The consent form explained and reiterated all information regarding supervisor contact details, the purpose of the study, anonymity, the right to withdraw at any time and the researcher's contact details. Participants were assured that they had the right to refuse to answer any questions should they desire. Both participant and researcher kept a copy of the consent form.

Participants were also requested to give informed consent to record the interviews. A copy of the consent to record agreement can be found in Appendix H. This detailed the conditions for consent and confidentiality relating to digital audio recordings of participants' interviews. All signed material such as consent forms and other material

pertinent to participants, such as demographic forms, have been kept securely in a locked cabinet at the researcher's home and will be destroyed when the research and assessment have been fully completed.

I did not anticipate any physical risks to participants during the data collection. The risk of both physical and mental harm to participants was considered to be no greater than that in ordinary life. On consideration of any adverse emotional consequences that might have occurred as a result of participation, I conducted a verbal debriefing in order to discuss the experience of participating and to monitor for any unanticipated negative effects. Participants also received a written debriefing (see Appendix I) at the end of the interviewing process.

The written debriefing contained information regarding the nature of the study and details of relevant resources that could be accessed in the event of participants needing support following the interview. It also contained contact details for the researcher and supervisor should participants have wished to withdraw from the project or raise any other issues regarding the conduct of the interview. Participants were advised that there was no penalty for declining to participate, or for withdrawal of consent or participation at any point in the process. In the event of withdrawing from the study, all relevant participant data and recordings would be destroyed.

For a reflexive discussion regarding relevant ethical issues, such as anonymity and the interpretative nature of the research, please see the section on methodological and procedural reflexivity.

Transcription

Each interview was transcribed verbatim by the researcher, paying heed to significant non-verbal behaviour such as gestures, laughter and noticeably long pauses (Smith & Dunworth, 2003). The transcripts included all false starts and extraneous words such as "umm" and "you know" in order that I should work from a transcript that was as close to the original dialogue as possible for the purposes of analysis.

All identifying features of participants were changed at the time of transcription in order to maintain anonymity. This included names, other individuals that were mentioned, place names and other identifying details as far as possible in order to protect privacy. A

key noting which participant corresponded to which pseudonym and transcript has been kept securely, but separately from the research data, at the researcher's home and will be destroyed when the research and assessment have been fully completed.

Analytic Strategy

IPA seeks to understand the complexity and meaning of the participant's world via their narrative (Smith & Osborn, 2008). In order to do this, I have engaged in an interpretative relationship with the transcript of each interview. As this approach is idiographic in nature (Smith & Osborn, 2008), the initial focus in the analysis was on the issues arising from each individual transcript and they were worked through one by one. Transcripts were formatted in landscape with a wide margin on the left hand side and a smaller margin on the right hand side to allow for notes to be made. The lines were numbered as were the pages for ease of reference throughout the analysis.

Each transcript was read a number of times whilst simultaneously listening to the recording of the interview. I found that this enhanced the analysis as participants' voices and intonations could almost be heard mentally on subsequent readings (Smith & Dunworth, 2003). Notes regarding initial thoughts about the transcript were made in the left hand margin. These notes included comments on sections of the text that captured my interest, summaries of the narrative, associations and speculations, links to other aspects of the account and some preliminary interpretations at a very basic level. The aim at this point was to stay close to the text and its meaning (Langdrige, 2007; Smith & Dunworth, 2003).

Emerging sub-themes were then identified and developed from the initial notes and noted in the right hand margin. These were words or phrases that captured the essence of the quote. Throughout this process the transcript was reread a number of times in order to ensure that the emerging sub-themes were still embedded in the original text and therefore truly representative of the participant's narrative. The preliminary sub-theme labels reflected a broader level of meaning for each particular quote from the text. The labels were not considered to be fixed at this point as I was aware that they might change during the cross-case analysis and indeed even during writing up. This process moved into a slightly higher level of abstraction and was more interpretative than the initial note-making (Smith & Dunworth, 2003). This process is demonstrated in an extract from a transcript that can be found in Appendix J.

The next step was to construct a table of themes for the transcript using a spreadsheet package. The sub-themes from the right hand side of the transcript were first clustered together according to apparent links between them, connections and similarities. Sub-themes were clustered into groups that seemed to belong together and might be aspects of broader categories. The clusters were then given tentative theme labels that seemed to capture their essence (Smith & Dunworth, 2003). The table listed the theme, sub-theme and the page and line numbers for the relevant quotes. This allowed each theme and sub-theme to be linked to the originating text so that they might readily be traced back through the analytic process and ensure good validity. An example of a table of themes can be found in Appendix K. Once again, the theme labels were not considered to be fixed at this point in the analysis.

Throughout this process of ordering the sub-themes, the transcript was continually checked and revisited in order to ensure that emerging themes were fully representative of the source material direct from the participant. It was vital that I constantly verified my interpretation against the participant's original dialogue in this way in order to ensure good validity. When the table of themes was finished, the entire procedure was performed on the next transcript using the table of themes from previous analysis to guide subsequent analysis. Care was taken to remain open to new themes arising in subsequent transcripts and initial analyses were amended and checked as the analysis continued through participants. The process was therefore iterative (Langdrige, 2007).

Once a preliminary analysis had been performed on all of the transcripts, a further review of each spreadsheet was performed. The transcripts were revisited once more and all quotes were checked to ensure that they were fully representative of the emerging themes. At this point a fellow researcher (a student peer) was also engaged in this process for four of the transcripts in order to establish that my emerging themes could be linked back to the text. Throughout this cyclical and iterative process, quotes that were not considered to fully represent the emerging themes were discarded and the clustering was reordered in the light of the other analysis. This process could be described as a "sifting" through the data and, slowly but steadily, a bigger picture of the entire data set was established.

The analysis was then performed across the cases. Each theme was compared and contrasted across participants. Connections between each participant's theme tables were examined. A master table of themes was constructed that captured the important shared aspects of the women's experience across the individual transcripts (Smith & Dunworth, 2003). The transcripts were revisited once again and each quote was rechecked to ensure that that it was truly representative of each theme. For each participant the most appropriate quote, or two if that was possible, was chosen. As before, the table consisted of theme, sub-theme, participant reference and the page and line references for each quote. An example of the basic master table of themes can be found in Appendix L.

Another master table was also constructed at this point in the analysis into which the quotes were cut and pasted from the transcripts. An example of this can be found in Appendix M. This process of mapping the themes with actual quotes was vital to once again check validity and also to allow easy reference once the writing up process had begun.

This final process allowed me once again to "sift" through the data set and discard quotes that were not felt to be good examples of the relevant theme. This led to a final paring down of the data in preparation for writing up. The entire process required flexibility as some themes were reworked at this stage and the data were yet again reorganised. As before, this was again a cyclical and iterative process.

The process also enabled the identification of similarities and differences in participants' accounts of their experience, thus the micro convergences and divergences in the participants' narratives emerged. A final master table was constructed with the divergent themes that were individual to certain participants only.

At this point the themes were clustered together to derive three super-ordinate themes. The super-ordinate themes appeared to capture and organize the majority of the data from the transcripts. They therefore represented a mapping of the analysis of the women's experience of their bodies and body image (Smith & Dunworth, 2003). This process was again iterative and took some time to finalise. The whole process therefore involved moving from a close case-by-case inspection and interpretation of the

individual accounts to a more abstracted and synthesised account of the group as a whole (Smith & Dunworth, 2003).

Once the process of analysis was finally complete, the writing up process began. As the super-ordinate themes were written up the data were further reorganised and super-ordinate, theme and sub-theme labels were revised and changed as the final analysis section of the thesis took shape. It was only at this point that the final decision was made as to what might be included in the write-up.

Throughout the analysis section, quotes were edited in order to improve fluency for the reader. Extreme care was taken not to alter the meaning of the quotes so as to remain true to the original dialogue. False starts and extraneous words that were not considered necessary for the main gist of the quote to be fully understood were edited out. Where appropriate, some quotes were left as originally transcribed as it was felt that false starts or hesitations were indicative of process and therefore necessary for the interpretation.

Methodological and procedural reflexivity

My first reflection concerns the interviewing process. It could be argued that it is the relationship between the researcher and the participant which brings the phenomenon into being. In other words, the phenomenon is a product of my interaction with the participant. That is not to say that it does not exist outside the interview but rather that it manifests itself in a particular way in that situation and under those circumstances. This is due to the co-creation of the interview by participant and researcher. My influence in the interview will therefore contribute to the phenomenon and so must be considered.

I felt that a number of things were going on in the interviews: firstly, the women themselves appeared to be reflecting and sense making in the moment. This was evident in their narratives as they give accounts of their relatedness with body, self and lifeworld. Reflecting on this process has affirmed the epistemological standpoint that I adopted for this research. At the time, it felt as though the women's sense of self were emerging through their talk and as part of our mutual engagement in the interview process. As meanings are generally negotiated between researcher and participant within a particular social context (Finlay, 2002b), this led me to question my part in this shared construction of meaning, experience, self and lifeworld.

One thing that did strike me was the possible impact of my appearance. I am slim, look and dress younger than my years and do not have any children. In addition, the group was ostensibly self-selecting with only one woman a post-pregnancy size sixteen. The rest reported a smaller dress size, similar to that of pre-pregnancy, and all were satisfied with their postpartum bodies. I suspect that had I been a size sixteen, as opposed to a size eight, some of the women would not have been as frank with me regarding some of the topics, such as weight, that arose in the interviews. I also wonder in particular about the impact of my size in the interview with Amanda who was a size sixteen at the time. Amanda did adopt a very nonchalant attitude to her weight gain and body image and I have wondered about the intersubjective dynamics at play in the interview as a result of our respective sizes. And what if I had looked older and “more like a mother” (whatever that may look like)? It is difficult to say how this might have affected the lifeworld of the interview. It is also difficult to speculate on how the interviews might have been different with less satisfied women or if they had all been of a larger dress size.

An additional source of reflection has been my assumptions regarding the women’s experience. These undoubtedly influenced the research questions that I posed and the interview schedule that I constructed. Had I had personal experience of childbearing, I am in no doubt that my schedule would have been different, along with my assumptions and tacit expectations of the interviews themselves. It is difficult to say how these latter constructs may have silently influenced the process of data collection. Although I endeavoured to take a passive role with minimal input throughout the interviews, I suspect their influence may have been manifested through my prompts and which material I decided to follow up at the time. After all, my behaviour will inevitably have affected the participants’ responses, thus influencing the findings (Finlay, 2002b).

Another reflexive epiphany relates again to my assumptions and preconceptions or fore-understandings. I found that my understanding of the women’s experience inextricably involved my fore-understandings and assumptions as these are “both my closedness and my openness to the world...the basis of my ability to experience” (Finlay, 2002a, p.4). In other words, my preconceptions are the conditions of my understanding. Thus, despite my efforts to reflect upon my assumptions prior to undertaking the research, I believe that I could not truly know them, let alone set them aside, until they emerged and became apparent to me through my understandings of the women’s experience

(Finlay, 2002a; Smith, 2007). In this way I could not help but bring myself into the research. Finlay describes this perfectly as she says:

New understanding emerges from a complex dialectic between knower and known; between the researcher's past pre-understandings and the present research process, between the self-interpreted co-constructions of both participant and researcher. Between and beyond... (Finlay, 2003b, p.108)

The way this manifested itself during the interviewing process was that I kept observing in myself a feeling of surprise. I realised that I was surprised at how satisfied the women were with their bodies and body image. This was not what I had expected although I do not think I was really consciously aware of the strength of my expectations or assumptions at the time. Gradually, the further I delved into the women's narratives through the analytic process, the more clearly I came to understand that I had expected and assumed that the women would have a quite different and more negative experience.

The analytical process itself was long and arduous, requiring much greater commitment than I had initially anticipated in my naivety. There were times when I felt completely and utterly overwhelmed by the sheer magnitude of the task in hand. I honestly believe on reflection that eight participants were too many and that I could have produced a similar piece of work, perhaps with more depth as opposed to breadth, with five participants. Indeed, it is conceivable that I could have even written a single case study, so rich were the data that many of the women provided. I have therefore had to find a delicate balance between presenting a comprehensive overview of the vast body of data collected and without sacrificing too much of the finer detail.

The analysis felt somewhat denuded as a result of this. There was so much of the original material that I could not include and I felt that to some extent, inevitably, something of the individual women's stories was lost in this process. In response to this I created a set of poetic condensations (Ohlen, 2003) from each participant's transcript. I have therefore decided to include my favourite of these for each woman in Appendix N along with a reflexive introduction to explain the process by which they came about. I hope that what these may communicate to the reader is another aspect of the women's experience that I felt was important to the individual but was unable to include in the main body of the report.

Something that became evident as I progressed through the analysis, which is again related to my assumptions and fore-understandings, was a gradual realisation that the women's experience was not simply confined to their body image. I came to understand that it was much more than that; it was about their *bodies and their body image* as it encompassed a much broader experience than just how they felt about their appearance. It was more about their embodied experience including function and how they related to their lifeworld with and through their bodies. This led me to review the aims, research questions and title of the research to reflect this broader conceptualisation of their experience. I find it almost embarrassing to reflect back and acknowledge my naivety and that I originally held such a one-dimensional view of this complex construct at the beginning of the research. On the other hand, I suppose that it is also demonstrable evidence of my progress and development as a researcher that has come about through conducting this investigation.

Furthermore, the iterative nature of the process has astounded me; continually moving between parts and whole as I have tried to develop an understanding of the bigger picture for the study while grappling with the participants' individual accounts and my understandings of them. This was a difficult and lonely process requiring stamina to see it through; at times it felt a bit like running a marathon on my own in the wilderness. Eventually, after many months, what feels like a huge and delicate web of interconnecting strands has finally emerged into clarity from what seemed for a long time to be a woolly, confusing and indistinct mess.

My final reflection relates to matters of ethics. Not surprisingly, a number of ethical issues came up as the research progressed. Firstly there is the issue of anonymity. I have made every effort to change names and other identifying details. However, there are some elements of the participants' narratives that are important to contextualise their accounts but could also be construed as identifying. For example, details about the participants' birthing experience, which may have a bearing on their experience as a whole. Although these details are not necessarily central to the analysis, they nonetheless provide contextual information that serves to thicken the description of the participants' experience (Brinkmann & Kvale, 2008).

After much deliberation, I have decided to include this type of information in the thumbnail sketches that can be found in the appendices. On careful consideration, I have concluded that this extra contextualising information may be useful for the examiners and for the purpose of the assessment. When I come to write the research up for publication, I will not include these specific details that could be more identifying. On the other side of the coin, it could be argued that these features of the women's experience are not unique and therefore could apply to many women who have had children. The exception here is, of course, Emily whose circumstances were very unusual. I was not aware of these circumstances until I conducted the interview and when I discussed anonymity with Emily she was adamant that she wanted to be open about her situation and had agreed to do the research with that very wish in mind. As a result of this discussion with Emily, and similar discussions with the other participants, I have decided to include this information in the thesis.

Another issue that I was confronted with was that of my interpretations. This has arisen in the context of what I might send to the participants once the research has been assessed. All participants requested a summary of the results and conclusions and here is where the ethical dilemma lies. I have no doubt made interpretations that, although grounded in the data, go beyond the self-understanding of the participants. Is it ethical to confront these women with unsolicited interpretations of themselves and their dialogue? What if they disagree with them? I have had to find a balance between taking the interview data to another level of interpretation, and therefore probing more deeply into the women's accounts, whilst also remaining at a level that is "safe" but will not be accused of only scratching the surface.

The conundrum of access to my interpretations has led me to realise that I have, as Brinkmann and Kvale put it, "upheld a monopoly of interpretation over participants' statements and enjoyed the privilege to interpret and report what [*I felt*] they really meant. These points all engender significant ethical questions." (2008, p.273, italicised text added by the current author). There is, therefore, an inherent power differential in the research. I have deliberated over this at length and I am still not sure what I will do. If I write a summary for the participant that is "sanitised" and errs on the side of caution, surely this is in itself dishonest and unethical? On the other hand, if I send the full analysis, interpretations and all, am I confronting them with an opinion they may not welcome? Is there some in-between state that may be ethically acceptable? The

answer is not clear to me at this time. I will definitely need to deliberate this point further and make full use of all available advice and greater experience before making a final decision.

Analysis

Overview

Analysis of the transcripts yielded data which covered a wide spectrum of the women's embodied experience during the postpartum year. Due to the extensive nature of the data it was necessary to prioritise the development of an account that firstly seeks to answer the research questions, offering some insight into the areas previously neglected in the literature, and secondly highlights some of the more interesting novel and unanticipated aspects of the women's experience. This section therefore aims to present and discuss a portion of the emergent themes under three broad organising categories or superordinate themes: the body, self and others; the body in cultural context; and the body as perceived and lived.

It is important to draw the reader's attention to the fact that these superordinate theme groupings are not necessarily distinct but have much overlap between and within themselves. The superordinate themes have therefore been constructed for clarity of presentation. Furthermore, as mentioned above, the author does not intend to present an exhaustive account of the three superordinate themes as this would be outside the scope of the report; rather the intention is to indicate and highlight some of the more interesting and representative extracts and issues that have arisen as a result of the research process.

The data will be presented in this section solely with the interpretative analysis and without further theoretical discussion or integration of the relevant literature. These supporting elements may be found separately in the following section. It was felt that this approach for presenting the findings was the best means of conveying the women's experience as a whole while also portraying something of the individual participant narratives. It was also felt that this manner of presentation would better represent the women's accounts in an unfolding manner, uncluttered by psychological theory and discussion, as they were experienced by the researcher throughout the process of analysis.

The first superordinate theme, titled the body, self and others, concerns the women's experience of their bodies and body image in relation to themselves and their lifeworld, along with interpersonal encounters that emerged as having an influence on this experience.

The next superordinate theme, the body in cultural context, seeks to explore the impact of societal norms and expectations that emerged from the women's narratives. It then moves on to scrutinize the effect of media and celebrity on the women's experience. This section concludes with an investigation of the emergent theme of comparisons and their function within the context of the women's experience.

The last superordinate theme, the body as perceived and lived, aims to present the women's experience of the bodily changes that accompany childbearing and the impact and meaning of these. The influence of the women's lifeworld on this experience will be described and the section concludes with consideration of some of the broader aspects of the women's experience of embodiment or being-in-their-bodies.

Finally, the reader's attention is drawn to an emergent theme that spans all three superordinate themes and their constituent parts. This theme relates to the impact of the women's experience on their self-concept and sense of self. Although these effects varied, they were universal among the group of women interviewed, and will therefore be discussed across the themes in the manner that they arose rather than in a discrete cluster. The theme could be described as the tie that binds the women's experience together.

Superordinate theme one: The body, self and others

The first superordinate theme presents an account of the significance of body image and appearance in the women's lives, illuminating how this appears to be inextricably entwined with aspects of their sense of self and self-concept. What emerged from the data is the messy and complicated nature of this relationship and that the latter constructs seem to be in a state of flux themselves due to the transition to motherhood and dramatic change in role and lifestyle that the women are experiencing. This superordinate theme then examines the influence of context and relationships in the women's lives and how these might modulate and shape the women's experience of their bodies and body image.

Although the themes are presented here as discrete and separate, there was a large amount of overlap between the two themes, "the body and the self" and "the body and the self in the lifeworld", in that the latter emerged as being integral to, and having a

bearing on, their experience. This overlap is evident within the themes despite their separate presentation. One element that is common throughout this section, however, is the women's experience of their sense of self or self-concept. This emerged as being entwined with body image for some individuals and this manifested in a variety of ways. This aspect could therefore be described as a thread that traverses all three themes.

Theme one: The body and the self

The women's accounts revealed a wide range of experience relating to the centrality or importance of body image and appearance in their lives. Some women were very clear about how fundamental and integral this was to them whereas others did not appear to regard this aspect of themselves as significant or something that they focused on. This in turn appeared to influence the values, ideals and opinions that participants held regarding an individual's investment in, and society's focus on, body image and appearance. Two participants who appear to be at opposite ends of the spectrum are Amanda and Emily:

I think you can probably guess it's [body image]⁷ not massively important...⁸I might be falling into the category of a woman who sort of...settles down with a man and has a baby and just lets herself go and stops caring...I don't not care because if I started getting fat...I would sort of...have a word with myself but again there are many more important things on the scale of priorities than my body image, it's there somewhere, I don't not care in the slightest but it's not a big...issue in my life at all

Amanda: 11,16-24⁹

so many women do let themselves go when they...have the child, it's not...my style I...could not let myself go cause I would feel bleuhh, I would feel disgusting, I'm one of those people...I can't leave the house...with not a scrap of makeup on, I'm vain, I'm too vain

Emily: 9,4-9

Interestingly both show a high level of self-awareness regarding this aspect of themselves. It seems apparent from the two extracts that Emily's appearance is much

⁷ [Text] indicates explanatory text added by the author.

⁸ ... indicates editorial omission of non-relevant material.

⁹ Key to notation: Participant pseudonym: transcript page number, line number-(page number,) line number

more central in her life compared to Amanda who seems to feel that there are far more important things to consider.

Eva comments on her experience of the importance of body image:

body image is important I think...from the age of about, well from whatever age you are as a girl when you start worrying about your body image and...worrying that your breasts are smaller than so-and-so's or your...legs are shorter than so-and-so. It's a real part of who you are as a woman I think, I'm sure much more than as a man and however intelligent and successful you are and however much you want not to be too governed by the way you look...I know I am...and aged forty with a baby and all that that means for your career and for...people's perception of you, if I was sitting here two stone heavier wearing an elasticated skirt I would be feeling bad...I mean even now I find myself thinking... if I had a second child...everybody says if you have a second child things snap back even less quickly, so even now I'm thinking well I got away with it this time, if I had a second child would I look mumsy after that? Cause I...don't think I look mumsy, I think...if I didn't have a baby I could get away with people not thinking I had a baby

Eva: 21,21-35

Eva feels that body image is integral to being a woman and, regardless of an individual's ability to evaluate themselves according to other domains in their life or self-concept, for her it is inevitable that body image will have an impact. As she acknowledges the impact that childbearing has on her life there is an implicit understanding that it also impacts her self-concept and that her body image is subtly tied into this. She also expresses a desire not to “look mumsy” implying that it is important that she does not appear to have changed. However, it could be interpreted from her account that she has, on some level, experienced a change in some aspect of her self-concept or identity as a result of the transition to motherhood.

Other women illuminate the range of experience further. For example, Helena commented on a life-long ambivalence towards her body:

I think I've always had a love-hate relationship actually with my body....Most of the time...I think...I'm either one or the other, I'm either thinking “god, oh it's just disgusting” or I'm thinking “actually I'm not bad for nearly forty”

Helena: 1,4 and 1,24-26

Her account goes on to reveal that an improved body image at an earlier point in her life had quite a substantial impact on how she felt about her appearance and, as a result, her self-confidence. This suggests a high investment in her appearance as a criterion for self-evaluation at that time in her life. Later, Helena is asked how important her body image is to her now and her response would suggest that within the context of ageing she is less invested in her appearance and body image in terms of self-evaluation.

Olivia also comments on her experience in this regard:

you are your body, it is who you are...it's something you have to kind of get over somehow, I mean I think we've gotta try and be a bit healthy and especially if you're a parent...I know I function better if I'm not totally tired and I get more tired if I'm not exercised and haven't eaten properly and I have to look after myself slightly consciously and make sure I get enough sleep and not get too dehydrated and...ok, in all honesty, of course I'd love to be a bit slimmer and have more toned muscles and...look a bit younger or something but...it's not like...a terrible thing or a...kind of dream that I kind of salivate over

Olivia: 12,4-13

Olivia's experience indicates that it is more about being-in-her-body than her body image per se as she says "you are your body, it is who you are, it's something you have to kind of get over somehow". She goes on to clearly prioritise her desire to be healthy and fit over her appearance, acknowledging toward the end of the extract that she does not particularly aspire to experience a different body image. Olivia's greater focus on being-in-her-body is reflected throughout her account and will be illustrated throughout the analysis.

The transition to motherhood was another aspect of the women's lives upon which they spontaneously reflected. This emerged as being integral to their experience as a whole throughout this period. It appeared that the impact of a change in role and lifestyle on the women's sense of self and self-concept inextricably contributed to the complexity of their experience of their body image and often could not be separated out. For example, Eva makes a remark that relates to her comment above:

I suppose particularly men, I'd...say men from about 25 to 35 who, until I had a baby, you know, that's the age of a lot of my colleagues and people...ok, yes they're younger than me but I would say I had experiences in common with those people and I would expect to be able to make friends very easily with those

people, I think a lot of those people would look at you and pigeon-hole you and say “woman with a baby...maybe...not a potential sexual partner for me...not someone who’s going to go out...not someone who has any money to spend on clothes...and someone who’s just going to talk boringly about her baby...bleuh” and...I sometimes find myself thinking “no, no, I’m a person too...I’m not just a mother and a pushchair and...I’m still here even though I’ve got baby sick on my shoulder”

Eva: 20,29-21,3

It seems that for Eva the transition to motherhood and its attendant change in role and lifestyle has impacted her sense of self and, as a result of this, how she anticipates others will perceive her. Eva seems to feel that, in the eyes of others, motherhood has negated the sense of self that is linked with sexual availability and some aspects of her prior social world. It is as if a new dimension of the self, Eva the new mother, is emergent and coming to the fore. There is a sense of the old Eva, the person she was before and still is despite the change in her circumstances, struggling to be seen or heard as she says *“I sometimes find myself thinking no, no, I’m a person too, I’m not just a mother and a pushchair and I’m still here even though I’ve got baby sick on my shoulder”*.

Helena makes a remark that sums up a number of the women’s experience:

you do lose your...sense of self and identity, particularly I think if you’re older...I mean my career I had for nearly 20 years before I had them [her babies] and that was what defined me in many respects and then suddenly I’m not Helena...the career woman, I’m Helena mum and it’s just like god, how did that happen...very weird

Helena: 8,1-6

It is clear that for Helena that there has been a radical shift in her sense of self and self-concept as a result of the transition to motherhood. The implications of this are far reaching as she notes that her career *“was what defined me in many respects”* and it could be suggested that the wider impact of such a change may reach as far as her body image.

Theme two: The body and the self in the lifeworld

The women’s experience of the centrality of their body image appeared to be inherently context-bound at this point in their lives; it could be described as embedded in their lifeworld. Multiple experiences such as mothering, childbearing, ageing and freshly

appreciating the body's achievements seemed to have a bearing on their experience of their body image. In illustration, the context of being a mother appears to feed into Amanda's general lack of focus on body image and appearance; her body image has become even lower on her list of priorities. She comments:

the way it happens is when you're just bumming around at home with a kid it doesn't really matter how you look anyway or you go out for a coffee or you go out and meet other mothers, but maybe if I get to the point where I have to put on my glad-rags and go to a party then I'll suddenly think [intakes a breath] "I can't...I look terrible and...I can't look good again" but...I imagine that there's a big gap between the being at home bit to the going back to work bit where you're back in work clothes and...you haven't got the excuse, no one knows you've just had a baby, you are just a person...and going out the way you did before, where you're out, where you're not a mother anymore, where you're just you again and then coming to terms with the different you, because at the moment the different me is always explained cause I've always got the baby with me, so anyone who would look at me and think "ooh she's a bit fat, ah, she's just had a baby" but...once that bit is over then you're just out there and...you look the way you look, so maybe...that will be a big change as well coming out into the real world

Amanda: 6,29-7,9

As Amanda makes sense of her experience she acknowledges the current context of mothering in her life, how this impacts upon her experience of her body image and that this will change at some point in the future. It is as though mothering has allowed a relaxing of standards regarding appearance for Amanda, although it could also be argued that there is an undercurrent of apprehension in her narrative as she contemplates a time and situations when this exemption may no longer apply. There is a sense that the liberation she has been enjoying will be curtailed when she resumes her working life.

She explicitly acknowledges "a big gap" between mothering and going back to work, the implications of which are highlighted as she says "you haven't got the excuse, no one knows you've just had a baby, you are just a person". She refers to what could be interpreted as a new dimension of the self, Amanda the mother. This facet has been brought to the fore but will recede when she resumes her working life "where you're not a mother anymore, where you're just you again". It is as if she anticipates her sense of self being in a state of flux in parallel with the dual roles of mother and employee. There is a sense of disorientation within her narrative as she says "and then coming to terms with the different you", giving the impression of a sense of self that is changed by this experience of mothering and can never be the same as before. She describes this

change in her self-concept as “*the different me*” which is “*always explained*” in the context of having the baby with her and how this appears to allow the relaxing of pressure to look a certain way. Amanda also makes sense of how this will not continue indefinitely and she anticipates experiencing a further adjustment in the transition to motherhood as she once again comes “*out into the real world*”.

For Emily the context of motherhood seems to have allowed a drop in standards regarding her appearance and body image to be more acceptable:

It's this whole thing of you don't wanna let yourself go, but you have to let your standards drop

Emily: 24,13-14

Emily thus highlights a sense of tension between the tyranny of societal standards which have been internalised and the demands of mothering. Claudia, like Emily, acknowledges an inevitable shift:

I think it's [body image] still very important to me but...I think I used to...spend a lot of time thinking about it...which I don't anymore... [short pause] I mean things like...clothes and just...the way you look, it was just so much more important to me before but again I think...a baby comes into your life and...suddenly your priorities completely change and you can't be self-obsessed anymore, you can't be selfish anymore

Claudia: 7,11-17

It seems that, for Claudia, her body image is still important but the baby is prioritised over these concerns, so that within the context of mothering she has experienced a shift in focus away from herself and onto her daughter. For Helena the context of childbearing ostensibly had a different effect on her experience of her body image:

I think I've allowed myself...it sounds terribly big headed, but I think I have allowed myself since I've been pregnant...to say I look really good today and to really feel that and...I've noticed the effect of it, I think you get...many more admiring glances when you feel that way about yourself...so yeah I think I've sort of maybe given myself less of a hard time compared to before...and I think...I've been much more able to look in the mirror and focus on...the good stuff than on the things that I don't like

Helena: 9,18-32

It is as if the experience of childbearing has enabled Helena to take a different perspective brought about by the confidence it has instilled in her. She is able to view herself in a different and more positive way to before. As she makes sense of this experience she attributes this change to childbearing and is aware of the wider impact it has had. In line with this change in Helena's attitude, she later elaborates on how the context of the ageing process also feeds into this:

maybe that's also to do with...again getting older and thinking to myself "do you know what Helena...you've got to value these things about yourself because you won't always have them" ...I mean I don't know how long I'm gonna be as I am now and...what toll gravity's going to take on me...and maybe that's...why I've become more interested in dressing well for me rather than...following fashions and...all of that stuff cause...I think women in their sort of forties and fifties can look incredible if they're well dressed and well groomed and...maybe I've started to focus on that a bit more...it's sort of slightly more, I'd like to think slightly more mature attitude...and an understanding that...looking good in clothes is not just about being small

Helena, 9,33-10,8

Again there is a sense of the childbearing process and ageing acting as a catalyst for Helena to re-evaluate her attitude and approach to her appearance, enabling a reframing and refocusing of her body image and the ageing process.

Another contextual factor related to the childbearing process that seemed to influence some of the women's experience was a newfound appreciation of what the body can achieve. Helena in particular exemplifies this as she comments:

I feel probably less obsessed with it [body image] now than I did before and maybe that's because I've realised that my body can do far more powerful things than just...look well adorned on a good day...but my body...is here for, you know, it's not just here to [short pause] ...fit into a pair of size ten jeans, it has a greater purpose

Helena: 9,13-17

Emily echoes this view:

I certainly see my body [short pause] as [short pause] I don't really know how to put in into words. I see my body more now as a tool, a tool for mankind if you know what I mean, as my body, women's bodies have to do this thing... [short pause] for us to reproduce as a species so I definitely see my body much more as a tool

Emily: 25,10-16

It seems that this newfound appreciation for what the body can achieve is an important factor for these women and has allowed them to contextualise their bodies in terms of a bigger existential picture. This in turn would appear to impact their experience of their body image in a positive way.

In summary, the women's experience seems context-bound within their individual lifeworld. The overriding factor that appears to have a bearing on their embodied experience is that of becoming a mother and the narratives reveal a real sense of motherhood as empowering.

Theme three: Interpersonal encounters

Interpersonal encounters that appear to influence the women's experience of their body image include interactions and relationships with their partners, friends and families and the impact of feedback from others. All of the women commented on relationships, however, individual experience varied as to which relationship emerged as being most influential in their account.

The influence of their partner's attitude was quite variable among the women. Amanda's account, for example, indicated a seeming lack of communication between herself and her partner regarding appearance and body image issues. In stark contrast, other women's accounts revealed more evidence of communication with their partners regarding their bodies and body image. For instance, it was apparent that it is important for Eva to be able to share her feelings and concerns with her partner. It was also noticeable that they use humour within the context of their relationship, possibly as an additional way of managing her concerns. For some other women there was a much greater concern regarding their partner's attitude to their body and the changes they have experienced as a result of childbearing. Sarah comments:

I would say my friends are less worried about what their partners think than I am and I think that's because my mother's always said to me... "you need to look good for your husband" all this sort of stuff... "do your hair, do your make-up" all this but...that's not good enough, that was good enough for my dad, but that's not good enough for Adam and therefore it's not good enough for me...and I would say my friends are...less concerned, as my mum was, about weight. I think it's a pressure I'm putting on, I think...Adam applies some and...I'm glad he does

Sarah: 10,6-18

Several readings of Sarah's quote are possible as it could be interpreted as exhibiting several influences. Firstly her mother's attitude towards maintaining her appearance within the context of her marriage appears to have some bearing on how Sarah feels about this. She takes it even further, however, and extends these standards to her weight as well. Sarah acknowledges that she applies pressure to herself in order to maintain her standards and it could be hypothesised that for her the additional pressure she perceives her husband applying is useful and possibly even necessary to keep her motivated.

Secondly, it could be that Sarah perceives her husband as critical and feels she must live up to his expectations regarding appearance. It could be interpreted that she might feel this is her duty as a wife and a woman, irrespective of the impact of childbearing. This could be elaborated to suggest that he is not accepting of the bodily changes and weight gain that is, for the most part, inevitable with childbearing. He may impose his standards on her as he fails to empathise with the unique physical experience of childbearing that is so separate from his own. Both of these are grounded in Sarah's perceptions of pressure from significant others. Finally, another reading could be related to a family history of obesity and associated health problems in both Sarah's and her husband's family. It could be hypothesised that their attitude to weight control may be linked to this powerful and immediate illustration of the health issues that accompany being overweight.

Similarly, Emily's narrative shows that her partner's attitude towards her body is very important to her and therefore influential. She also notes, however, that within the context of motherhood this influence is perhaps attenuated:

I do think "ah I hope my husband will still find me attractive"...I think that's in every woman's mind and I do think that and I think that's where it's really, really difficult with breastfeeding and I thought a lot about this before I had Marcus [her son] cause I was determined to breastfeed and I sort of did some research before I had him...so that I would know what I'm letting myself in for...so yeah, I am a bit concerned but at the end of the day I will be very, very proud if I've got a healthy child or healthy children so [short pause] ...the way my husband sees me is very important but my children's well-being is more important

Emily: 7,10-15 and 7,38-8,3

There is a sense of tension between Emily's concerns regarding her partner's attitude to the likely changes in her breasts and the prioritisation of her child's health. The reader's attention is drawn to the fact that with all there is to consider when planning a pregnancy, particularly in Emily's circumstances, she spent time researching what might happen to her breasts so she "would know what she was letting herself in for". This could be interpreted as further supporting the centrality of body image in her life and as reflecting the complexity of concerns that are unique to the female as she goes through this experience. Furthermore, it would appear that this is a clear example of a radical shift in perspective for Emily as her child is prioritised over her body image concerns.

Anna seems to inhabit a sort of middle ground, revealing evidence of communication with her partner regarding her body:

I asked him [about her body] this morning actually. I think he'd say he doesn't think it's changed that much... [pause] ...I think he's more aware of the changes because of the bits that I talk about so...he'd probably...mention the stretch marks but only because he knows that I'm aware of them and that they were a surprise [laughs] ...but neither of us are, I mean that's not what our relationship's based on and it's never been based on kind of what we look like, although we're obviously physically attracted to each other otherwise we would never have had Aaron [both laugh] but yeah he was in for a penny, in for a pound as well really...and...I think he's relatively chilled out about it, I think he genuinely doesn't, it doesn't make any difference to him...and it comes as being part of kind of being mum

Anna: 14,30-15,7

For Anna there is a positive relational aspect in her life that seems to override physical concerns. It is as though the supportive aspects of her relationship afford her some protection from body image concerns. Interestingly, it also seems possible that the context of childbearing allows Anna to feel that her bodily changes are more acceptable to both her and her partner as they are seen as part of the process of motherhood. The power of the participants' relationships to protect against body image concerns was also evident in other women's accounts.

The women's experience regarding the influence of friends and family was also diverse and seems to span a continuum. For example, Emily appears to experience a degree of pressure and is concerned about scrutiny and judgement from her husband's family

regarding her postpartum body. A comment by Amanda is in direct contrast to this and further highlights the difference in their experience:

what happens...when you have a baby is that that's all they [friends] see, they just see the baby...they just look at the baby and coo at the baby...they don't really look at my stomach, or maybe they do and think things but...they don't comment on anything certainly cause all the comments are about the baby, so I don't really necessarily know what they think and they probably don't think a lot and I certainly don't have any, I feel absolutely fine

Amanda: 14,38-15,9

Amanda's experience is almost the polar opposite of Emily as she feels that all attention is focused on the baby and away from her. It seems that even if other people do look and "think things", Amanda is not concerned enough to worry or speculate about what this might be, reflecting a lack of concern that contrasts with Emily.

One participant for whom familial influence came across as being hugely significant was Sarah. Her account heavily emphasises the impact of both her own and her partner's family history of obesity and how this had shaped her attitude to weight:

I've been slim I think partly because my mother was always overweight...as a reaction. I think...that she [her daughter] needs to get a good...she needs to see that I care about my weight and how to because...in Adam's family and in my family there are obesity issues, it's not just fat, obese, ok and so for me it's extremely important that my child does not go through that because it causes so many problems...really does cause a lot of problems

Sarah, 8,38-9,6

Sarah's family history has influenced her attitudes and values regarding weight and has a direct effect on her experience. It has become vitally important for her, not only within the context of motherhood but also the influence of her own family history, to set a good example to her daughter regarding health issues as well as appearance.

Feedback from others in the form of both positive and negative comments also influence the women's embodied experience. In general the women felt that positive comments about "getting back to normal" or losing weight were affirming and served to enhance their well-being and confidence. Eva remarks upon the effect of positive comments in the face of a change in self-concept:

I mean that's [comment positively] also very much something I would do for other friends who had babies, it's something I would have done automatically before I had a baby and I would always do it now having had one and realised how important it is,...with all the changes that are going on, to feel ok about...yourself and about your body cause I think that all that is tied up. You do lose your identity a bit when you've had a baby...cause everything is so focused on the baby and you stop being you and you start being the baby's mother and...you want to kind of keep hold of you...and so...if someone said "wow you look good" ...it means an awful lot more I think than it used to...it doesn't even need to be true

Eva: 17,9-18

Eva acknowledges that her sense of self is connected to her body image as she says *"how important it is, with all the changes that are going on, to feel ok about yourself and about your body cause I think that all that is tied up"*. Again there is a sense of trying to contain multiple dimensions of the self during this time as she says *"you stop being you and you start being the baby's mother and...you want to kind of keep hold of you"*. It seems that for her the positive comments are therefore important to bolster her sense of self in the face of such a life changing event and dramatic change in role.

Superordinate theme two: The body in cultural context

This superordinate theme explores cultural influences on the women's experience of their body image. Three themes will be presented with the first examining the women's accounts of norms and expectations, including those of a cultural, societal and familial nature. Theme two seeks to explore the possible influence of media and celebrity on the women's experience of their body image, with theme three examining the ways in which the women used comparisons and how these may influence the experience of their body image.

As before, the reader's attention is drawn to a thread that traverses all three themes in this section. This could be described as the women's experience of their sense of self or self-concept and will be highlighted throughout.

Theme one: The impact of norms and expectations

The data reveal an interesting mixture of experiences regarding norms and expectations. All the women acknowledged some type of norm or expectation but some felt more influenced by these than others and some experienced these in relation to breastfeeding

rather than body image. Claudia acknowledges the Western slim ideal and the impact of this in terms of weight control:

there's a big pressure on women to be slim and to be attractive and etcetera and slim often means attractive...in our minds...so I suppose I've always watched my weight

Claudia: 2,23-25

Emily also felt under considerable pressure to conform to ideals and she reflects on the source of this in the following extract:

there is a pressure, there's a pressure on me, I mean the fact that I thought about cellulite cream today...maybe I should actually be patting myself on the back thinking I should go on a beach tomorrow, day after, proud of how I look having had a baby three months ago but I'm putting pressure on myself to make myself look better. I mean that's not coming from, that's...surely not my nature that's surely a nurture thing, that society has told me...I've got to, there's a pressure...and maybe because...I feel I'm, you know, looking ok...I wanna excel even more, I don't know

Emily: 19,33-20,4

Within Emily's narrative there is evidence of her struggle to make sense of her experience and the origins of the pressure she feels to conform to the slim ideal. She demonstrates an inner conflict between blaming societal expectations and accepting the possibility that the pressure is in fact internally generated from her own drive to look good. There is a strong sense of her wrestling with this issue as she hesitates and stumbles towards the end of the excerpt. Earlier in her account she is even more explicit regarding her focus on weight:

it all comes down to the weight at the end of the day...if people tell you "wow, you look great" after you've had a baby it's not about, I mean maybe...you're happy and maybe that shows...cause you look...happy and over the moon and everything, but I think it actually comes down to the weight thing...I was into my normal,...my pre-pregnancy clothes immediately more or less so...I think it always comes down, I think even in pregnancy it comes down to the weight...and...that is one of the barometers we use to sort of judge people, pregnant, male, female, children, old people, weight is what we sort of... "he's nice guy but he needs to lose some weight", "she's nice but she's very thin" I mean...we don't sort of comment on...the colour of somebody's hair...we often comment on their weight

Emily: 13,12-25

With Emily it seems that, as for body image, her weight is a criterion of self-evaluation. She also appears to expect others to apply this criterion and does so to them. Her sense making could also be argued to echo a societal focus on weight leading the reader to ask themselves if her attitude is simply a product of societal influence and social construction as Emily appears to succumb to the dominant discourse in society regarding weight.

In contrast to these experiences, Helena gives a very different account:

I think now maybe I feel like the pressure's off a bit because I think society...is quite forgiving of, certainly women who've recently had babies. I think it's almost like, you know, I think as women we are expected to conform to certain stereotypes but...when you have a baby you get a bit of a reprieve, yeah I think you sort of get a little bit of a...reprieve for a while...when you've just had kids and that's really nice...I mean...I think all this size zero stuff is...so utterly, utterly ridiculous that I don't even, I think it must be very difficult for teenagers nowadays because, you know, I, we didn't have that pressure

Helena: 15,26-34

It seems that Helena feels the opposite of Emily and experiences a relaxing of societal expectations and standards regarding the way that she looks within the context of, and indeed even as a direct result of, childbearing. Despite this, however, there is an element of uncertainty in how she talks and there appears to be a caveat as she notes that this may only be “for a while when you've just had kids”. This might lead the reader to wonder how long this “little bit of a reprieve” will last. Furthermore, Helena notes that she does not experience the pressure to conform to the ultra slim size zero ideal, and possibly even actively resists it. She also acknowledges that she has never experienced the amount of pressure that she perceives teenagers face in today's climate.

Later in her account Helena elaborates further on her experience and it seems that for her it is less about the slim ideal or body image and more about her face and the ageing process in terms of her appearance concerns:

it's a lot of pressure, a lot of pressure on young girls I think...I personally don't feel it. I think with my generation...it's the looking younger thing...it's hanging on to the looks and...not ageing... so yeah I think that's...much more of an issue...for...women of my age, sort of late 30s to mid-40s, I think that's what we

worry about is...how our faces look...really and...trying to look younger than we actually are

Helena: 17,3-15

This is in clear contrast to the younger participants such as Claudia and Emily and could be interpreted as a contextual difference relating to age and the ageing process that can also be found in the other two superordinate themes.

Olivia also acknowledges her experience of both cultural expectations and representations of women relating to ageing:

there are massive cultural expectations...in the wider sort of meaning of it, about how women look and how we're judged so much more than men. It's really bad and crap and double standards and pisses me off, and about getting older, and I just hate the way you don't see older women on TV...and it really drives me a bit crazy and I think it's...so crap...and that's why I don't wanna be judged by my looks...and then Hackney's very...kind of, there's no normality...in other parts of London you have to kind of have blonde highlights...and go out to dinner and stuff but here...you're more normal if you're alternative really so there's no pressure locally...all the kind of local mums are sort of dreadlocked...so...there's really nothing to aspire to which is great but as I say in the wider world and in London and if you're trying to have a career and get ahead and all that...and if you work in the media...or in...those kind of professions...well there's a lot more at stake really...I kind of slightly remove myself from that umm [pause] yeah I hate it, I hate it

Olivia: 11,10-31

Within Olivia's account it is clear how strongly she feels about the cultural emphasis on women's appearance and how physical attractiveness and youth relate to women's value in our society. As she makes sense of her experience and feelings it becomes apparent that these feed into her own value system and have possibly even influenced her choice of where to live. She notes that her local neighbourhood is such that she does not feel subject to the pressure to conform to an accepted ideal or dominant discourse that she might experience in other areas. It seems that for her this is a relief as she comments on her perception of these pressures and her desire to remove and therefore protect herself from their influence as she does not want to become involved in that discourse or value system.

Theme two: The impact of media and celebrity

The topic of media and celebrity and their influence on the women's experience and perception of their body image gave rise to a wide range of responses with a variety of different experiences and opinions. For example both Helena and Amanda recognised the media portrayal of the celebrity lifestyle ideal as unrealistic and not something that relates to their circumstances. In contrast, Emily seems to feel more pressure than Helena and Amanda:

I think it's...very tough, there's a lot of pressure... you see all these magazines, you know, Elle McPherson, look she only had a baby three weeks ago, look at Victoria Beckham, she only had a baby a few weeks ago, look how amazing she looks and...women then aspire to be like that when in fact...for the first three weeks you shouldn't even step foot outside your door because you can't, you are just feeding...you don't even have time to wash your hair, you just feed non-stop, so here we all are hoping we'll be...looking like one of those models...and then I think this business of being back to some ridiculous, ridiculous sort of size whatever so soon after you give birth I think is, is not irresponsible but I think it's crazy, I just think it's really erm, umm [short pause] so I do think it's, in some ways I do think it [short pause and exhales] it's not the responsibility of the magazines and all that nonsense but...it's definitely another pressure put on women and it's hard enough having a baby without having to look like a model...a few days afterwards

Emily: 9,23-10,24

Emily comments on the idealised portrait of celebrity mothers that the media tend to present and the perceived impact of this on new mothers. She highlights the conflict between the media picture and the reality of having a newborn baby and how this could result in some women feeling under pressure. Emily's confusion over this issue is revealed as she hesitates and changes her mind throughout her narrative. It is as though she recognises that the media is an influence and "another pressure put on women" but that she also places responsibility with the individual as she says "this business...is not irresponsible but I think it's crazy" and "it's not the responsibility of the magazines". This inconsistency in her account perhaps reflects Emily's confusion regarding the source of the pressure (from the media or her), whether the media portrayal of celebrity mothers does exert an influence on her postpartum experience of her body and body image, and whether it is right for them to report as they do.

Claudia sums up the pervasive influence that the media appears to have in all of our lives:

I think these things just do affect you...subliminally whether you're aware of it or not. I don't read...celebrity mags, I don't watch rubbish TV...[short pause]...I don't sort of stress about that at all but...I think it does definitely affect you and I think that that's just ingrained in us. I think that...from me being a sort of young...teenager getting obsessive with sort of... models and, I mean I used to put pictures of models up on my wall and I was probably...I dunno ten or eleven, so I think that's...just part of what we're all affected by as women definitely and also just this feeling like slim is beautiful and I mean it...is in that...I think all...most women do look better when they're slimmer...because you sort of lose...fat and...you become more kind of toned and more sort of defined I suppose, but not to say that you're not as beautiful when you're a breastfeeding mother...and this, there's sort of lots of, I dunno

Claudia, 10,27-11,4

Claudia acknowledges the subliminal influence of the messages we are bombarded with throughout our day-to-day lives from childhood onwards. Later in this extract she appears to wrestle with her thoughts as she contradicts herself. She begins by commenting that “*all, most women do look better when they're slimmer*” making an interesting switch from a blanket “*all (women)*” to a more forgiving “*most women*”. It could be interpreted that in this section of her narrative she appears to almost succumb to the internalised message relating to the slim ideal but then checks herself and does an about turn as she comments “*not to say you're not beautiful when you're a breastfeeding mother*”. It is as though she is tussling with two powerful internalised discourses that are dominant in society: one of “*slim is beautiful*” which, for Claudia at this time, appears to conflict with “*breast is best*”.

She later elaborates and acknowledges further the influence of the media in establishing an unrealistic ideal:

but I think we all as women probably, I mean...maybe not all, but I think we probably do have sort of ideal body images...that actually are quite unrealistic and that probably is a reflection of the media as well...this sort of pressure to...be...really skinny and sort of this sort of hourglass shape...and...look good in a bikini

Claudia: 12,14-19

Moreover, Sarah's account portrays a tension between the allure of how celebrities' appearance is portrayed and the reality of their rapid weight loss:

I think that frankly it's crazy that they [celebrities] lose the weight that quickly...I don't think it can be healthy, everyone always says that it's not healthy, but then they look great so [laughs]

Sarah: 12,17-20

She appears to use health as an alternative discourse to resist the celebrity ideal while at the same time she succumbs. Indeed, even Olivia who initially refutes any influence from the media later acknowledges that it does have some negative impact upon her which she manages through avoidance:

if I kind of stumble across Vogue or something and I look at all those pages and then afterwards I think "oh my god, you know, come on, I could do, I could do that if I wanted to" but...I just avoid all that kind of stuff [laughs] so I know it just makes me unhappy

Olivia: 12,13-19

Of all the women, Helena revealed the strongest views regarding the impact of media and celebrity upon societal values, and therefore the individual, regarding body image:

I think it's absolutely...abhorrent that we as a society...think there's something to be admired in someone who looks as though they're starving, it's really sick, what does that say about us? ...it's damaging the health of hundreds and thousands of young girls...because that stuff affects everything, it affects your fertility, it affects your bones...if you're not being nourished, particularly when you're growing and...it worries me for her [daughter], for him [son] as well because I think...increasing numbers of boys are affected by it as well, but particularly for her because I don't want her...to go through life thinking that...if she's not a size zero, or a size four or whatever it is, that she's somehow inadequate...it's much more important...for girls to be healthy and fit and...enjoy their food and enjoy life and be intellectually developed and stimulated it just...really annoys me, it annoys me that there's all this focus on physicality and not enough on...brain power basically...sorry, that's a bit of a rant isn't it

Helena: 16,1-20

It is clear that Helena finds this an emotive issue as she uses language which is strong and evocative. She speculates upon the current media climate and resultant dominant discourses and societal attitudes regarding body image issues and how these might impact upon young people. More importantly, she contemplates the impact of this phenomenon on her own children. Given that she is clear earlier in her account that she does not feel subject to the pressure she describes, one is left to conjecture that the process of having her own children has impacted upon her view and even her values.

Finally, at the end, she recognises the strength and depth of her feelings as she uses the term “rant” to describe her account.

Theme three: The use of comparisons

Participants appeared to use comparison in a number of ways. Primarily they seemed to use downward comparison to manage body image concerns and make them feel better about themselves. For example, it seems that for Emily downward comparison allows her to appreciate her own lack of weight gain:

I can tell you now if I had, if I was sitting here now with two stone to lose as some of the, a lot of the women I know tell me they have...I met a woman yesterday...she said she's still got like [short pause] a stone and a half to go, I mean I would be depressed [laughs] absolutely would be depressed

Emily: 18,28-32

Helena observes her process and seems to take a more philosophical stance which appears to allow her to manage her concerns:

I compare myself to friends probably because I always think I'm the biggest out of everybody...I sort of look at my friends thighs [laughs] so...yes I do compare...myself to people...and I think...well she's...got a fatter tummy or she's got slimmer legs or whatever but then for every woman that's...slimmer...there are other women who are bigger and I just think well...[short pause] ...I'm not...a size eighteen and...sixteen stone so let's be realistic about it

Helena: 14,5-20

For other women the use of comparison seems more complex. For Olivia it is not simply about body image or even her body, but encompasses a range of life domains:

OLIVIA: [pause] I suppose I compare myself to people...who are sort of in my most exact...age group, sort of social environment and...I suppose I compare myself to other mothers with very small children... [pause] and I suppose I compare myself to some of my friends who haven't had a baby yet or maybe not gonna have one...a little bit [short pause] hmmm

EGR: how does that make you feel?

OLIVIA: well its sort of variety because I mean I feel lucky because I'm quite healthy and some of my friends have had you know problems and diseases and...bad, bad, bad shit so I feel fortunate really... [pause] I feel fortunate cause...I've got a lovely healthy baby and...I'm very happy in my relationship and...I'm financially sort of hanging in there

Olivia: 10,29-11,1

Claudia seems to use a combination of social comparison to others and drawing on common biological discourses in order to help her make sense of her experience and manage her concerns:

I mean to me...I know that some, I mean I've got a friend who had a baby about the same time and she just shrunk...straight back to her figure,...her prepregnancy figure but I've never been that kind of, I think...different women have different shapes and different metabolisms and I've never ever been that kind of person, I've never been that sort of, someone who loses weight very easily so, and I'm quite used to that now

Claudia: 5,29-34

Later in her account she appears to make an upward comparison to a friend who she feels is doing better than her but counters this with comparison to another friend, who she seems to use as a template for what to expect, possibly in order to manage these concerns. At the end of the extract she seems to feel a need to reassure the interviewer, or perhaps herself, that these comparisons are not too negative as if she is aware of her own process and the impact that this might have:

I do compare myself to other people...I compare myself to my friend Anita who lives up the road...who's got...a son, she's the one who's just sprung back. I suppose I find myself always comparing myself to her and sort of feeling a bit sort of...she's so lucky sort of feeling because she can fit into skinny jeans...and I compare myself to a good friend of mine who's had a child...who's three now and we're quite...similarly built and...similar sort of physiques and I suppose I compare myself to her cause she's sort of maybe the representation of where I'll be...in a couple of years...but I mean I don't compare myself in a...horribly negative way

Claudia: 10,9-18

Anna also uses comparison to a close friend as a possible template for what to expect:

my model for quite a lot is my best friend, whose daughter is just over one and she's kind of been there before me...and we've always been quite similar...and I was very conscious that she had a tiny bump and...she pinged back very quickly...and I didn't expect me to be the same but was very pleased when I was...so I guess I do [compare myself] a bit

Anna: 17,5-11

In complete contrast to these accounts and further illuminating the range of experiences represented within this theme is Amanda's account:

I probably compare myself to other women my age...and I have a few friends my age and they are [short pause] ...the friends I have who are sort of slimmer and fitter than me are the friends...who make a real effort, who go to the gym and they look good on it and if I could snap my fingers and look like that...I'd love to, but the effort they put in I know I can't be bothered putting in, so it's kind of good for you, you earned it type thing and I'm going to eat some cake and then I'm...happy with this...so I kind of...I know, I can tell that I don't look like this forty year old friend or that forty year old friend but I also...know that...there's a reason for that...so in that sense I compare...myself. I don't come out unfavourably in the sense that...it's as though my body's my choice...through not doing anything to...look fitter or slimmer or whatever...I eat a lot of crap cause I like it...and I don't do any exercise cause I hate it and so I think that it would be very unfair if I looked super fit, it would be unfair on all the women who work really hard to look super fit...so...that's as far as the comparison goes really...if you look better than me, which...a lot of them do, ...good for you

Amanda: 16,1-22

Amanda's sense making of her process is apparent and seems to lead her to a philosophical acceptance of her responsibility for her body, body image and feelings about it. This could be interpreted as again reflecting Amanda's low investment in her appearance as a criterion to support her self-concept or self-esteem. She makes an active choice not to invest heavily in this domain or to evaluate herself according to this criterion. This is in striking contrast to other participants, such as Emily for example, for whom appearance is a much more important domain in her self-evaluation.

Another way that some of the women used comparison was in relation to their former selves. The following two quotes reveal opposite uses for this process:

I was just looking in the mirror the other day and thinking that...I suddenly had turned into...what I think of as a mum, with the mum look and I wore a combination of...these trousers and this top and I thought "oh yeah this is how middle aged women look" when...you sort of think of friends' mothers when you were a kid, that sort of thing...when I've spent my life being, thinking of myself as a sort of a...hot chick, a single woman in London...doing her thing...and being attractive and...having a nice body and stuff and suddenly I'm thinking "oh I've gone into that other world now" where I've got a bit of a...belly and then...I tighten the trousers round the waist and something bulges out under the waistband and something bulges out over the waistband

Amanda: 4,31-5,4

Amanda describes suddenly becoming aware of a change in her look. As a direct result of this she also seems to experience a change in her self-concept as she realises "I suddenly had turned into what I think of as a mum". There is a definite temporal sense

of before and after in the extract as she compares her current self with her former self. Her use of language is interesting and serves to heighten the comparison particularly when she says “*oh I’ve gone into that other world now*” generating a sense of finality, as if she can never go back.

Olivia, on the other hand, appears to use comparison with her former self in a downward direction to make herself feel better about where she is today and possibly to manage any concerns that she does have about her postpartum body:

I dunno, I think at this time of my life I feel quite stable I guess and...I suppose...I also compare myself to an earlier version of myself and...that makes me feel kind of better really cause...I’m in a sort of better place really than sort of a few years ago because I mean I might have been slimmer or looked better but there were so many other things that were kind of wrong really

Olivia: 11,2-6

Once again for Olivia it is less about her body image and more about her life as a whole. It could be interpreted from this that her appearance is not something that she relies on to support her self-concept.

Superordinate theme three: The body as perceived and lived

This final superordinate theme is more abstract and conceptual than those presented previously and is concerned with the women’s experience of the bodily changes. The primary focus will be the way in which their lifeworld and life project has shaped the impact and meaning of these changes. Theme one focuses on what is described as the embodied dimension of becoming a mother. Theme two considers variations in terms of the objective body that is observed compared to the subjective body that is lived (Finlay, 2003a, 2006; van Manen, 1998) and the desexualisation of the breast as a result of breastfeeding which is suggested to represent the experience of the lived body in relation to the self and the world.

Theme one: The embodied dimension of becoming a mother

The women’s experience of the bodily changes emerged as being inextricably embedded in their lifeworld. The process of childbearing and becoming a mother appeared to be an overriding factor brought to bear on the meaning and impact of changes. The women’s experience regarding these was dominated by changes to their breasts and stomach. Emily comments:

I'm very aware that I probably will never return to my former glory so to speak...because they're going, I'm going, I'm undergoing quite an ordeal, you know, but, you know, err it's a, it must be quite a, umm, obviously it's what they're built to do, but I'm sure my boobs I'll, I'll sort of always pine for the boobs I had going forward, at the moment they look great but you know they're full of milk at the moment...so I am at the back of my mind thinking "oh" but actually my overriding feeling is of I don't care, my child is the most important, at the end of the day I don't care

Emily: 7,2-10

There is a certain tension in Emily's narrative as she tries to make sense of her feelings regarding the changes to her breasts. She begins by acknowledging the fact that her breasts may suffer permanent changes from breastfeeding. She refers to their "*former glory*" giving the reader an indication of how she felt previously about this area of her body and setting the scene for her concerns regarding the changes. She identifies the process of breastfeeding as "*quite an ordeal*" firstly for her breasts but then actually for her. One reading of this could be that Emily experiences a shift from the objective to the subjective as she says "*they're going, I'm going, I'm undergoing quite an ordeal*". She initially talks as though her breasts are a separate entity to her but then appears to modify this. The result is that the line between Emily's physical experience of breastfeeding, what it means to her and her feelings about her body seems blurred, confused and indistinct at this point. This is further indicated in the manner of her speech as she hesitates and stumbles through her sense making.

Emily's use of the expression "*I'll sort of always pine for the boobs I had*" creates a vivid sense of anticipated longing for her former breasts. This could be interpreted as again highlighting the centrality of body image in her experience, the importance of this particular area of her body to her as a woman and the sense of loss that she may feel if her breasts do not return to their pre-breastfeeding state. She continues and apparently rationalises more assuredly regarding her feelings about the possible changes in her breasts within the context of childbearing and mothering. This might be an attempt at integrating the experience more fully. At the end of the quote, the tension between Emily's concerns over the possible impact of breastfeeding and the prioritisation of the baby's needs is again evident.

Again Emily's account demonstrates the centrality of physical appearance for her, notwithstanding her evident acceptance of the changes and prioritisation of the baby.

Another interpretation of Emily's effort to integrate the changes in her breasts might be hypothesised as related to a link between appearance and attractiveness to the opposite sex or sexual availability. Perhaps the potential for this to be radically changed as a result of the bodily changes arising from childbearing, particularly those relating to Emily's breasts, contributes to her struggle to integrate.

The women also talked about lasting reminders of the childbearing process which were changes that had not resolved. For example, Olivia talks about her pelvic floor:

oh yeah the pelvic floor...it's a bit better actually but if I run and I need to go to the loo it leaks...it leaks a bit, I was like "oh god" [laughs] but...I always talk to my sister about it and we always have a laugh, you know, it's like what is going on? And...it's not quite back to normal but...it's probably about eighty, ninety percent...but it's sort of a reminder...of the sort of big trauma that your body goes through

Olivia: 5,18-22

There is a sense of Olivia's initial dismay as she says "I was like oh god" but she then appears to try and integrate the experience through using humour along with support from her sister. This could be interpreted as further illuminating a relational aspect to the women's experience of their bodies as discussed in superordinate theme two. This process of integration appears to allow Olivia to manage her experience and possible concerns regarding the impact of this particular change. Later she elaborates:

it feels just part of the process really, yeah...it feels...integrated into, and I don't know, in a way...they're all very annoying but they're all kind of physical signs or symbols...of childbirth really so you can't separate them off, you just have to [short pause] sort of get your head round it or, I dunno, not. I don't think about it too much really

Olivia: 5,25-30

Again the changes seem to be integrated into Olivia's experience in order to make sense of it. She draws on the fundamental nature of these experiences within the context of childbearing, perhaps to help her accept the change to her pelvic floor and the implications of this. There is a sense that despite them being "all very annoying" the prioritisation of the child transcends the effect of these changes and so the repercussions are less negative than might be expected.

Later in the quote, however, it could be argued that an ambivalence is revealed, despite Olivia's earlier integration, as she comments "*you just have to sort of get your head around it or, I dunno, not*". It could also be argued this interpretation is further supported when she discloses that in actual fact she avoids thinking about it too much. A conclusion that might be drawn from this is that the complexity of this issue is evident and the overriding experience appears to be one of integration, however, there is no question that these are issues that the participants have not had to confront before and have difficulty wrestling with.

Eva comments in a similar vein:

I wish I did have that slightly slimmer waist but then I think well actually I've got my lovely baby and it's a price worth paying...I look at myself and I think...well yes...I've got more or less the figure I had before which is really lucky and any bits of sagginess,...yeah it was, was a price worth paying for my...adorable baby...I almost kind of feel...that...there are indications that I went through what I went through and...that in a way is ok

Eva: 15,22-31

For Eva it seems that the context of being a mother and having her "*adorable baby*" has made the bodily changes more acceptable as she says "*any bits of sagginess...it was...a price worth paying*". It is almost as if the primacy of the baby enables her to integrate and rise above even the changes resulting from the tear she experienced as she comments "*there are indications that I went through what I went through and that in a way is ok*".

Amanda also comments:

you know, there is a before and after in my life and I am a mother now and you don't necessarily have to look different because you're a mother, but it's very hard not to and I think...again it's part of the natural course of things...you're not going to have your twenty five year old body forever and the obvious time when you're going to stop having it is...when you have a child, especially when you have a child at forty when it would have probably happened anyway. The body...wasn't...what it used to be anyway before...but I think in my head before I got pregnant I was probably still twenty five... in that I was still that person, or twenty or whatever, I was still that young girl who came to London and then in my head having a baby meant that I was now a different person when in fact my body before I gave birth was nothing like it was when I was...in my twenties cause it had changed, I mean like I said...I've never made an effort for it not to change, I didn't go to the gym...it's almost as though you're faced with your body in a

different way now, you can sort of delude yourself for years and just think you're the same you've always been but then you go through something that changes your physique like this...and it makes you look, whereas before you just didn't look, so it's probably not even that different from before but because in my head I've just snapped from being in my twenties to being middle aged, a middle aged mother

Amanda: 5,11-34

This extract is very dense, with a large element of Amanda sense making in the moment. There is a strong temporal dimension to her narrative as she talks both about her transition to motherhood and the ageing process. It seems that childbearing has had an impact both on her sense of self and her perception of her body, with the two intermingled in her convoluted speech. It is as if the process of having the baby has caused a shift in her sense of self as she says “*and then in my head having a baby meant that I was now a different person*”. This appears to have been accompanied by an enlightenment regarding tacit assumptions that she had about herself and her body being unchanged from her twenties onward.

She describes a sudden transformation in how she sees her body as she says “*it's almost as if you're faced with your body in a different way now, you can sort of delude yourself for years and just think you're the same you've always been*”. Amanda portrays childbearing as a tipping point or a catalyst that “*makes you look, whereas before you just didn't look*” thus forcing her to attend to an area of her life and self that she had previously neglected.

The ageing process also featured for Olivia along with the change in her lifestyle:

I was thirty nine, I'm forty now, it's not like I'm, if I was a kind of model, kind of nineteen...you know, lived on my looks or something it'd probably be a bit different but [coughs] umm I think it's, I feel it's all, I mean I don't wanna totally sort of turn into a kind of [laughs] blob or anything but I don't mind that it's [childbearing] changed my life and my mind and my career and my look, you know, I think it's supposed to really

Olivia: 2,30-35

Later she adds:

[I feel] quite philosophical about it [changes] really, yeah, yeah [short pause] quite accepting I think [short pause] umm [pause] I mean it's, yeah, it feels like it's part of the progression of time really and uh mmm, you know, I haven't gone,

I mean, I don't know maybe it would be different but, you know, I haven't gone back to work and I haven't, you know, I'm with her [daughter] all the time so, and she's sort of important to me and so I don't, I dunno, I've, how I feel about my body doesn't, it's not in the ascendant

Olivia: 3,33-4,1

There is a real feeling of Olivia making sense of her experience throughout these two extracts that is evidenced in the way she speaks hesitantly and thoughtfully. It seems that within the context of her age and the transition to motherhood she is able to accept the inevitable changes that span many domains of her life. The second extract affirms this, emphasising the change in her role and lifestyle along with a greater focus on her daughter rather than her body.

Anna describes a similar experience:

I am conscious of [short pause] of the changes, that my tummy's a bit bigger than it was...but most of my clothes still fit...and the ones that don't, I've just bought...a slightly bigger size and just got on with it...and...I've just kind of taken it as part and parcel of, and my whole life has changed...in every way so that's just one more thing...and it hasn't happened in isolation...I mean I'm not trying to get into my work clothes and going off to work

Anna: 13,18-27

Anna also highlights that her “*whole life has changed*” as a result of having her son and it seems that this allows acceptance of changes as “*part and parcel*” of the process. In addition she also is not going back to work yet which, it could be interpreted, might require some focus to shift back onto her appearance and therefore body image.

Theme two: Being-in-my-body

This theme seeks to present some of the more unanticipated aspects of the women's experience that emerged from their accounts. There was a strong sense of an embodied dimension to the women's experience as the focus at times seemed to be more about the “*lived body*” (van Manen, 1998, p.16) rather than their body image per se. The two predominant features that emerged and will be discussed here are differences between the women in terms of their description of their embodied experiences along with the desexualisation of the breast in relation to breastfeeding.

The women appeared to have quite different attitudes towards their bodies; some participants, such as Amanda for example, described their bodies as though they were an object:

I was reasonably happy with it, as happy as I would have expected to be with it considering...I've never spent any time...working on it, owning it, exercising it or anything...I made a point of cycling to work because that was the only way I was ever going to get any exercise so I was concerned enough to want to...stay as fit as I could with the least, you know, with the minimum effort...but anything requiring any effort I've never really put into it and oh yeah, I've tried not to eat like a pig...so I felt that the body I had before...that was probably as good as it was going to get and it wasn't fabulous and it wasn't awful and...like most women there are lots of things I would have changed, I didn't love it but I was quite accepting of it

Amanda: 8,24-34

In this excerpt there is a sense of Amanda discussing her body as if it were a separate entity, not really connected or belonging to her, as she says: “*considering I've never spent any time working on it, owning it, exercising it or anything*”. One reading could be that this relationship with her body as an object suggests that Amanda places little value on it, or by extension her body image, something that would support earlier interpretations. Her comment “*but anything requiring any effort I've never really put into it*” further supports this lack of interest in her body. It is as though it is something that she is aware of but is simply functional, requiring a minimum of attention and not something that she is particularly engaged with. Overall, this is a very Western Cartesian discourse of the body separate from the mind and, by extension, the individual.

Amanda's relationship with her body as an object is in stark contrast to some of the other women who tend to speak about their bodies in a distinctly different way throughout their accounts. This is exemplified in Olivia's account:

I love not having periods. I haven't had a period since, well for a year, over a year, it's great, and not since she was born...cause I'm not ovulating and [clears throat] usually I've got some kind of, I've either kind of got my period, or I've just had my period, or its just come and my womb is aching a bit or I'm slightly bloated or something...or there's a bit of ovarian pain or there's a sort of constant dialogue that I'm having with my kind of reproductive organs but now because I think, I'm not sure what the hormones are but...your oestrogen or something is low or something so...I feel very tranquil, I feel quite steady and that's really nice and we don't have kind of aches in my belly like I usually do...they've sort of quietened down. I think that's from breastfeeding cause it...suppresses ovulation

Olivia: 2, 8-19

One interpretation of this could be that Olivia is much more in touch with her body and in tune with it. Her reflections hold a real sense of the “*constant dialogue*” that she describes having with her body and there is the impression of Olivia being much more connected with her body than Amanda. She relates her emotional state to the effect of her hormones, drawing on a common discourse to explain her feelings of being “*tranquil*” and “*steady*”. Interestingly she uses the plural personal pronoun “we” and then switches back to the first person as she says “*we don’t have kind of aches in my belly like I usually do*”. This leaves the reader to wonder whether the “we” refers to the whole family. Perhaps this could be interpreted as signifying that it is not only Olivia who is benefitting from the temporary change in her hormones and mood, but also those closest to her. Olivia’s way of describing her body is reflective of her experience in general which seems to be less about her body image and more about her lived body as discussed earlier.

Olivia’s experience of her lived body appears to impact her life in many ways, such as enjoying walks for the mental and physical effect which appear to be interrelated. It could be argued that there is no evidence of a Cartesian mind-body dualism in Olivia’s account. She clearly links physical activity and how she feels in-her-body to her mental state, with the two being firmly interconnected. There is a sense of Olivia being fully in touch with her lived body and having a very integrated experience of the changes resulting from pregnancy and childbirth. Amanda and Olivia therefore appear to represent two extremes of a continuum along which all the women lie.

Yet another experience that the women described was the apparent desexualisation of the breast as a result of breastfeeding. For example, Emily says:

with boobs, how can they be a sexual object and something so fundamental to the development of...your beloved baby? How can you have a part of your body that fulfils those two, you know, one minute, you know, you’re using them as an object of, you know, whatever and the next minute, you know...you’re looking at your baby with it in your mouth [sic]. I mean...it’s a really difficult one, it’s a difficult one and...you know, I thought I was gonna really struggle with breastfeeding in public and stuff and I do a little bit, I do a little bit, took me...quite a long time to be able to do that and I definitely plan my day around feeding at home because, yeah I’m breastfeeding and that is more, if he’s hungry, don’t really care at the end of the day but, you know, if I was going into work or something I would never feed in the office because there is that weird, don’t know what you’d call it, juxtaposition, I mean...it’s very, very strange so I do hope that when they’ve

stopped being the source of my child's nutrition, I hope they can go back to being part of me being a woman again

Emily: 7,16-31

There is evidence of Emily's struggle in her narrative. Her confusion is palpable in the extract as she hesitantly ponders over the dual role and function of her breasts. She seems to grapple with her sense making and find it difficult to reconcile the dual function as she says "*one minute you're using them as an object of whatever and the next minute you're looking at your baby with it in your mouth*". Her accidental use of "your" rather than "their" serves to enhance the feeling of uncertainty that emanates from this excerpt. It could also be inferred that this topic is difficult for her as she distances herself whilst talking and depersonalises her account through the use of "you" instead of "I" to describe her experience.

She seems to contradict herself as she tells the interviewer that she anticipated a real struggle and has experienced it "*a little bit*" in an attempt, perhaps, to play down its extent but then reveals that she actually does "*plan her day around feeding at home*". This appears to belie the earlier minimising of her struggle with breastfeeding in public; an interpretation that may possibly be supported by her failure to finish elaborating as she changes the subject mid sentence and goes on to assert that the baby would be prioritised over her sensibilities. However, the reader is left to wonder whether she is, in actual fact, trying to convince herself.

The end of the quote again highlights the "*weird...juxtaposition*" of the breast in its dual role for Emily and she, quite poignantly, shares a glimpse of her loss and uncertainty regarding the future for her breasts as she says "*I hope they can go back to being part of me being a woman again*".

Eva also comments explicitly on her experience of the dual role of the breast:

I find that really weird that whole kind of...well I suppose it's the kind of re-sexualisation of your breasts which happens I think...only when you stop breastfeeding...at the moment we've got the baby in our room so...I really couldn't feel less sexual [laughs] but...hopefully at some point he'll move on and then that will be...a whole other phase of how to readjust back to something, not the person you were before but something that more closely approximates how you felt about your body before you had a baby, but I suppose there'll be some kind of level of feeling a bit bereft I think though cause I really like breastfeeding...it feels quite

nice and it's a very nice kind of bonding thing to do with your baby so...I will be a little bit sad when I stop doing that but then at that point then I'll be just me again rather than...I'm so much me and him at the moment because he's...attached to me quite literally...less of the day than when he was tiny...but still enough of the day [inaudible] and rather more of the night than I'd like

Eva: 24,14-29

The issue of the dual role seems less complicated for Eva as she negates her sexuality during this period. She disregards the sexual role of the breast, leaving only its nutritional role, and thus avoids the necessity for her to hold the tension between the two as with Emily. That Eva feels discomfort around this dual role and therefore, it could be interpreted, needs to avoid it may be implied from her statement *"I find that really weird that re-sexualisation of your breasts"*. Her subsequent categorical assertion *"which happens I think only when you stop breastfeeding"* suggests that, for her, it is not possible for the breast to assume the dual role suggested by Emily. Eva then seems to contextualise her lack of sexual feeling through the baby being in their room. Once again, the sensitive nature of this material may be indicated through Eva's laugh and her use of "you" rather than "I" that serves to distance her from her account.

She goes on to explore how it might be on both a physical and emotional level when she and the baby finally begin to separate as she describes an anticipated process of readjusting *"back to something, not the person you were before"*. One reading of this might suggest that this experience of childbirth and the transition to motherhood has fundamentally impacted her sense of self and she is in the process of reconceptualising this. She continues and qualifies this statement, however, as relating to how she feels about her body and yet another interpretation could be that her body image and her sense of self are inextricably entwined as suggested earlier in the analysis.

Eva acknowledges the sense of loss that she will likely experience when she stops breastfeeding and relinquishes the level of intimacy that she currently enjoys with her son. She recognises the enmeshed nature of the relationship that she has with her son at this time saying *"I'm so much me and him at the moment because he's attached to me quite literally"*. There is a real sense of two being as one and of the bond between mother and child.

Claudia also raised similar issues:

I still don't feel sexual, I don't feel that my body is his [husband's] and I don't feel it's mine at the moment...I wear a bra in bed and I feel very kind of private about my breasts I feel that they're to feed Amy and...that's it, I can't...I don't even let myself sort of think about them in any other way so I don't let Carl [husband] think about them in any other way, I don't want him to even really see them so I feel quite sort of private about them... that's how I felt towards the end of the pregnancy as well... my body was there for my daughter for nourishing her and...that's the way I still feel...and I quite look forward to...having that back I think, I mean...I don't know whether other women feel differently about it...but that's just the way I feel

Claudia: 9,11-28

Claudia's account of her experience shares features with the other women's narratives. It could be interpreted that she seems much more at ease than both Emily and Eva with her experience of the dual role of the breast as she describes her experience entirely as "I" implying that she is able to fully own how she feels. She describes feeling as though her body does not belong to her or her husband but is solely for the baby. Furthermore, she is more explicit than Eva and describes clearly that it is not possible for her breasts to fulfil both functions at the same time as she says "*I feel that they're to feed Amy and that's it, I can't, I don't even let myself sort of think about them in any other way so I don't let Carl think about them in any other way*". This feeling is so powerful for her that she doesn't "*want him to even really see them*" and feels "*quite sort of private about them*". The reader is left to speculate again about the impact of this on intimacy within the relationship. As with Emily and Eva, however, Claudia also looks forward to a time when she will regain autonomy of her body once again.

Summary

In summary, the analysis has sought to present the three superordinate themes of the body, self and others, the body in cultural context and the body as perceived and lived. Within these superordinate themes a diverse range of areas have been introduced. The body, the self and others has put forward a number of features including the centrality of body image and appearance and body image in relation to the transition to motherhood and changes in self-concept. Furthermore, this section portrayed the influence of the lifeworld on the women's experience and explored the interpersonal encounters that emerged as shaping the women's experience of their body image.

The second superordinate theme, that of the body in cultural context, put forward cultural influences upon the women's experience of their body image. This included

norms and expectations, media and celebrity and comparisons that were used by the participants in a number of ways.

The final superordinate theme to be presented was the body as perceived and lived. This offered features that included the experience and impact of bodily changes within the context of the women's lifeworld. Furthermore, it explored an embodied dimension described as the experience of the lived body in relation to the self and the world. This was exemplified through divergences in the manner in which the women described their experience and their sense making in the face of the desexualisation of the breast as a result of breastfeeding.

Finally, an overarching theme that could be described as a thread woven throughout the analysis, spanning all themes and binding them together, was the impact of the women's experience on their sense of self and self-concept. This diverse feature emerged across participants and across themes and was therefore incorporated across the analysis rather than being represented as a discrete cluster.

Discussion

Theoretical insights

The women's accounts of their experience support the notion of body image being a complex and multi-faceted construct (Pruzinsky & Cash, 2002). Moreover, participants' descriptions of their experience were embedded in their lifeworld, being inextricably context-bound and context-dependent. There was an embodied dimension to the women's accounts; some participants focused less on body image per se and more on the lived body. This could also be described as the subjective body as lived and pre-reflectively experienced (Finlay, 2006; van Manen, 1998) as opposed to the objective body that is simply observed (Finlay, 2006). These aspects of body image have been previously neglected in the literature with a lack of focus on experience reflected in the predominantly quantitative nature of the existing corpus of research. The author would therefore argue that an advantage of the current study is the detailed picture that has been constructed of the women's experience. This reflects the complexity of this experience and its embedded nature in the individual lifeworld. This has been achieved through the "detailed and inductive approach of IPA, with its roots in phenomenology and hermeneutic enquiry" (Eatough & Smith, 2006a, p. 496).

The women's lifeworld could be defined as that which is lived and experienced by them (Finlay, 2008). Their experience of childbearing cannot, therefore, be separated from it (Finlay, 2003a). Ashworth (2003) describes the lifeworld as involving an individual's lived situation and intersubjective social world; for these participants it is a relational world and includes fundamental features such as their sense of self, embodiment, sociality, temporality, the life project that they are engaged in and their discourse about this (Ashworth, 2003; Finlay, 2008). Finlay argues that such features "act as the lens through which to view the data" (2008, p.2). The author has endeavoured to draw out these aspects and illustrate the common structural whole of the women's experience while also highlighting the individual divergences (Finlay, 2008; Smith & Osborn, 2008).

The women demonstrate a high level of self-awareness and self-reflection throughout. The process of reflection is apparent in their narratives; the interviews have created a space in which this has occurred. The experience of childbearing and its impact on their bodies and body image emerged as being overwhelmingly positive for the participants.

The existing literature gives a mixed picture regarding body image in the postpartum. These findings are therefore contrary to some studies that found participants dissatisfied with their weight and shape in this period (e.g., Hisner, 1986; Patel et al., 2005; Stein & Fairburn, 1996; Wood Baker et al., 1999). The more positive experience of these participants, however, is consistent with the findings of Strang and Sullivan (1985), Drake et al. (1988) and Morin et al. (2002). The current study therefore adds to the existing body of research as it has provided a detailed investigation of the lived experience of body image in the postpartum year that was revealed as positive.

Even though the women's experience is significantly positive, however, this does not negate body image issues. There is still evidence of participants wrestling with concerns and sense making regarding their relatedness to their bodies and the world. Thus despite an absence of body dissatisfaction in these women there is nonetheless compelling evidence from the accounts that body image issues are prominent, pervasive and seen in all the participants to some extent; even those who make a conscious choice to avoid or claim that it is not a concern. What is common between the women, therefore, is a high level of awareness of body image and its relative importance; the difference lies in how they live this. In terms of the existing literature, this could be argued as consistent with the conclusion of Jordan et al. (2005) that body image was of variable importance for the mothers in their study. In addition to this, Nicolson's (1999) longitudinal qualitative investigation of postpartum depression in twenty four British women aged 21 to 41 found that participants revealed varying degrees of anxiety relating to appearance in the postpartum period.

There are, no doubt, many possible reasons for the women's positive experience of their body image. One explanation may be that their social class and level of education has enabled them to engage with their experience at the highly self-reflective level evident in their accounts. This in turn may have enabled them to challenge the dominant discourses regarding body image and appearance in modern Western society thus increasing their enjoyment of the experience. Indeed, their level of self-awareness is such that they appear to be conscious of which discourses they are engaging with or choosing to reject. It could be argued that the women demonstrate considerable agency within their accounts as they use one discourse to reject another, such as using a health discourse to resist the celebrity ideal. This is supported by Bailey's (1999) discourse analytic study of changes in self-identity in the transition to motherhood where it was

found that participants were also able to resist certain discourses by drawing on others, thus offering a sense of agency.

There is a very real sense of the empowering dimension of motherhood prevailing from the women's accounts. There is evidence on the one hand of motherhood negating the women's former sense of self as, for example, a career woman or a sexually available person. This dimension of the former self is receding into the shadows as a new dimension of the self is brought to the fore. They are not just women anymore, they are mothers now. It is also very clear from the narratives that, even though ostensibly they have lost something in becoming a mother, they have also gained. They have gained an expression of existential meaning in having a child; the process of childbearing for these women could be described as an embodied and symbolic act of meaning-making (Radley, 2000; Young, 1984) and could be argued to establish their potential as a woman. Moreover, they have gained freedom from the tyranny and social constraints of the dominant discourse regarding women's bodies and appearance in today's society. This resonates strongly with Bailey's (1999) study which reports pregnancy excusing participants from feeling a need to conform to the dominant images of beauty in society. In conclusion therefore, there is a sense in the current study that despite negating their former sense of self, and despite the women feeling that they might have changed in appearance and even "look mumsy", they still reveal a hugely rewarding experience.

Finlay notes that "the best phenomenology highlights the complexity, ambiguity and ambivalence of participant's experiences" (2008, p.7). The women's accounts in the current study could be argued to demonstrate such tensions and contradictions and the author would argue that these *are* the lived experience for these women. They have one foot in both camps: that of the old self and the emergent new self, that of career woman and mother. The multiple dimensions of the self are waxing and waning within the context of their lifeworld as these women negotiate the experience of motherhood for the first time. Inherent in this is the messy and intricate set of contradictions and ambiguities that is their experience at this time of transition. The women's process demonstrates these complexities and how fundamental life feelings are inexorably bound up with our embodied experience (van Manen, 1998, p.20). What is clear from their accounts is that the transition to motherhood is both desired and feared. The transition to the new self brings with it a fear of loss of the old self, that one might never be the same again (Young, 1984), or look the same again, and yet this is inextricably

intertwined with the joy of becoming a mother. This demonstrates a fundamental “intertwining of body, self and world” (Finlay, 2003a, p.1).

These findings could be argued to further support Jordan et al. (2005). The authors report a family centred narrative that suggests dissatisfaction with appearance but is within the context of children and the family assuming a greater importance. They therefore note that issues other than body image tended to be prioritised by the mothers in their sample. This is consistent with the experience of the women in the present study.

Another aspect of the women’s experience that emerged from the transcripts was that the process of childbearing seemed to have brought the women’s bodies into sharp relief. Although we may objectify our bodies, we tend not to notice them in an embodied way ordinarily as we pursue our life projects. However, when something changes, our awareness of our body is suddenly amplified (van Manen, 1998). Such heightened awareness of one’s body has generally been considered in the context of illness (Radley, 2000) but could also be argued to occur through the process of childbearing (Young, 1984).

Also evident from the data is how crucial the intersubjective and social realms of the women’s lifeworld are (Finlay, 2003a). Their postpartum bodies and body image are embedded in their lifeworld and experienced in the context of significant relationships with baby, partner, family and friends. The importance of the relational aspect of their lives is clearly highlighted through their accounts, particularly during this time of transition when both their body and their sense of self are in flux. Investment in these relationships appears to protect against body image concerns for these women. Furthermore, the fundamental emotional attachment between mother and child incorporates a powerful physical link with the two enmeshed through the experience of breastfeeding. Once again this highlights the embodied nature of the women’s experience, emphasising the relationship between body and world, as body serves child.

It is evident from the narratives that childbearing has affected both the women’s experience of their body itself and how the world is experienced with their body (Radley, 2000). This is demonstrated in the women’s accounts of the meaning and impact of bodily and functional changes and exemplified in their sense making around

the desexualisation of the breast. What is apparent from the narratives is that the experience of bodily changes has also been complex, ambivalent and firmly embedded in the lifeworld. These women have therefore had to find a “liveable relation” (van Manen, 1998, p.9) with their bodies in order to integrate these changes, particularly those of a lasting nature. This liveable relation appears to have been achieved by the women directing their consciousness at the process of mothering. In other words, their intentional relationship (Finlay, 2008) with motherhood appears to facilitate this liveable relation with their changed bodies and therefore enables integration.

Furthermore, it could be argued that the experience of childbearing has had a lasting effect on the nature and quality of the women’s intimate appreciation of their embodied selves (van Manen, 1998, p.18). It is clear that for some participants this experience has contextualised their bodies in terms of a bigger existential picture. This has allowed them to adopt a different perspective to their body image which has in turn fundamentally altered their relationship with their bodies. There is a striking parallel here with the study by Bailey (1999) where pregnancy is reported as affecting participants’ relationship with their bodies. These women are also reported as experiencing a sense of liberation on finding a purpose and value to their bodies through the process of childbearing. In addition to this, some found pregnancy an excuse to renegotiate their feelings about their bodies as well as presenting an opportunity to celebrate aspects of their femininity that were previously seen as problematic. This particularly resonates with Helena’s experience, as discussed below.

Furthermore, the women’s accounts have demonstrated a distinction between the subjective body as lived and experienced pre-reflectively and the objective body as observed (Finlay, 2003a, p.167). This reveals again a sense of the body and the world being intertwined (Finlay, 2006, p.20). The lived body therefore represents being-in-the-world; it is an embodied consciousness that engages with the world whereas the objective body is that which is observed rather than lived. In observing the body we become aware of it as biological and material and the body is then experienced as an object separate from the self (Finlay, 2006, p.21).

In line with IPA’s interest in the variability and diversity of human experience, the convergences and divergences in the women’s accounts have been highlighted throughout the analysis. It is evident from the narratives that there are both

commonalities in the women's experience and elements on which they differ widely. Amanda and Emily emerged as representing opposite ends of an apparent continuum in terms of the centrality of body image in the women's lives and their investment in appearance. Although they are both highly aware of this aspect of themselves, Emily's appearance is far more central and she describes a much greater level of self-evaluation according to this domain than Amanda. Amanda stood out from other participants in her explicit lack of interest in her body or body image. Her account communicated clearly that she regarded her body as an object quite separate from herself and she tended to heavily emphasise the ageing process and childbearing as the context allowing changes to be acceptable. Amanda was one of the older participants and did comment that her family had never been particularly body conscious. Other than this, it is difficult to say how these divergences in her experience have come about. It is possible that a greater understanding of Amanda's history and upbringing would shed more light on the differences in her account.

Interestingly, Eva also communicated a central role in terms of body image in her self-concept, however there was a notable difference between her and Emily. This was manifested in Emily's greater concerns regarding her husband's attitude to the changes in her body, his family's opinions and an apparently greater susceptibility to cultural and media pressures. Eva on the other hand communicated less concern and was very clear regarding the positive and even protective relational aspect in her life that was associated with her partner. The reason for this difference between the two is not clear. The women's demographic details are very similar and the age difference between them is not that great. One speculative hypothesis could be that it is perhaps related to the quality of their significant relationship or their history. It is possible that more detail relating to these areas may have shed light on features that might account in some way for this difference.

Claudia also revealed a high investment in appearance but this appeared to have been tempered by the process of childbearing and becoming a mother. Interestingly, she also mentioned both cultural and media pressures but did not seem to experience the same degree of need to conform as Emily. Again, it is not possible to speculate on the reason for this from her narrative. Sarah's account reflected one extreme of a continuum regarding the influence of significant others on participants' body image. It was apparent from her narrative that both her family history and her partner's opinion held

great significance. She was explicit about an emphasis on weight control and this dominated the interview. Sarah attributed this focus to a family history of obesity and associated health problems on both her own and her husband's side.

Olivia also had interesting differences in her narrative. Of all the women she gave the most embodied account of her experience and communicated explicit and passionate values relating to cultural and societal expectations regarding body image and appearance. It is difficult to account for these divergences and again it is possible that a more comprehensive understanding of Olivia and her history would be required in order to speculate further. One feature which may in part explain the latter difference was Olivia's experience of living in different cultures, such as Japan. This appeared to have forced her to confront her body image as she was outside the accepted norm in this environment in terms of appearance being quite a tall and heavy set woman. Anna's account was unremarkable except that her interview was dominated by her relationship with her breasts, which are large for her frame and she has never liked, and her experience of difficulties with breastfeeding.

Helena's account is possibly the most noticeably different. She recounted a lifelong ambivalence toward her body and an apparently high investment in her appearance when younger. It emerged, however, that she felt less pressure to conform to societal expectations in comparison to other participants but at the same time placed greater emphasis on the ageing process. Interestingly, Helena also gives the greatest impression of having experienced a journey through the process of childbearing as she is explicit about its impact on her relationship with her body and her body image. The empowering dimension of motherhood can be felt as Helena re-evaluates and reframes her body image and the ageing process; the existential expression of having children appears to liberate her from an ambivalence toward her body and body image. One aspect of Helena's experience that might account for these divergences is that she had fertility problems. She reported the process of in-vitro fertilisation (IVF) as lengthy, expensive and emotionally demanding, taking a number of cycles to conceive. She then had twins via caesarean delivery. It is possible that these features may have contributed the differences in her experience. For example, Helena demonstrated a lack of concern relating to changes in her breasts as she was not breastfeeding the twins. It is possible this could have contributed to her emphasis on the ageing process.

In summary, the women's accounts demonstrated many similarities with their experiences often lying along a continuum and therefore demonstrating a wide range within each particular theme. Within this there were also clear divergences within the group, the most striking being that of Helena. In this case it is possible to see elements of her experience that may have contributed to this difference. In other cases, however, the basis for variation is not clear especially as the women's demographics are all very similar. It is possible that a greater understanding of each participant's life history might provide further information upon which one could speculate. The similarities and differences in the women's accounts will be further considered within the framework of psychological theory and the existing literature in the next section pertaining to empirical considerations.

In conclusion, there are therefore many gaps that cannot be filled in terms of an interpretative and phenomenological account of the women's experience. Perhaps, however, this simply represents the complexity of individual experience in all its richness and nuanced texture.

Empirical considerations and applications to practice

The centrality of body image and investment in appearance

The literature holds that body image concerns an individual's attitudes to and perceptions of their body, particularly those concerning their physical appearance, and also includes an affective component (Striegel-Moore & Franko, 2004). Cash (2002) identified a number of core features of body image and these include evaluation, investment and affect; where evaluation refers to an individual's satisfaction or dissatisfaction with their body; investment concerns the importance placed on appearance or body image for an individual's self-evaluation and internalised ideals; and affect refers to emotional responses related to body image. The participants referred to all of these core features to varying degrees throughout their narratives; however the report has focused on a particular approach to the construct of body image for reasons discussed below.

Much of the research conducted over the last 30 years has concentrated on the evaluative facet of body image and its relationship to the development and maintenance of disordered eating. More recently, however, greater attention has been paid to other

dimensions of body image as its centrality to self-concept and self-esteem has become increasingly accepted. Body image, therefore, has critical implications for psychological functioning and quality of life (Cash, Theriault & Milkewicz Annis, 2004). Furthermore, there has been a move towards conceptualising body image as a central aspect of psychological functioning in both sexes rather than a gender-specific concern of women only. Body image is therefore becoming “a central topic of interest in its own right” (Dittmar, 2005, p.1082) rather than solely an area of clinical application in psychopathologies such as eating disorders and body dysmorphic disorder.

This holds implications for counselling psychologists who tend to work in a wide range of settings with clients of varying severity in terms of mental health issues. For these reasons, and as a result of the emergent themes arising from the analysis, the current study has moved away from the general focus on the evaluative component of body image that is found in the literature. It has tended instead to focus on the investment aspect of the women’s experience within the context of their lives along with other elements that might influence the women’s experience of their bodies and body image. The current study is therefore proposed to be of interest and relevance to counselling psychologists for whom body image may be pertinent when considering the general psychological well-being of this and other groups of clients in their clinical practice.

The women’s accounts revealed a continuum of experience relating to the centrality of body image and appearance in their lives. Participants ranged from being clearly aware of how fundamental and integral body image and appearance were to them to indicating unequivocally that they did not regard this aspect of themselves as something of importance that warranted particular attention. For yet other participants, the centrality of their appearance appeared to have diminished over time and with ageing or as a result of the transition to motherhood and the prioritisation of their baby. Once again, the women’s experience of this aspect of their body image was unique to the individual, complex and contextually-bound.

The theoretical relevance of the centrality of body image and appearance within the context of the current study could be argued to be its apparent relationship to investment in appearance or contingent self-worth for some of the participants. The accounts reveal a link for some participants between holding body image as central in their lives and an investment in appearance as a criterion for self-evaluation. For some of the women this

was a current feature, for others not. It was also apparent that for certain participants this aspect of their experience had changed over time. The change tended to be due to context, for example ageing and mothering, indicating that this was not necessarily an enduring feature for participants but was malleable depending on circumstances.

This finding is supported by research showing that the importance of body appearance and body image seem to decrease as age increases (Tiggeman, 2004; Webster & Tiggeman, 2003). Webster and Tiggeman account for these effects through older women's greater use of "cognitive control mechanisms" (2003, p.242) whereby they reappraise their bodies and lower their expectations regarding body appearance compared to younger women. This could be argued as consistent with Amanda's experience, as her narrative suggests that she lowers her expectations of her general appearance and body. It could be argued that she does this in order to increase her acceptance of changes and this serves to maintain her self-concept in the face of these changes (Webster & Tiggeman, 2003). Helena's account also seems to exemplify this process. She was explicit regarding an age-related re-evaluation of her attitude to her appearance. This seemed to enable a positive reframing of her body image and the ageing process which also seemed to be associated with a newfound appreciation for her body's achievements in terms of the bigger existential picture. As a result of this Helena reveals an apparent decrease in her investment in appearance.

Another framework that might account for these changes is that of self-objectification theory (Fredrickson & Roberts, 1997). This is a feminist perspective proposing that the female body is socially constructed as an object to be looked at and evaluated in Western societies. This sexual objectification of the female body leads women (and girls) to internalise an observer's perspective of their physical self. They then begin to treat themselves as an object to be looked at and evaluated on the basis of their appearance. This invariably results in constant scrutiny of the body's outward appearance which in turn may result in negative consequences including body shame and appearance anxiety. This objectification is considered at its highest during childbearing years. The theory therefore suggests that as women age and their bodies are less sexually objectified they may abandon the internalised observer's perspective, and the associated body monitoring, leading to a reduction in negative consequences (Fredrickson & Roberts, 1997).

Tiggeman suggests that self-objectification can be conceptualised as a manifestation of the importance placed on appearance (2004, p.33). Thus, as women age, self-objectification decreases and less emphasis is placed appearance-related attributes. The body is then scrutinised and monitored less, resulting in lower levels of appearance anxiety. In addition to this, control strategies are adopted that involve a reduction in the importance of, and therefore investment in appearance, resulting in a further reduction in appearance anxiety (Tiggeman & Lynch, 2001). This would fit with the women's experience in the current study. It could be argued that as a result of being in a long-term, committed relationship, and childbearing, these women feel less pressure in terms of the need to attract a partner. Appearance may therefore be less important (McKinley, 1999).

In addition to this, the women may be focused on different developmental tasks than when they were younger. For example, there may be less focus on the self and individual achievement (in establishing a career, for example) and more focus on contributing to the next generation and society in general (McKinley, 1999). Research suggests that the transition on finishing further education or university, along with the formation of committed relationships, is associated with improved body experience (McKinley, 2006). Perhaps the combination of these factors, along with the empowering dimension of motherhood, has over time facilitated a reduced investment in appearance for some of the participants. The fact that the women appear to lie along a continuum regarding this dimension of their experience is consistent with the notion that self-objectification gradually reduces with age. As such, it follows that some of the older participants may be expected to be, and appear to be, less invested in their appearance than some of the younger women, on the whole.

Although the women's accounts did not indicate that they were experiencing significant body image concerns, it could be argued that those participants with a greater investment in their appearance may be at increased risk of experiencing self-worth that is to some degree contingent on their body image and appearance. It is clear from the data that, for example, for Eva, Emily, Claudia and Sarah, body image is quite central in their lives. From this it might be interpreted that they have quite a high investment in their appearance. The possibility remains that had these women experienced a greater degree of weight gain and physical changes postpartum they may have been considerably more concerned about their appearance. This in turn could impact upon

their self-esteem and in the worst case scenario even give rise to depressive symptoms or disordered eating (Geller, Johnston & Madsen, 1997). In actual fact, however, what is clear from these women's accounts is that the impact of becoming a mother appears to have tempered the centrality of body image and appearance in their lives at this time thus giving rise to an apparently reduced investment in appearance for these particular participants during this period.

Self-concept effects and the transition to motherhood

An emergent theme found to run like a thread throughout the analysis, arguably the glue holding it together, was that of the impact of the women's experience on their self-concept and sense of self. This feature was again unique to the individual, multifarious and context-dependent for each of the participants. Self-concept effects intersected all themes and were not solely associated with physical appearance, but also with other dimensions of the women's sense of self, such as their identity in the transition to motherhood. This once more highlights the multifaceted intricacy and convoluted nature of the women's experience that is context-bound and embedded in their lifeworld, particularly at this time of transition.

The women's accounts appeared to reveal effects on many dimensions of their self-concept. These were manifested through experiences such as childbearing and the transition to motherhood and what these meant for participants in terms of their roles and self-concept as career women and identities as mothers. These effects appeared to vary according to the individual supporting the notion that self-concept is shaped by context and life events in an idiosyncratic way (Marsh et al., 2006). This is something that is illuminated by a qualitative approach such as IPA that is both phenomenological and idiographic.

As discussed earlier, the transition to motherhood is understood to generate substantial changes in a woman's life. Along with the physical changes that accompany childbearing there are also dramatic changes in a woman's relationships, roles and lifestyle that may give rise to a need to restructure or even reconstruct their self-concept (Lewis & Nicolson, 1998; Salmela-Aro et al., 2000; Smith, 1991, 1994). The women's accounts in this study clearly confirm that they are experiencing these changes, with all participants reflecting explicitly on their experience of the change in role and lifestyle accompanying childbearing.

The women's narratives demonstrate how the impact of the transition to motherhood on their self-concept and identity has inexorably contributed to the complexity of their experience of their bodies and body image. For a number of participants these dimensions of their self-concept appear to have merged or become entangled. This could be interpreted as perhaps indicating how important these particular facets of their self-concept are in terms of their sense of self or self-worth. Alternatively it may simply be a reflection that these dimensions are in a state of flux as a result of bodily changes due to childbearing and the transition to motherhood. Smith argues that at a time of radical change such as the transition to motherhood, a woman may "feel a need to retain or construct a sense of order by emphasizing the degree to which she is remaining constant despite the change" (1994, p.389). The current study could be argued to support this, certainly in the domain of physical self-concept, in that many of the participants, and in particular Eva, revealed a need or desire to appear unchanged physically by the process of childbearing.

The study by Bailey (1999) also supports the findings of the current investigation as the participants were found to experience both continuity and concurrent changes to their sense of self in a number of different dimensions. Bailey describes this as a "refracted self" (1999, p.346), revealing hitherto concealed facets of the self that have come into the women's awareness, as opposed to the development of a new self or the old self being fundamentally altered or fragmented. Interestingly, and in a similar vein to the current study, the women in the study by Bailey (1999) varied in how much they emphasised continuity as opposed to change. Bailey (1999) suggests this transitional period appears to offer the opportunity for change to those who want it. In effect she describes her participants as being excused from maintaining an old narrative sense of self and having the option to introduce changes to their story as a result of the transition. In other words, the women seem to reposition themselves with respect to some discourses about the self and this repositioning serves to either emphasise change or continuity, depending on the individual. In the current study, some of the women such as Eva did not seem to feel the need to emphasise change and, if anything, appear to feel a greater need for continuity with their former selves on a physical level. Other participants however, such as Helena for example, seem to find that the experience of childbearing liberates them from their old relationship with their bodies thus enabling a

new attitude to be adopted. This could be argued as consistent with the study by Bailey (1999).

The women's sense of self therefore emerged from their narratives as shifting and changing. Elements of their new self, the mother, are coming to the fore while elements of their old self, the career woman, retreat into the background. This resonates strongly with the IPA case study by Smith (1991) following one woman, Clare, through her pregnancy and transition to motherhood. Clare's perception of her identity was found to shift in the postpartum period as her roles of mother and partner became more central to her sense of self. This can be seen to parallel the experience of all the women in the current study, but in particular Eva, Amanda, Helena and Claudia. Smith links this with "the notion of a relational self" (1991, p.236) where self concept is informed by, and consists of, experience of the other (Smith, 1991, p.240). For Clare, greater involvement with significant others such as partner and child "leads to a shifting conception of the self" (Smith, 1991, p.236). Again there are striking similarities with the current study; a strong relational component to the women's experience was found alongside transformations in their sense of self thus illustrating the inextricable link between self and other, particularly at this transitional time. This theme of the "relational sense of self" can also be found in the study by Bailey (1999, p.339).

In their qualitative study of five older mothers' narratives regarding the transition to motherhood, Shelton and Johnson (2006) found that the majority of their participants experienced a transition to motherhood that challenged their sense of self and identity. The women emphasised an ambivalent experience for the most part, with the transition complicated by changes in their well-established lifestyles that accompanied the mothering process. The current study could be argued to support this as some of the women were explicit regarding mixed feelings surrounding lifestyle changes and the impact of bodily changes on their self-concept within a similar context. Furthermore, Shelton and Johnson note that their participants' narratives suggest that they were moving toward "the goal of an integrated maternal identity" (2006, p.328). It could be argued that this is echoed in the current study as the women demonstrate a parallel process of integrating their experience of the bodily changes arising as a result of childbearing.

Interestingly, Nicolson's (1999) longitudinal study identified losses experienced in the transition to motherhood and how these relate to depression in the postpartum. Consistent with the current study was the finding that, despite the prevalence of loss that led to feelings of depression in these particular women, there was nonetheless "some sense of psychological fulfilment which is unmistakable and directly connected to motherhood" (Nicolson, 1999, p.174). Nicolson (1999) reports that over time the women tended to integrate the loss they experienced and came to acknowledge it in the context of gains from being a mother. She also argues that the change in a woman's status when she becomes a mother represents a desired move to a "recognized social position and identity" but simultaneously involves the "disruption and loss of her former status" (Nicolson, 1999, p.175). Furthermore, being a mother is central to female identity and means that women may not feel able to truly experience the loss of their former self. If they grieve or mourn they may be pathologised as suffering from postnatal depression. As a result of this taboo Nicolson (1999) contends that women may fail to admit their sense of loss.

There are therefore striking similarities and differences between the experiences described in both studies. The fundamental difference of note is that participants in the current study did not reveal the losses they experience as leading to depressed feelings. They also appeared to integrate the loss of their former self, or come to terms with it in some way, in the context of the empowering dimension of motherhood. It is possible that the women felt constrained by the taboo that Nicolson (1999) discusses and felt unable to reveal such negative issues and feelings. This was not the sense conveyed in the interviews, however, and the current author would argue that for these women there was a greater salience of the psychological fulfilment of mothering.

Again these themes are echoed in the study by Bailey (1999) who found that, whilst some participants felt ambivalent about their pregnancies, they all felt that it had increased their sense of self-worth in some respects, with some feeling fulfilled or self-satisfied. These mothers felt that they had progressed in life and that their status was improved as a result of becoming a mother. This again has striking parallels with the prevailing sense of motherhood as empowering that is found in the current study.

In addition to these studies, the qualitative study into concerns about body shape and weight in 21 new mothers by Patel et al. (2005) requires consideration. The authors

found that their participants also experienced a sense of loss relating to their sense of self as a result of the transition to motherhood. The authors comment that these women appeared to resolve the loss of their pre-pregnant body and former self with the development of a new self as a mother. Furthermore, it seems that for these women, focusing on the baby rather than themselves assisted in this process (Patel et al., 2005). These findings could be argued as consistent with the current study whereby the empowering dimension of motherhood and prioritisation of the baby appears to assist the women in integrating the loss of their former selves on a physical level.

The sociocultural perspective

A number of cultural influences emerged from the women's accounts in the current study. Some of the younger participants in the sample explicitly referred to the Western slim ideal prevalent in today's society (Jackson, 2002) and also acknowledged feeling pressure to conform to this ideal. In addition to this, these women made a direct connection between the slim ideal and dieting behaviour and weight control. In contrast, the older participants tended to focus more on the ageing process and the sociocultural pressure to stay looking young that is prevalent in society today. This appears to reflect a difference between the participants that is age-dependent.

The women's experience of media influence and the portrayal of celebrity mums again appeared to vary along a continuum. Some participants were aware of how unrealistic this depiction might be and could not relate it to their life in any way. In this way they seemed to resist the pressure that might be felt. Other participants appeared to recognise and be aware of the impact of the messages presented by the media and yet others seemed confused in their response to the picture painted in the press and perceived pressure to live up to celebrity standards. These appear to reflect variability regarding the degree to which participants might have internalised or accepted cultural norms for appearance. It is possible that several factors could contribute to this. For example, even if the women question the messages conveyed by these norms they may still believe, implicitly or explicitly, that others accept the norms and will judge them by these standards regardless of whether they consider them legitimate or otherwise themselves. In addition, it may be that appearance is seen as controllable and that women believe they should be able to achieve promoted appearance norms with effort and discipline. On the other hand, some women may view particular norms as more salient or relevant

to them than others, such as norms around ageing rather than thinness for some of the older participants in the current study for example (Strahan et al., 2006).

The women in the current study gave accounts that revealed a notable absence of dissatisfaction with their postpartum bodies. Only two participants expressed some dissatisfaction relating to weight gain and this appeared to be tempered in the context of breastfeeding. Furthermore, the majority of the sample either felt that they met the slim ideal or did not seem to experience a great deal of pressure to conform. The women's experience may be accounted for through research investigating why some women are vulnerable to media effects and others remain relatively unaffected.

Factors that mediate the relationship between exposure to the thin ideal and negative self-directed effects have been identified to include social comparison processes and body image self-discrepancy (Bessenoff, 2006). Participants tended to use downward social comparison in their accounts. This type of comparison to others who are perceived to be less fortunate in some way tends to enhance feelings of self-worth and mood (Wheeler & Miyake, 1992). Upward comparison to others who are perceived to be better off tends to generate negative mood and may threaten self-evaluation (Wheeler & Miyake, 1992) but may also motivate an individual to improve themselves to the comparison standard (Higgins, 1987). Interestingly, very little upward comparison was evident in the participants' narratives. The narratives reveal that on the whole they tended to use social comparison to actual individuals known to them personally, and who are also quite similar; in other words "relevant others" (Strahan et al., 2006, p.213). This appears to be in service of improving their mood and self-esteem regarding their bodies or helping them make sense of their experience of bodily changes.

Body image self-discrepancy, where an individual has a discrepancy between an internalised body ideal and their subjective evaluation of their own body, has been shown to moderate the likelihood of making social comparisons to media promoting the slim ideal (Bessenoff, 2006). The women in this sample did not reveal high levels of self-discrepancy in their interviews, in that they did not reveal the experience of a great difference between their ideal body and their postpartum body. It could therefore be argued that the women's narratives support these findings. As they experience low levels of body image self-discrepancy they have engaged less in social comparison with media ideals, resulting in low levels of body dissatisfaction (Bessenoff, 2006).

Another factor that may account for the women's experience of media influence may be that they are critically processing media images (Engeln-Maddox & Miller, 2008). It is highly likely that this group of women are not just passively receiving media content but are critically analysing and rejecting images as unrealistic. This may account for the apparent lack of social comparison to media images in this sample and lack of body dissatisfaction (Engeln-Maddox & Miller, 2008).

Interpersonal influences

This study investigated older first-time mothers and the analysis supports the notion that body image is influenced by significant others found at different times in our lives (Tantleff-Dunn & Gokee, 2002; Thompson et al., 1999) as the primary relationship that these women tended to talk about in relation to their bodies was their partner. Participants' accounts varied regarding the impact of their partner's attitude, and contrasting degrees of communication between the couples emerged from the narratives. This appeared to span a continuum from little or no communication regarding the woman's body to an active involvement from participants' partners. Further to this, the women also communicated differing levels of concern regarding partner attitudes to their bodies and the bodily changes resulting from the childbearing experience.

Research has demonstrated that beliefs about weight may be learned from within the family (Ogden & Steward, 2000) and that familial values may contribute to body dissatisfaction (Ogden & Chanana, 1998; Ogden & Thomas, 1999). Other research suggests that perceived negative communication within the family may contribute to young women's body image with respect to body dissatisfaction (Byely, Archibald, Graber & Brooks-Gunn, 2000; Kichler & Crowther, 2001). As familial influences appear to be significant in these terms it has therefore been suggested that a woman's sexual partner may contribute to her satisfaction or dissatisfaction with her body and could be the source of body image concerns. This influence may be exerted via positive input such as compliments or negative input such as criticism (Ogden & Taylor, 2000). The majority of research in the area of intimate relationships and body image has tended to investigate their effect on body dissatisfaction due to its association with psychological problems such as low self-esteem, depression and disordered eating (Pole, Crowther & Schell, 2004). In the current study, however, the women were

generally quite satisfied with their postpartum bodies and any dissatisfaction was tempered by the context brought to bear on their experience at that time. One participant who stood out from the rest in being less satisfied with her current weight was Sarah. Interestingly, Sarah also demonstrated a higher level of concern than the other women regarding her partner's attitude to her weight gain.

Interestingly, Sarah's experience could be argued as strikingly consistent with McKinley's (1999) finding that perceived spousal disapproval or negative evaluation of a woman's body or appearance is associated with body dissatisfaction or lowered body esteem. Furthermore, this finding could also be argued as consistent with a study by Pole, Crowther and Schell (2004) that investigated the role of spousal influence and marital communication patterns in married women's body dissatisfaction. They found that perceived negative evaluation by a spouse was significantly associated with body dissatisfaction. This led them to suggest that the perception, evaluation and comments made by a woman's spouse have a significant impact on her satisfaction or dissatisfaction with her body, however, this was within the context of a destructive marital communication pattern. The researchers also found that positive constructive communication was significantly negatively correlated with body dissatisfaction. Although causal inferences cannot be drawn from correlational data, this could be interpreted as implying that a supportive communication style with a significant other could positively impact and therefore enhance body satisfaction. Given that an aspect that emerged from the data was that of the protective nature of a steady relationship on the women's experience of their body image this could therefore be relevant to the current study. The women generally reported their partners to be accepting and supportive of their bodily changes as part and parcel of the childbearing experience and this positive relational aspect in their lives appeared to offer some protection against body image concerns.

Sexuality and breastfeeding

Most participants in the current study mentioned sexual activity, or a lack of it, within the context of lifestyle issues such as a lack of time or fatigue, their experience of breastfeeding and the continued presence of the baby in their bedroom. No participants linked a lack of sexual activity to poor body image or dissatisfaction with their postpartum bodies which is consistent with the findings by Pauls et al. (2007). The wide

variability in the women's reports of their postpartum sexuality is consistent with findings in the literature (Avery, Duckett & Frantzich, 2000).

The current study presents some of the women's response to the desexualisation of the breast. This was varied and the three women presented respond differently to the dual role of the breast during breastfeeding. It is notable that in Western society, and particularly in the UK, the breast has come to be equated with sexuality and its nutritional role has been relegated to that of secondary importance. This shift in emphasis from maternal function to sexual object (Jackson, 2000) could be argued to impact women in terms of how comfortable they are holding the dual role throughout the period of breastfeeding, particularly with their first child. The three women demonstrate variability in their experience: one openly grapples with the dual function of the breast, one appears to experience discomfort and negates her sexuality to resolve this, and the third seems to be more open and at ease with her decision to reject her sexuality during this period.

There are several factors which may contribute to this experience for the women. Firstly, breastfeeding is heavily promoted as the best source of nutrition for infants these days (Jackson, 2000), particularly to the middle classes and particularly by the NCT, the organisation from which the women were recruited. Women may therefore experience pressure to breastfeed and feelings of guilt or inadequacy if they do not wish to or have difficulty doing so (Jackson, 2000). Some individuals may continue to breastfeed even if it is a problematic and unfulfilling experience and this may impact upon their psychological well-being, their sex life and relationship (Corkhill, 1996).

Another factor that may come into play is the physiologic similarities between breastfeeding and coitus. These similarities are attributed to changes in the levels of the hormone oxytocin. This is secreted during breastfeeding, to stimulate let-down of breast milk, as well as in labour and orgasm when it stimulates uterine contractions (Bartlett, 2005; Jackson, 2000). These physical responses may lead to psychological dissonance for some women who may find it difficult to come to terms with sexual arousal during breastfeeding or with an increased awareness of the sexuality of breastfeeding (Jackson, 2000, p.84). It is possible that this type of experience could provoke confusing or disturbing feelings for some individuals. This, coupled with the pressure to continue breastfeeding, could lead to a need to negate or separate off one's sexuality through this

period. From a feminist perspective, this may be compounded by the fact that “maternal sexuality has become a muted discourse, sometimes bordering on the immoral and illegal” (Bartlett, 2005, p.67) with many women understanding the postpartum period as “a time of abstinence” (Bartlett, 2005, p.68). If this was an aspect of the women’s breastfeeding experience, however, they did not talk about it in the interviews. It is possible that being sexually stimulated by the baby suckling could be shame and guilt inducing, as well as confusing, thus prohibiting open discussion, or that it simply did not feature.

Limitations and suggestions for further research

The sample was purposive and was essentially self-selected from a pool of women likely to belong to a particular social class, educational and economic status; furthermore it was small in size and homogenous. These factors suggest that it is therefore unlikely to be a good representation of the population of postpartum women in general, thus limiting the generalisability of the research. It would be very interesting, therefore, to examine these issues in other groups of postpartum women of different social, ethnic, economic and educational backgrounds and of different age ranges in order to investigate differences and commonalities in their experience. From this identification of significant and central themes it may be more possible to move from the particular to the universal (Eatough & Smith, 2008; Smith, 2004).

In addition to this consideration, the fact that the sample was self-selected means that it is probable that the participants were happy with their postpartum bodies and therefore prepared to discuss their body image with a stranger. This notion is supported by the overwhelmingly positive nature of the women’s accounts. It may be that women who were dissatisfied with their bodies would not be willing to discuss this and therefore may not be represented here. It would be of interest perhaps to investigate a similar group of women who were dissatisfied with their postpartum bodies for comparison, if such a group exists.

It is also possible that the very fact that the women were recruited from the NCT, essentially a postnatal support group, may have had a bearing on their experience. This may have manifested itself in contributing to the positive nature of their experience of their bodies and body image. This possibility gives rise to several considerations: firstly, this may or may not be relevant to the analysis as the women made very little reference

to the NCT groups in the interviews. They did not seem to really feature as part of the women's experience. Much greater emphasis was placed on partners and families than either friends or the groups. Secondly, women of this socio-economic and educational background are likely to seek support and access services available to them. It could therefore be argued that membership of an organisation such as the NCT is quite typical in a group of participants such as this. On the other side of the coin, these women might also be more likely to access psychological services making them a pertinent group to study from the perspective of counselling psychology.

Another limitation of the present study could be argued to be the restrictive nature of a single interview for each participant. It may have been more valuable to longitudinally examine the experience of fewer participants. Interviews repeated on two or three occasions, either close together or spread out, would have provided the opportunity to build a greater rapport and gather more in-depth data. This could have included the women's life history and past experience of their bodies and body image as well as their postpartum experience. A more rounded investigation of their lifeworld in the context of their history may have proved of greater use in illuminating factors that contribute to the divergences in their accounts of their experience. In addition, a more longitudinal examination of the women's experience over the course of a wider timeframe or even the entire postpartum year might yield interesting data relating to the experience and processes of change, such as going back to paid employment for example, which would be of interest.

In addition to this, it is notable that the women were between three and seven months into the postpartum year at the time of interviewing. This could be argued as still relatively soon after the birth and that they may still be experiencing changes associated with the birthing process. It may have been of more interest therefore to also interview participants who were further along in the postpartum in order to allow for comparison of experience in the later stages of the postpartum year.

Finally, a significant limitation that must be acknowledged is the fact that the women's experience or perception of the quality of their intimate relationships was not determined. This might have been achieved through including questions in the demographic questionnaire asking participants to rate the perceived quality of their relationship with their partner. Alternatively, a question could have been included in the

interview schedule in order to open up this area in the interview. As such it is difficult to comment on how the quality of the women's relationships may or may not have impacted on their experience of their body image during the postpartum period. This would have been an interesting avenue to explore in the research.

Methodological and personal reflexivity

In this section of the report I will continue to consider how I have been implicated in the research process. I have already positioned myself in terms of my interest in the topic, the assumptions that I believed I held at the beginning of the process and some reflections on the data collection and analysis. I would now like to further consider how I have shaped and influenced the process of the research and the findings (Willig, 2001) through clarifying the impact of my position and perspective (Finlay, 2003b).

As described earlier, a notable reflexive element throughout the research process relates to my assumptions and preconceptions or fore-understandings. I found that my assumptions only truly emerged and became clear to me through my developing understandings of the women's experience (Finlay, 2002a; Smith, 2007). In this way I have only come to realise some fundamental points regarding where I was at the beginning of the research process as I have come to the end.

A perfect example of this is my realisation that I had absolutely assumed the women's experience would be much more focused on the body as an object; that they would be more invested in their body image and would be dissatisfied due to the impact of changes. This understanding in itself has revealed a number of personal insights including a realisation of the extent to which I myself have internalised the thin ideal and objectified my own body. This has been simultaneously fascinating and shocking and demonstrates that in focusing closely on another's embodied experience we can also focus reflexively on our own (Finlay, 2006, p.24).

Furthermore, I have come to realise that without the experience of childbearing, it was impossible for me to fully appreciate its impact, particularly on body image. This again relates to and supports the emergence of a clearer understanding of my assumptions only as I came to know more about the women's experience. Doing the research has fundamentally changed the way I think about the experience of childbearing: through immersing myself in the participants' accounts I have been privileged to reach a better

understanding of an experience that I have not gone through and that is so fundamental to being a woman. I hope that this research may therefore also illuminate this experience for others who are “other” to this group of participants such as male counselling psychologists and those who have not had a child.

In addition to influencing the research questions and interview process, my assumptions have inevitably impacted upon the analysis and construction of meaning from the data. I endeavoured to be as open as possible in my analysis of the transcripts; acknowledging my emergent and ever-changing assumptions and attempting to put them to one side in order that I might engage with the participants’ world from a fresh and different perspective. I wanted, as far as possible, to “allow the phenomenon to present itself to me instead of imposing preconceived ideas on it” (Finlay, 2008, p.5). This was an incredibly difficult process, however, and I am not sure to what extent I managed to achieve my aim. I therefore acknowledge that my findings have emerged in the specific context of myself and my lifeworld and that a different researcher would probably have told a different story (Finlay, 2003b).

I take solace, however, in my understanding that any analysis and presentation of data will inevitably “simultaneously reveal and conceal” being “incomplete, partial, tentative, emergent, open and uncertain” no matter how “rich and comprehensive” (Finlay, 2008, p.6). I hope that I have managed to provide a glimpse of the women’s lived experience despite the findings being still partial and emergent. The fact remains that lived experience cannot be accessed directly; the moment we attempt to convey our experience we are interpreting it even as we do this. Access to a world prior to interpretation is therefore impossible. The best we can do is try to uncover something of our unreflective experience (Finlay, 2003b). I feel that in particular superordinate theme three may do this to some extent. This particular theme differs from the others in being more abstract and conceptual and I really feel that it captures something of the women’s pre-reflective embodied experience.

In terms of the process itself, the research has required immersion to a level for which, I must admit, I was not prepared. It has also been more iterative than I had anticipated despite being aware of the nature of the method. I have found it difficult continually moving between parts and whole in terms of both the project itself and my reflexivity. There has been a need to move back and forth between the bigger picture and the detail

of the report and between experience and awareness regarding reflexivity. These two processes have run in parallel throughout. I have had to continually reflect upon my interpretations of both my experience and the phenomenon so as to move beyond the partiality of my previous understandings (Finlay, 2003b, p.108). I have been engaged in a process of making myself more transparent through reflecting on my experience of the research, my fore-understandings and my developing understandings, my perceptions and my interpretations. I hope that as a result of this I have been able to better recognize, and disentangle to some degree, the fusion of horizons between the participants and myself in order that I can more fully understand their “otherness” and their experience (Finlay, 2002a, p.4).

Something that has also become increasingly apparent to me is how the experience of conducting a qualitative study has opened up a whole new vista on a number of levels. In a parallel process to my participants, I have reconceptualised myself as a qualitative researcher. Following a career as a pharmacist in an environment dominated by the medical model, and therefore a very traditional positivist paradigm, I have found the experience of delving into the qualitative paradigm exciting, stimulating and also scary at points. The depth and breadth of what is available to me in terms of thinking and doing is both wonderful and terrifying. I have found this process simultaneously a delight and a chore, sometimes feeling quite a buzz and at other times feeling as though I am floundering around in quicksand. It has encouraged me to delve much deeper into philosophy and epistemology; to consider the nature of how we experience ourselves, the world and others, and most of all to reflect with wonder on what it is that we can know and how it is that we know it.

I have realised that my epistemological standpoint has been fundamentally and radically altered by the experience of my training as a counselling psychologist and of doing this piece of qualitative research. I can no longer unquestioningly embrace a positivist view that there are immutable causal laws regarding human behaviour that we can discover through nomothetic study. I am firmly committed to a belief that both qualitative and quantitative paradigms may complement each other in providing an insight into the particular that can further illuminate the universal. For me the strength of IPA therefore lies in its idiographic and phenomenological approach with attention to individual lived experience and the lifeworld. I also believe body image research invites an idiographic approach as it is so variable, particular to the individual and embedded in the lifeworld.

This notion is supported by the findings of this study and by the inconsistencies noted in the extant quantitative literature. A quantitative approach alone cannot possibly capture the complexities and context-dependent nature of a multi-faceted construct such a body image; in particular, such an approach sacrifices the embodied dimension of an individual's experience of their body and body image that I would suggest is fundamental to our understanding of the pre-reflective nature of our experience.

Conclusions

Body image is of interest to counselling psychologists due to its crucial role in human experience (Pruzinsky & Cash, 2002). It is increasingly accepted as being central to self-concept and self-esteem and therefore has significant implications for psychological functioning and quality of life (Cash, Theriault & Milkewicz Annis, 2004). The development of this broader conceptualisation of body image relating it to general psychological well-being has placed it in a mainstream arena rather than exclusively in more specialist clinical fields such as eating disorders. As a result of this it could be argued to be increasingly pertinent to many counselling psychologists who tend to work in a wide range of settings with a broad variety of clients, often from more normative populations (Ponterotto, Kuriakose & Granovskaya, 2008).

As the review of the literature indicates, current research into body image in the postpartum period is contradictory and mainly quantitative in nature. Very few qualitative investigations have been conducted. It is arguable that the quantitative approach to body image as a one-dimensional fixed construct assessed through the use of measures on a nomothetic basis is limited in its utility (Gleeson & Frith, 2006). Such a simplistic view neglects the complexity and diversity of individual experience and the embedded nature of body image in the lifeworld. In this sense, quantitative research tends to ignore the intricate nature of how people perceive and evaluate their bodies in a socio-cultural context and how they make sense of and give meaning to their embodied experiences (Gleeson & Frith, 2006).

A qualitative approach was adopted for the current study in order to best serve the research aims and consider the context and complexity of women's experience of their bodies and body image in the postpartum period. The research explored in-depth the lived experience of a small and homogenous group of women in the year after the birth of their first child. Particular attention was given to the influences that might impact upon their experience and the meaning and implications of bodily changes as a result of childbearing. The qualitative methodology of IPA was considered best suited to address these research objectives due to its idiographic nature and distinct focus on lived experience and sense making. IPA has also made a unique contribution to qualitative investigation in applied psychology (Eatough & Smith, 2008; Smith, 2004) and is

considered by the author to be particularly compatible with the philosophy of counselling psychology.

The women's accounts of their experience are consistent with the conceptualisation of body image as a complex and multi-faceted construct (Pruzinsky & Cash, 2002). Participants' experience of their bodies and body image were embedded in their lifeworld and were found to be inextricably context-bound and context-dependent. An embodied dimension to the women's experience was also observed. This has been previously neglected in the literature due to the predominantly quantitative approach and lack of focus on experience. It is therefore argued that this study has made a unique and valuable contribution to the current understanding of body image in this group of women. This is due to the detailed picture that has been constructed of their experience reflecting both its complexity and embedded nature in the individual lifeworld.

Other phenomenological insights that the study has provided include a greater understanding of how the women's experience of childbearing, their bodies and body image is inextricably entwined with their lifeworld and cannot be separated from it (Finlay, 2003a). Different features of the women's lived situation and intersubjective social world were drawn out in the analysis. These were used to illustrate the common structural whole of their experience whilst also illuminating the individual divergences (Finlay, 2008; Smith & Osborn, 2008). A conclusion regarding the significance of the relational aspect of the women's lives may be drawn from this, as the women experience their postpartum bodies and body image in the context of their significant relationships with baby, partner, family and friends. Investment in these relationships appears to protect against body image concerns for these women.

Other features of the lifeworld that were examined included the influence of cultural context upon the women's experience. The emergent picture further reveals the complexity of the women's experience of their body image in the modern climate. It is concluded that the influences operating in terms of body image for women in this group are complex, multifactorial and embedded in their lifeworld, which may account for the wide variation in individual experience.

The women's accounts also highlight the ambiguities, tensions and contradictions that are their lived experience as they negotiate motherhood for the first time. The notion of

the self emerged from the narratives as being an important aspect of the women's experience during this significant and transitional period in their lives. There is evidence of a tension between both continuity and change in their sense of self or self-concept. This, however, is tempered by the empowering dimension of motherhood that emerged from the narratives. This appears to arise from an embodied expression of existential meaning (Radley, 2000; Young, 1984) held in having a child and serves to free the women from the dominant discourse regarding body image and appearance in society today.

The women's experience of bodily changes was also found to be complex, ambivalent and firmly embedded in their lifeworld. A liveable relation (van Manen, 1998) with their changed bodies, and integration of the changes as a result of this, appeared to be facilitated through their reconceptualisation of themselves as mothers. The narratives clearly demonstrate that childbearing has therefore impacted the women's experience of their bodies and how the world is experienced with their body (Radley, 2000) as their accounts relating to breastfeeding particularly reveal.

The methodology has therefore enabled a detailed account of the women's lived experience to be constructed. Furthermore, this is not simply descriptive but has incorporated an interpretative element that is firmly grounded in the data (Eatough & Smith, 2008). In this way the author has endeavoured to represent what it is like for these women to experience their bodies and body image at this time and also to ask questions of their accounts, giving a rich analysis (Smith & Osborn, 2008). The women's experience is simultaneously deeply embedded within their lifeworld, embodied and fundamentally relational in nature. This is something that could not be captured with questionnaire measures in a quantitative and nomothetic approach. Investigation in the latter vein cannot hope to access and describe the complexity of such an experience. It can therefore be concluded that an idiographic approach such as IPA can reveal a far more detailed picture, capturing both nuance and texture. This allows it to make a valuable contribution to a greater understanding of what it is actually like to go through this experience.

Findings from the current study have also been related to the extant empirical literature in areas such as the centrality of body image and investment in appearance; self-concept effects and the transition to motherhood; the socio-cultural perspective on body image

and changes in sexuality related to breastfeeding. The study is exploratory and aims to improve counselling psychologists' understanding of the socio-cultural context that may impact on this and similar groups' experience. The interpretations and findings are not claimed to be generalisable but it is hoped that they may to some extent be transferable to other groups that are similar. In this way the study may complement and supplement the existing quantitative literature thus giving a broader understanding of the topic and having direct clinical relevance (Ponterotto, Kuriakose & Granovskaya, 2008). In addition, the resulting theoretical insights and empirical considerations are hoped to inform therapists and facilitate them in offering support tailored to a specific context (Silverstein, Auerbach & Levant, 2006).

In conclusion, the fundamental contribution of this study to counselling psychology is hoped to be the rich description of subjective and intersubjective experience and meanings it provides to those who are both "same" and "other" to this group of participants. Those who are "other" will include counselling psychologists who have no children, those who are male and those from differing socio-economic and cultural backgrounds. The value of knowledge regarding the subjective experience of this particular group is that it relates to the underpinning philosophy of counselling psychology, and the goal of clinical practice, whereby the practitioner is encouraged to engage empathically with the world of the client (British Psychological Society, 2000). It is also hoped that, through a greater understanding of the women's experience, a deeper and more meaningful connection may be fostered with similar clients along with a heightened level of therapist empathy.

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Appendix A

Demographic form

BACKGROUND INFORMATION

To begin, I would like to obtain some basic information about you, such as your age, education and occupation. The reason for this is so that we can provide some general details about the group being studied in the report for the project. The information you provide will not be used to identify you in any way, and your name will not be used at any point in the report. Nonetheless, if you don't want to answer some of the questions, please don't feel that you have to.

Thank you for your cooperation.

1. How old are you? _____years.

2. What is your highest educational qualification?
(Please tick the appropriate answer)

None _____

GCSE / O-Level / CSE _____

A-Level _____

Diploma (HND, SRN etc) _____

Degree _____

Postgraduate degree / diploma _____

3. Have you returned to work? Yes / No
(Please circle the appropriate answer)

4. What is your current occupation, or if you are no longer working, what was your last occupation? (Please write below)

5. What is your current marital status?
(Please tick the appropriate answer)

Single _____

Living with your partner _____

Married _____

Separated _____

Divorced _____

6. How many children do you have? _____child(ren)

7. When was your child born? _____
(Please write the date)
8. How did you give birth to your child? Vaginally / By Caesarean
(Please circle the appropriate answer)
9. Are you breastfeeding at the moment? _____Yes _____No
(Please tick either yes or no)
10. What is your current weight? _____
(Please give a rough idea if you are not sure)
11. What is your height? _____
12. How would you describe your ethnicity? _____

Appendix B

Information for participants

Thank you for considering taking part in this research project. This information sheet provides some details about the project in order to help you understand what it is about, why it is being conducted and what your participation will involve. This is so that you can make an informed decision about whether or not you would like to consent to participate.

The project is titled “Women’s Experiences of Body Image in the Postpartum Period: An Interpretative Phenomenological Analysis”. It is an investigation into women’s experiences of their body image in the year following the birth of their first child. I hope that the study will increase our understanding of the psychology of body image and particularly in this group, i.e. women who have had their first baby. The transition to motherhood is a very important time in a woman’s life, and I hope to increase our understanding of some of the issues and challenges faced by first-time mothers.

Your participation will involve doing an interview with me that will last for around one hour and a quarter. I will ask you questions to get you to talk about your experience of your body image in this first year after having had your first baby.

I would like to record the interview so that I can transcribe and analyse it later for the project. I will need your consent for this and have a form that you will need to sign for consent to participate and another for consent to record the interview.

I will come to your home to conduct the interview, at a time that is convenient for you. If you are not comfortable for me to interview you at home, we can arrange to conduct the interview at another location should you wish.

Your participation is not expected to involve any risks of mental or physical harm any greater than those involved in your daily life, but nonetheless you will be debriefed fully at the end of the interview. I will ask you how you found it to participate and will provide some information about where you can get support should any difficult issues arise as a result of the interview.

All the material you provide will be anonymous and your name will be changed so that it will not be recognised by anyone else. Should you wish to have a copy of the report when it is finished, then I can arrange for you to receive one.

Once you have consented to participate, you have the right to withdraw your consent and participation at any time during or after the interview. I will provide you with my contact details and those of my supervisor, so that you may withdraw at any time, should you so desire. There will be no penalty for withdrawing your participation from the project and I will destroy any recordings or data related to you.

I hope that this information is enough to give you some idea of whether you would like to participate in this research. Your participation will be invaluable and also much appreciated. Should you have any further questions that you would like answered, please contact me at: Elena Gil-Rodriguez. Telephone: 07974328827 or 020 7487 5428
Email: egilrodriguez@yahoo.co.uk

Appendix C Flyer

**Are you a first-time mum with a child less than one year old?
Are you aged between 30 and 45 years old?**

I am interested in hearing how you feel about your body since you gave birth to your child.

I am carrying out research as part of my Doctorate at City University, Islington.

Would you be prepared to talk to me about this topic?

If you would like more information about what this might entail, please contact Elena Gil-Rodriguez on:

020 7487 5428 or 07974328827 or egilrodriguez@yahoo.co.uk

Thank you

Project supervised by Susan Strauss
susan.strauss.1@city.ac.uk 020 7040 0167

**Are you a first-time mum with a child less than one year old?
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Thank you

Project supervised by Susan Strauss
susan.strauss.1@city.ac.uk 020 7040 0167

Appendix D

Participant thumbnail sketches

In order to contextualise the women's experiences, brief details of each participant's circumstances will be presented. These details are relevant contextually as one notable feature that emerged from the transcripts was how the each woman's interview was dominated and coloured by their individual experience. None of the women had returned to paid employment at the time of the interviews. Although the interview schedule did feature questions relating to interpersonal relationships with family, friends and partners, the women varied considerably in which of these relationships featured in their accounts. The thumbnail sketches will present some further information regarding this. All the women talked about their babies in relation to their experience. What may have been useful on reflection, as mentioned in the methodology section, would have been more information regarding the length and perceived quality of the women's relationships with their partners.

Amanda

The first participant was Amanda who was 40 years old. She had a Ventouse assisted vaginal delivery and her son was six months old at the time of the interview. She had just stopped breastfeeding. Amanda was co-habiting with her partner and had not yet returned to paid employment, although she intended to. Amanda reported her family as "not particularly body conscious people" and they did not feature in her account. In addition to this, Amanda's partner and friends were mentioned briefly in response to questioning, but otherwise did not feature particularly in her account.

Emily

Second to be interviewed was Emily who was 37 and also had a vaginal delivery. Her son was three months old and was being breastfed. Emily had very unusual circumstances as she had used a donated egg in order to have her baby as she had gone through an early menopause at 30 years old. She was very clear that she wanted to be open about this experience and "break down taboos" that might surround it. Emily was married and her partner featured heavily in her account. They had been together for around seven years. Emily reported being very close to her husband's family who also featured quite considerably in her account. Emily's family of origin did not feature at all, however, and neither did friends. Emily was not planning to return to paid employment at the time of the interview.

Helena

Helena was 39. She had IVF treatment resulting in the birth of twins, a boy and a girl of four months old. She had a Caesarean section and was not breastfeeding. Helena was co-habiting with her partner and did report that she felt the relationship had been under strain as a result of going through IVF and the pregnancy. Despite this, however, she also felt that her partner was very supportive regarding her body after the pregnancy and with childcare. Helena had not yet returned to paid employment but was very clear that she intended to and was looking forward to it so that she could "regain a bit more of herself". Family and friends did not feature particularly in Helena's account, however, she did mention using various internet forums and message boards for support throughout her pregnancy and after the birth of her twins. Helena did comment quite extensively on the media and celebrities. In addition to this, Helena's children also featured heavily in her narrative.

Sarah

Sarah was 34 years old with a daughter of four months, born vaginally. Sarah had a very difficult birth resulting in quite a negative experience for her. She also had an episiotomy and had to have some stitches. Sarah was breastfeeding her daughter. She had had a breast augmentation when she was 25 and went from an AA cup to a C cup. She had her implants inserted behind the muscles of the chest so that she would be able to breastfeed when she had children. Sarah was married and her partner featured a great deal in her account along with his family. She reported being very close to her family, in particular her mother and sister, who also featured heavily in her account. In addition to this, Sarah was one of only two participants who mentioned friends from the NCT groups they attended. She also talked about other friends in relation to her body image and comparisons. Sarah was planning to return to paid employment but was also planning a speedy second pregnancy. She also talked about her workplace and colleagues in relation to her post pregnancy body image and comparisons. One thing that was predominant in Sarah's interview was her concern with weight gain as a result of the pregnancy and the tension she felt between breastfeeding and her desire to diet and lose weight.

Olivia

The next participant was Olivia who was 40. She had a daughter of seven months who was being breastfed. Olivia also had a vaginal delivery although it was protracted and difficult, requiring considerable medical intervention. She too had an episiotomy. Olivia's recovery from the birth was also difficult as she had refused a blood transfusion and was very anaemic for some time. She was previously divorced and was co-habiting with her partner who did not feature predominantly in her account. Olivia did mention her sister but other than this did not talk about her family of origin or her partner's family. She also briefly mentioned some friends, but again these relationships did not feature a great deal in her account. Olivia's partner was European and she had also lived in the Far East so an interesting feature of her narrative related to cultural comparisons. As with Helena, Olivia had strong views regarding the media and celebrities. Olivia did not make it clear in the interview whether she was planning to return to paid employment.

Claudia

Claudia was 33 with a daughter of six months. She had a vaginal delivery at home with an independent midwife and was breastfeeding. Claudia had been married for three years and her husband featured a great deal in her interview. As with Sarah, Claudia's account was dominated by concerns with her pregnancy weight gain and a tension between her desire to diet and lose the weight and her desire to continue breastfeeding. Claudia did not mention either her family of origin or her husband's family in her narrative, however, friends featured quite heavily, particularly in terms of comparisons. Claudia was planning to return to paid employment at some point in the future.

Eva

The penultimate participant was Eva who was 40. She had a son of five months old who was being breastfed. Eva had a vaginal delivery but also had unusual circumstances as she had suffered a third degree tear during labour and had had a difficult and lengthy recovery from this. As might be expected, this experience dominated the interview. Eva was co-habiting with her partner and he featured a great deal in her account. Eva talked briefly about her family of origin in her interview, but not about her partner's family. Friends also featured quite heavily in her account, particularly in terms of comparisons,

as did the workplace and colleagues. Eva was planning to return to paid employment at some point in the future.

Anna

The final interviewee was Anna who was 35 with a son of four months old. She had a vaginal delivery and was breastfeeding. Anna reported having ambivalent feelings towards her breasts as they were large for her frame. She also had a fungal infection of the breast resulting in great difficulty breastfeeding at first and this experience dominated her interview. Anna was married and her partner featured quite heavily in her account, as did her family of origin and her husband's family. Friends also featured a great deal in Anna's account in terms of support and comparisons. Anna also mentioned her NCT group in relation to breastfeeding support and social networking, along with other groups she attended in order to access support.

Appendix E

Interview schedule

1. How concerned were you while you were pregnant, if at all, about getting back to your prepregnant figure?
2. Do you feel that you have regained your prepregnancy figure since the baby was born?
Prompt: how do you feel about that?
3. How do you feel about the changes in your body from your pregnancy?
Prompt: weight, shape, figure, stretch marks, loose skin, varicose veins
4. How do you deal with these changes?
5. How did you feel about your body before you were pregnant?
6. How did you feel about your body during your pregnancy?
7. How do you feel about your body since having your baby?
8. How satisfied are you with your body since giving birth?
9. How do you feel about specific parts of your body?
Prompt: stomach, breasts, hips, bottom
10. How do you feel about your current weight?
11. How do you feel about your current shape?
12. How important would you say your body image is to you?
Prompt: now, before the pregnancy
13. How do your feelings about your body affect your life?
Prompt: do they interfere with anything? e.g. clothes you would like to wear, activities such as swimming
14. What does your partner think about your body now you have had the baby?
Prompt: how do you feel about that?
15. What do family or friends think about your body now you have had the baby?
Prompt: weight, shape, getting back to normal or not
Prompt: how do you feel about that?
16. Do you compare yourself to other people, and if so, who do you compare yourself to?
Prompt: how does that make you feel about your body?
17. What other influences, if any, do you feel affect the way you see or feel about your body now you have had your baby?
18. How much of a difference do you feel there is, if any, between your body now and your ideal body?
Prompt: does anything make you consider this difference?
19. Is there anything else you would like to mention before we finish?

20. How did you find the interview?

Appendix F

Ethics release form

Ethics Release Form for Psychology Research Projects

All students planning to undertake any research activity in the Department of Psychology are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department of Psychology does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2004) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by 2 members of Department of Psychology staff.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc M.Phil M.Sc Ph.D D.Psych n/a

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

WOMEN'S EXPERIENCE OF BODY IMAGE IN THE POSTPARTUM PERIOD:
AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

2. Name of student researcher (please include contact address and telephone number)

ELENA GIL-RODRIGUEZ, 13 DE WARDEN ST LONDON W1G 8RL
07974 328527

3. Name of research supervisor

SUSAN STLAUSS

4. Is a research proposal appended to this ethics release form? Yes No

5. Does the research involve the use of human subjects/participants? Yes No

If yes, a. Approximately how many are planned to be involved? TWO FOR PILOT STUDY & MINIMUM
OF SIX FOR RESEARCH

b. How will you recruit them? VIA LOCAL BRANCHES OF NATIONAL CHILDREN
TRUST IN LONDON

c. What are your recruitment criteria? WOMEN AGED 30-45 YEARS WHO HAVE HAD THEIR
(Please append your recruitment material/advertisement/flyer) FIRST CHILD IN THE PREVIOUS
YEAR

d. Will the research involve the participation of minors (under 16 years of age) or those unable to give informed consent?

Yes No

e. If yes, will signed parental/carer consent be obtained? Yes No

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? (If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).

EACH PARTICIPANT WILL BE INTERVIEWED FOR AROUND 75 MINUTES.
SEMI-STRUCTURED INTERVIEW FORMAT WILL BE USED.

7. Is there any risk of physical or psychological harm to the subjects/participants?

Yes No

If yes, a. Please detail the possible harm? -----

b. How can this be justified? -----

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes No

(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

9. Will any person's treatment/care be in any way compromised if they choose not to participate in the research?

Yes No

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes No

(Please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

I WILL DIGITALLY RECORD THE INTERVIEWS & STORE THE RECORDINGS ON CD-R. THE INTERVIEWS WILL BE TRANSCRIBED VERBATIM. THE TRANSCRIPTIONS WILL BE ANONYMOUS, WITH PSEUDONYMS USED FOR PARTICIPANTS. PLEASE SEE METHOD SECTION OF APPENDED PROTOCOL

12. What provision will there be for the safe-keeping of these records? -----

RECORDS WILL BE KEPT IN A LOCKED CABINET AT THE RESEARCHERS HOME. ANY KEY IDENTIFYING THE TRANSCRIPTS WILL BE KEPT SEPARATELY & SECURELY.

13. What will happen to the records at the end of the project? -----

THE RECORDINGS WILL BE DESTROYED WHEN THE RESEARCH & ASSESSMENT IS FULLY COMPLETED

14. How will you protect the anonymity of the subjects/participants? -----

TRANSCRIPTIONS & ANY WRITE UP WILL BE ANONYMOUS AS PARTICIPANTS WILL BE GIVEN PSEUDONYMS.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

PARTICIPANTS WILL BE VERBALLY DEBRIEFED AT THE END OF THE INTERVIEW & GIVEN A WRITTEN DEBRIEF WITH INFORMATION REGARDING CONTACT DETAILS & RESOURCES THAT MAY BE ACCESSED FOR SUPPORT. PLEASE

(Please append any de-brief information sheets or resource lists detailing possible support options)

SEE METHOD SECTION OF APPENDED PROTOCOL

2

If you have circled an item in bold print, please provide further explanation here:

THE RESEARCHER INTENDS TO USE HUMAN PARTICIPANTS - WOMEN
AGED 30-45 YEARS OLD WHO HAVE HAD THEIR FIRST CHILD IN
THE PREVIOUS YEAR (IE THE CHILD IS LESS THAN ONE YEAR OLD)
& FOR WHOM ENGLISH IS THEIR FIRST LANGUAGE. THE RESEARCHER
DOES NOT ANTICIPATE ANY PHYSICAL OR MENTAL RISK FOR PARTICIPANTS
BEYOND THOSE OF ^{EVERYDAY/} NORMAL LIFE

Signature of student researcher *[Signature]* Date 21/11/06

Section B: To be completed by the research supervisor

Please mark the appropriate box below:

Ethical approval granted

Refer to the Department of Psychology Research Committee

Refer to the University Senate Research Committee

Signature *[Signature]* Date 19 Nov 06

Section C: To be completed by the 2nd Department of Psychology staff member (Please read this ethics release form fully and pay particular attention to any answers on the form where bold items have been circled and any relevant appendices.)

I agree with the decision of the research supervisor as indicated above

Signature *[Signature]* Date 22/11/06

Appendix G

Consent form

I consent to participate in the project entitled “Women’s Experience of Body Image in the Postpartum Period: An Interpretative Phenomenological Analysis” conducted by Elena Gil-Rodriguez, a Counselling Psychologist in Training at the Department of Psychology, City University, London.

The project is supervised by Susan Strauss at The Department of Psychology, School of Social Sciences, City University, Northampton Square, London, EC1V 0HB. Telephone: 020 7040 0167.

The research will be conducted according to the Code of Conduct and Ethical Principles of the British Psychological Society.

The purpose of the study is to investigate women’s experiences of their body image in the year following the birth of their first child. I understand that the only requirement will be for me to be interviewed by Elena Gil-Rodriguez, which will take approximately one hour and a quarter.

I understand that the results of this research will be anonymous, and I will be given a pseudonym in any written material so that my identity will not be attached to the information I contribute. The key that lists my identity and pseudonym will be kept securely and separately from the research data in a locked file. It will be destroyed when the research is completed. In addition, I understand that the purpose of the research is to examine groups of people and not one particular individual.

The research project is expected to provide further information on women’s experience of their body image in the year following the birth of their first child. This hopes to increase our understanding of the psychology of body image as well as the issues and challenges that women face in the transition to motherhood.

I understand that the results of this research may be published in psychological journals or otherwise reported to scientific bodies, but that I will not be identified in any such publication or report.

I understand that my participation is voluntary; that there is no penalty for refusal to participate or for withdrawing from the study, and that I am free to withdraw my consent and discontinue participation at any time. I understand that, if I withdraw my consent and participation, my data, including any recordings, will be destroyed.

I understand that this project is not expected to involve any risks of harm greater than those involved in everyday life, and that all possible safeguards will be taken to minimise any potential risks.

If I have any questions about any procedure in this project, or wish to withdraw my participation at any time, I understand that I may contact the researcher, Elena Gil-Rodriguez at 13 De Walden Street, London, W1G 8RW. Telephone: 07974328827 or 020 7487 5428
Email: egilrodriguez@yahoo.co.uk

Signed (Participant).....

Name (Block Capitals).....

Date.....

Appendix H

Confidentiality and consent agreement on the use of digital audio recordings

This agreement is written to clarify the confidentiality conditions and consent for the use of digital audio recordings made by Elena Gil-Rodriguez for the purposes of psychological research.

The participant gives Elena Gil-Rodriguez permission to tape the research interview on condition that:

- The permission may be withdrawn at any time
- The digital audio recordings are used solely for analysis by Elena Gil-Rodriguez
- The digital audio recordings will not be heard by any person other than Elena Gil-Rodriguez
- The digital audio recordings will be stored under secure conditions and destroyed at the appropriate conclusion of their use

This agreement is subject to the Code of Conduct and Ethical Principles of the British Psychological Society and the law of the land.

I have read and understood the above conditions and agree to their implementation.

Signed (Research participant).....Date.....

Name (Block capitals).....

Signed (Researcher).....Date.....

Name (Block capitals).....

Appendix I

Debriefing for participants

Thank you for taking part in this research project. Your help is much appreciated.

The purpose of the research is to gain a more in depth understanding of women's experience of their body image in the year following the birth of their first baby. Your contribution and your views and feelings on this subject have therefore been invaluable, and are much appreciated.

It is hoped that the study will increase our understanding of the psychology of body image, particularly during this important time in a woman's life - the transition to motherhood.

If you have any questions regarding the research, or wish to withdraw your consent or participation at any time, you may contact me directly at: Elena Gil-Rodriguez, 13 De Walden Street, London, W1G 8RW. My telephone number is 07974328827 or 020 7487 5428.
Email: egilrodriguez@yahoo.co.uk

The contact details of my supervisor, Susan Strauss are as follows: Department of Psychology, School of Social Sciences, City University, Northampton Square, London, EC1V 0HB.
Telephone: 020 7040 0167. You may contact my supervisor should you have any queries or issues regarding the research or the conduct of the interview, for example, which you do not wish to share with me.

If you would like to receive a copy of the results of the research for your interest, please give me your postal address and I will send one to you when the research is finished.

At the end of the interview, I asked how you had found it to take part in the research and how you were feeling after the interview. If as a result of participating, you have experienced or are experiencing any difficult feelings such as sadness, embarrassment, emotional stress or feelings about yourself or your body that you are uncomfortable with, for example, I have provided below some details of organisations that you can contact in order to get some support. I hope that these might be useful if issues have come up for you during or after the interview that you would like to talk to someone about.

Samaritans: Provides 24-hour confidential emotional support for those experiencing feelings of distress or despair.

Tel: 0845 790 90 90

Website: www.samaritans.org.uk

Careline: Provides confidential crisis telephone counselling to children, young people and adults. Careline maintains an extensive information system which contains details of other agencies and support groups throughout the country and can refer callers to a specific agency when required. Volunteers are all trained crisis telephone counsellors who also receive ongoing training and regular supervision.

Tel: 0845 122 8622

Website: www.carelineuk.org

Open: 10am - 1pm & 7pm - 10pm, Monday - Friday.

The Eating Disorders Association:

The adult helpline is for people over 18 in the United Kingdom who wish to talk about eating disorders and to obtain information about help available in their locality. About a third of the calls are from people with an eating disorder, a third from friends and relatives and the rest a mixture of professionals and students. The purpose of the helpline is to provide a confidential service including:

- a listening ear
- non-judgmental response
- information about eating disorders
- information about help available

You can contact the helpline service by e-mail at helpmail@edauk.com

Tel: 0845 634 1414

UK Helpline Opening Hours

Open 10:30am to 8:30pm Monday to Friday

Saturdays 1:00pm to 4:30pm

Sunday- Closed

Website: www.edauk.com

You could also go to your GP or could contact the BACP for information regarding finding a counsellor.

The British Association for Counselling and Psychotherapy:

BACP House
15 St John's Business Park
Lutterworth
LE17 4HB

Tel: 0870 443 5252

Website: www.bacp.co.uk

1 feeling of a shift or crossing a line or
 2 turning points or 2 before it after
 3
 4
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Doesn't see self as overweight

10 transition to adulthood: acceptance of
 11 that body being changed as result of
 12 becoming a woman & that men in child
 13 the way you look
 14 to acceptance of that as normal / should
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 16 importance that ^{cannot} will keep young
 17 body forever especially through
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referred by /
 several shift accompanied pregnancy
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body changes draw attention to body & body image
 transition in terms of age (2 text)

having a nice body and stuff and suddenly I'm thinking oh I've gone into that other
 world now [EGR mmm] where I've got a bit of a, bit of a belly and then I, I, I, you
 know I tighten the trousers round the waist and something bulges out under the
 waistband and something bulges out over the waistband [EGR ok] and that is how I
 see, I remember seeing women sort of over, over I'm exaggerating because it's not
 that bad [EGR umm humm] because when I think of that look I think of someone
 who's overweight [EGR umm humm] umm whereas I don't really see myself as
 overweight

EGR but there's something about a shift a before and an after
 P2 without a doubt yeah absolutely umm then / then again I think well but there is,
 you know there is a before and after in my life [EGR umm humm] and I am a
 mother now [EGR mmm] and you don't necessarily have to look different because
 you're a mother but it's very hard not to [EGR mmm] and I think it's just erm again
 it's part of the natural course of things [EGR ok] you know you're not going to
 have your 25 year old body forever [EGR right] and the obvious time when you're
 going to stop having it is when you're giving, when you have a child especially
 when you have a child at 40 [EGR right] when it would have probably happened
 anyway the body, you know, the body wasn't, you know what it used to be anyway
 before I gave, but, but I think in my head before I got pregnant I was probably still
 25 [EGR ok] mmm in, in, in, that I was still that person or 20 or whatever I was still
 that young girl who came to London [EGR ok] and then in my head having a baby
 meant that I was now a different person

[EGR right] when in fact my body before I gave birth was nothing like it was when
 I was ~~pregnant~~, in my 20s cause it had changed / mean like I said I've
 done you know, I no, I've never made an effort for it not to change, I didn't go to
 the gym / I didn't [baby coughs violently] [whispers to baby: all right ok have a
 snooze have a snooze] / mmm so umm it's almost as though you're faced with your
 body in a different way now you can sort of delude yourself for years and just think
 you're the same you've always been [baby cries] but then you go through
 something [sound of JS patting baby on the back] that changes your physique like
 this and it, and it, and it makes you look whereas before you just didn't look so it's
 probably not even that different from before but because in my head I've just
 snapped from being in my 20s [EGR right] to being middle aged [EGR yes] a
 middle-aged mother //
 EGR and this is a big event to have a baby so it's a big event [P2 huge] and I
 wonder if there's something about also the kind of, erm whether you might think,
 whether you might agree or disagree with this but whether there's something about
 the rapidity of the changes through the childbirth experience whereas perhaps from

(context of childbirth
 & giving attention
 to body changes in life
 wasn't accepted)

/ body image was 2 /
 / notes

context of childbirth
 / interest or frustration
 / st body

kind of considerable change in breath
over 2 yrs as result of childbearing

uncertainty over end result of
change -> unknown possibility
rapid & considerable change in breath
going from able to walk so well as
result of childbearing

lost of focus on self / body -> how
directed away from body & onto
other things

sense of body left separate from her
& doing it on own thing? = embodied
-> almost felt as if self left
behind with every pregnancy so
gradually

relationship (relationship status for
of standards) not of distance
but in a different situation
not protection / allowing of standards
may not have had effect -> some relationship

Sense making of her experience

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the mid 20s to the, to your 40th if you like that it's quite a slow gradual change in, in your physique [P2 mmm] and it's something you might not even really notice [P2 mmm] necessarily and then boom you have the baby and go through this 9 month experience and it's quite a rapid kind of oh, dramatic change and then coming back again if you like and whether that's there's some quality of that?

P2/oh I'm sure there is I mean just in terms of like I was saying I tried on some old bras [EGR mmm] you know where are we now? We're in March [EGR umm humm] I was pregnant in March ok before I got pregnant I wore these bras and then I went through 3 different types of bras whilst being pregnant cause you have to keep changing them and then nursing bras and I'm thinking in a year I've, I've gone just in that area there's been a huge change in a very very short space of time [EGR yeah right] and I don't even know what my natural breasts are any more because they're still just coming back [EGR changing] from breastfeeding I mean I, I don't know where they're going to end up necessarily [EGR ok] and it has all happened very quickly/you know I went from having umm a reasonably nice flat stomach to having this great big protruding thing which I quite liked it was nice and firm erm and it was a nice pregnant stomach erm and then to just blubber which is pretty much what's left and that's ~~what~~ happened in the space of yeah not, you know a year [EGR quite a rapid time really] it is /

EGR if you think about it over time, in terms of time frame that's quite quick P2 and it also and you don't really stop so much because you r mind seems well pregnant what's, what's the baby doing what's the baby development like and, and I'm trying to work and I'm trying to you know do up a fat and blah blah blah and your body just kind of does what it does, you don't need to give it any you know you don't need to make anything happen it happens [EGR ok] so you don't have to think about it so much it just kind of once in a while you look in the mirror you think whoah yeah it is very very quick and maybe that, maybe it takes a while for your brain to catch up with what's happening to you/and maybe it wor, the way it happens is when you're just bumming around at home with a kid it doesn't really matter how you look anyway or you go out for a coffee or you go out and meet other mothers but maybe if I get to the point where I have to put on my glad-rags and go to a party then I'll suddenly think [makes a breath] I can't, you know I look terrible [EGR right] and I, I, I can't look good again [EGR yeah] but I think, because umm, it's interesting that you, I can see why you've chosen to do this in the first year postpartum umm and probably in the first year you, you probably do have that situation but I imagine that there's a big gap between the being at home bit to the going back to work bit where you're back in work clothes and no one know,

experience in the night
to breast

experience of
change in breast

helped her feel
at body

embodiment?
experience as
pregnancy

relationship to relationship
current (the body) / embodied
has always been a relationship

sense making
of embodied
experience

Strategic review when work

- 1 ? reviewed? by body / management /
- 2 considering which allows making
- 3 of standards / details
- 4 context of usefulness / debility
- 5 = others for body changes to be
- 6 acceptable to use P2 at times
- 7 P2 is of usefulness / usefulness
- 8 being really "a different world"
- 9 that is not "real"
- 10
- 11 also practical strategies to manage
- 12 changes / concerns
- 13
- 14
- 15
- 16 bodily changes were of a practical
- 17 (subtle) issue to an emotional
- 18 issue about P2 acknowledge
- 19 that will impact change depending
- 20 on the situation
- 21
- 22 difficult to go shopping - with P2
- 23 or even healthy?
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- 35 P2 acknowledge can't fully
- 36 / aware for the unknown
- 37

you haven't got the excuse no one knows you've just had a baby you are just a person [EGR right] err and going out the way you did before, where you're out where you're not a mother anymore [EGR right] where you're just you again and then coming to terms with the different you [EGR right] because at the moment [EGR yes] the different me is always explained cause I've always got the baby with me [EGR yeah right] so anyone who would look at me and think ooh she's a bit fat aahh! She's just had a baby but when, once that bit is over then you're just out there and people you know you look the way you look so maybe that, that will be a big change as well coming out into the real world

EGR umm yeah right good interesting point so have you done anything practically to deal with these changes say in your breasts or stomach at all?

P2 not at all I, I know my stomach I, I went to some post natal exercise classes and I know there are exercises I can do

EGR umm humm and so how, how have you dealt with the changes emotionally has it been a problem for you has it not been a problem for you?

P2 it hasn't really been a problem for me it might become, it might be one later like I was saying when I'm out in different situations but at the moment [short pause] it hasn't really no I mean sometimes I think it would be nice if I could get into my old clothes because I haven't really got the money to go out and buy a swanky brand new wardrobe so

EGR so you'd have a wider wardrobe [inaudible]

P2 yeah in a practical sense I could look a lot smarter I just haven't had the time, you know it's difficult to go shopping with a baby umm I just haven't been able to replace my wardrobe I think it would worry me a lot less if all my clothes fit me so the problem is now that oh what am I going to wear cause [EGR ok] none of my trousers really fit me [EGR right] umm so it's more a practical thing, emotionally [pause] I, I don't really think about it much so that must mean something that I'm not too hugely bothered about it [EGR ok] I really don't think I am

EGR ok right well erm how prepared were you for the changes in, in your body as a result of the pregnancy and giving birth as well?

P2 umm I was expecting changes I, I knew that things were, were going to be different and they were and so I wasn't surprised [EGR ok] I there's a limit to how much you can prepare for something when you don't know what it's going to be like [EGR no right] but umm eeh I, I was completely expecting more or less what happened

EGR ok and erm what information if any was available to you about what to expect?

practical strategies

practical strategies

emotional or

issue to an emotional

practical strategies

Appendix K

Example of table of themes for Amanda

Theme	Sub-theme	Page and line number
Context of aging	Allowing bodily changes to be more acceptable and appropriate	(2,4-8)
Context of aging and childbearing	Allowing bodily changes to be more acceptable	(2,30-36) (5,10-19) (18,1-23)
Context of breastfeeding	Uncertainty over impact on breasts	(2,16-17) (6,6-15)
Context of childbearing	Changes seen as temporary	(2,26-30) (3,9-10) (3,29-4,3) (10,8-19) (18,15-21)
	Body image not a priority	(3,12-17) (10,8-19) (11,4-13) (11,16-24)
	Allowing bodily changes to be more acceptable	(3,29-4,3) (15,3-10)
	Impact on perception of body	(5,27-34) (6,21-29)
	Allowing for relaxing of ideals/standards	(11,16-24)
Context of pregnancy	Allowing changes to be more acceptable	(8,37-9,20)
	Allowing for relaxing of ideals/standards	(9,25-10,3)
Dissonance	Expectations fit with reality	(3,29-4,3) (7,31-35)
Embodiment	Experience of pregnancy	(6,25-29)
	Objective relationship with body	(8,24-34) (9,31-34) (11,3-13)
Influences	Social comparison	(2,1-4) (9,31-34) (10,31-34) (12,17-31) (16,1-20)
	Comparison to former self	(4,13-20) (4,31-5,4)
	Influence/impact of family	(8,8-10) (14,1-9) (17,16-35)
	Influence/impact of relationship/partner	(13,1-25) (13,31-35)
	Influence/impact of friends	(14,9-17) (14,26-30) (14,35-15,10) (15,28-36) (17,16-35)
	Seasonal influence	(15,16-26)
	Influence/impact of positive comments	(15,28-36)
	Lack of influence from media/celebrity	(16,23-17,2)
	Lack of defined cultural norm	(17,12-13)
	Acceptance that ideal is no longer attainable	(18,24-38)
	Values relating to body image	(19,5-26) (19,32-37) (20,4-12)
Information	Lack of interest in information	(8,1-4)
	Impact of information from others	(8,10-14)
Managing body image concerns	Cognitive strategies/sense making	(1,33-2,8) (2,26-36) (3,12-17) (3,29-4,3) (4,22-28) (4,31-5,34) (6,21-7,9) (8,24-34) (8,37-9,20) (9,25-10,3) (10,8-19) (10,31-11,2) (11,4-13) (14,9-17) (15,13-26) (16,1-20) (18,1-23) (18,24-38)
	Practical strategies	(7,10-13)
Relationship with body	Body image not a priority	(1,33-2,10) (5,24-26) (8,8-14) (8,24-34) (12,22-27) (16,1-20) (17,30-34)
	Lack of focus on weight	(2,11-16) (10,31-11,2)
	Experience of changes to breasts	(2,16-17) (4,13-20) (6,6-15)
	Experience of changes to stomach	(2,18-26) (4,7-13) (6,14-19) (11,4-13)
	Negative body image postpartum	(3,29-32) (12,13-16)
	Positive body image throughout pregnancy	(4,22-28) (8,37-9,20) (9,25-27)
	Ambivalent body image prior to pregnancy	(8,24-34)
Transition to motherhood	Changes in self concept	(4,31-5,34) (15,13-16)
	Current lifestyle/early motherhood allows for relaxing of standards	(6,29-7,9)
	Limitations of new lifestyle	(7,16-28) (10,8-19)
	No need for support around bodily changes	(8,18-19)
	Impact of changes is situational	(6,29-7,9) (7,16-28) (12,2-31)

Appendix L

Example of basic master table of themes

Importance of body image/appearance		
P'ant	Page & Line No	
P2	(1,33-2,1) (11,16-24)	
P3	(9,4-9) (18,27-19,7)	
P4	(1,4-26) (9,1-9)	
P5	(10,33-38) More emphasis on weight	
P6	(1,5-16) (11,32-12,16)	
P7	(7,7-18) (11,35-12,19)	
P8	(21,7-21)	
P9	(1,3-10) (13,5-13)	
Body image linked to self-concept		
P7	(12,25-33)	
P8	(17,9-28) (21,21-35)	
Body image linked to sexuality		
P3	(18,20-26) (25,18-32)	
Values relating to body image/appearance		
P'ant	Page & Line No	
P2	(19,5-26) (19,37-20,120)	
P3	(19,12-22) (28,5-14)	
P4	(15,35-16,19) (16,29-17,4)	
P5	More about weight than body image	
P6	(8,32-9,13)	
P7	More about weight than body image	
P8	See importance. Other values about weight really?	
P9	No values really	
Baby prioritised over body image		
P3	(8,8-9&8,15-18)	
P7	(4,2-12) (7,3-5)	
P9	(7,9-13) (10,17-21)	

Contextual factors feeding into importance of body image and values			
P'ant	Context	Page & Line No	
P2	Motherhood	(3,12-17) (6,29-7,9)	
P2	Pregnancy	(9,25-10,3)	
P2	Situational	(12,2-31)	
P2	Wider world	(18,30-38)	
P3	Aging	(26,34-27,7)	
P3	Early motherhood	(24,12-34)	
P3	New found appreciation for the body's achievement	(7,31-34) (25,10-16)	
P4	Aging	(3,26-4,1) (9,33-10,8)	
P4	Childbearing	(9,18-32)	
P4	Fertility problems	(4,36-5,6)	
P4	New found appreciation for the body's achievement	(3,8-10) (9,13-17)	
P4	Pregnancy	(1,8-18) (1,32-2,4)	
P5	Breastfeeding	(7,29-8,1) (17,10-20)	
P6	Aging	(7,33-37)	
P6	Motherhood	(8,6-12)	
P8	Motherhood	(22,17-28)	
P9	Motherhood	(13,28-14,4)	
Seasonal Influence			
P'ant	Page & Line No		
P2	(15,16-26)		
P3	(8,29-36) (20,10-12)		
P5	(15,13-18) (17,21-28)		
P6	(13,2-10)		

Interpersonal experiences		
Partner/friends/family		
P'ant	Subject	Page & Line No
P2	Partner	(13,1-35)
P3	Partner	(7,10-12&7,38-8,3) (8,5-29)
P4	Partner	(12,21-24) (13,21-25)
P5	Partner	(10,6-18) (19,4-7)
P6	Partner	(9,21-31)
P7	Partner	(9,5-9) (12,36-13,2)
P8	Partner	(4,20-26) (16,18-17,6)
P9	Partner	(14,30-15,18)
P2	Friends	(14,9-17) (14,35-15,10)
P6	Friends	(9,35-10,11)
P9	Friends	(16,16-18) (16,32-17,3)
P2	Family	(14,1-9)
P3	Family	(20,15-26)
P5	Family	(8,36-9,9) (13,14-14,6)
P8	Family	(3,3-15)
Impact of positive and negative comments		
P'ant	Page & Line No	
P2	(15,28-36)	
P3	(6,12-15) (8,36-9,3)	
P4	(9,25-28&13,29-14,2) (11,35-12,5)	
P7	(9,34-10,2)	
P8	(16,5-10) (21,35-22,8)	

Appendix M

Example of master table with quotes

Social comparison		Quote 1
Part	Page & Line No	
P2	(12,17-31) (16,1-20)	<p>EGR ok would you say erm that has an impact on you sense of self at all or self-confidence then? P2 umm not in the day to day but I think you know in that moment if I had to go to a wedding on Saturday I probably be worrying about it and feeling a bit self-conscious and thinking what am I going to wear and I might find myself walking out the door thinking oh I look really horrible [EGR right ok] so it could in specific situations [EGR ok] I could feel a bit under confident and, and feel a bit sort of oh I look a bit shit [EGR ok] umm it, it's, it's, it's not an underlying emotion in my life sort of when I'm normally out and about when I'm with friends and [EGR yeah] umm I don't mind if there's a roll of fat over my jeans when I go out for a coffee with a friend [EGR ok] type thing [EGR yeah] or just out with him but if it's the kind of situation where everybody makes an effort and everybody looks nice and everybody has a look at everybody else then I wouldn't want to be the one who, yeah who, who turned up with a with a muffin top and some ill-fitting get up and [EGR ok] and I'd feel a bit like a heftalump then</p>
P3	(6,15-20) (18,28-32)	<p>I don't know if you, you've probably never had a weight problem I mean you're very very slim [EGR yeah] umm when you've, when you've sort of felt a bit lardy at times it must be so depressing you know cause I've got other, there are women umm sort of you know you'll probably interview half of them who say they've got like 2 stone to lose I mean [EGR right ok] oh god</p>
P4	(14,5-20)	<p>compare myself to friends probably because I always think I'm the biggest [EGR ok] out of everybody erm I sort of look at my friends thighs [laughs]...but then, I've, I'm, I'm a big fan of Tyra Banks, you get so addicted to daytime TV [EGR ok] I'm a big fan, fan of Tyra she has a, this chat show in the afternoons and I think she's great I really do I really like her and she's a big woman now you know, and she's allowed herself to, she, but she always just looks so fantastic [EGR ok] you know, she's got a good set of thighs on her and I kind of look at those and I think well actually, you know, they're not that bad after all [EGR ok] so you know, err yes I do compare, compare myself to people erm and I do, you know, and I think you know, well she's you know, got a fatter tummy or she's got slimmer legs or whatever but then for every woman that's, that's slimmer you know, not in my group of friends but there are other women who are bigger and I just think well, you know, [short pause] [EGR yeah] I'm not, you know, I'm n, I'm, I'm not 8, a size 18 and, and you know, 16 stone [EGR right ok] so let's be realistic about it, you know</p>
P5	(11,4-21) (17,4-8)	<p>P5 on the weight front erm I, I have to say actually in recent times Emily I compare myself to [EGR ok] because she's doing really well. She, I mean in my mind she might not say that she's as good as she was but she hasn't got necessarily the tummy she's back in her old jeans and she's doing you know, a bit more exercise than me so yes in terms of before not really because as I say I was pretty mu, I was one of the slimmest people I know [EGR ok] I wasn't one of those people who are really slender you know, umm one our friends she's a Pilates teacher and clearly I'm never gonna be as slim as she is [EGR ok] but then you know, skin quality's another thing [EGR right] I mean people who smoke [EGR yeah] that is so damaging umm thin skin everything I, I mean I don't smoke or anything and that's important to me you know, not to have, you see people who are really slim and they, but they've got floppy skin you know, it's loose on their, and that, that's not good I wouldn't want that umm I think post, now I've been pregnant and my body's changed yes I would say I compare myself to Emily and a couple of the other girls in our NCT group [EGR yeah] who</p> <p>are, who, Emily's older than me but the ones who seem to be the slimmest at the moment are, are younger [EGR right ok] [laughs] which might have a bearing I mean I don't, I'm 34 and I, L, L, people say that I don't necessarily look that but it must have a bearing I think [EGR ok] umm but yeah definitely now I do</p>

P6	(10:29-11:6)	<p>P6 [pause] I suppose I compare myself to people that, who are sort of in my most exact age gr. age group [EGR right] sort of social environment and umm I suppose I compare myself to other mothers with very small children umm [pause] and I suppose I compare myself to some of my friends who haven't had a baby yet or maybe not gonna have one or, a little bit [short pause] Hmm EGR how does that make you feel? P6 well its sort of varied because I mean I feel lucky because I'm quite healthy and some of my friends have had you know problems and diseases and dis, you know had, had, had shit [EGR yeah] so I feel fortunate really umm [pause] I feel fortunate cause you know, I've got a lovely healthy baby and a, and a, I'm ha, I'm very happy in my relationship and you know I'm financially sort of hanging in there, where, you know kind of, I dunno I think at this time of my life I feel quite stable I guess and I, I suppose I compare mys, I also compare myself to an earlier version of myself and feel, that makes me feel kind of better really cause in feel I'm, I'm in a sort of better place really than sort of a few years ago [EGR right] because I mean I might have been slimmer or looked better but there were so many other things that were kind of wrong really</p>
P7	(5:29-34) (10:9-18)	<p>I mean to me, to me, I know that some, I mean I've got a friend who had a baby about the same time and she just shrunk stra, straight back to her figure erm you know, her prepregnancy figure but I've never been that kind of I think, you know, different women have different shapes and different metabolisms and I've never ever been that kind of person I've never been that sort of, someone who loses weight very easily [EGR right] so, and I'm quite used to that now</p>
P8	(4:14-17) (17:29-18:24)	<p>yeah I, I mean I do feel again you know, kind of lucky and quietly slightly smug and I sympathise with friends who are really struggling to lose the weight and worrying</p>
P9	(9:9-18) (17:5-11)	<p>everyone experiences their pregnancy so differently and, and how their body changes I guess differently and kind of, and how their body is at the end [EGR ok] kind of afterwards I mean I was, my best friend's daughter is just one and a bit and she pinged right back and I was like oh god that's never gonna happen to me [EGR ok] this is it and then it did and I was really surprised [EGR it did] but there's just no rhyme or reason to it erm and there wasn't anything in particular that either of us did it was just that I suppose we were both relatively slim to start with but it just, we were just lucky that the weight we put on was all baby and wasn't despite the huge amount of cake erm [EGR laughs] that we continue to eat</p>

Appendix N

Poetic condensations

Reflexive introduction

While I was analysing the data and writing up the research I found that I became very familiar with all of my participants and their transcripts. I suppose it is only natural that I should have this experience given the amount of time spent engaging with each individual transcript and therefore each participant and their experiences. In addition to this, I found that through engaging closely with the text and developing my interpretations I cultivated a feeling of being even more intimate with the women. As I employed a more critical or interrogative hermeneutics, as well as those of empathy, and delved deeper into the subtext of their conversation, they felt even more real and present to me.

On writing up I felt quite bereft in a way, as there was so much of the original material that I could not include. I also had the feeling that in deconstructing and then reconstructing the data to form a coherent narrative for the report, something of the participants' individual stories was lost. I did my best to preserve some sense of a narrative for each woman that ran through the analysis but there was no way that I could communicate the full understanding that I felt I had for these women and their experiences in the limits of the thesis report.

At this time I was also attending a monthly phenomenological research seminar at City organised by Carla Willig. One week she gave us a paper to read by Joakim Ohlen in which he discusses the evocation of embedded meanings in a narrative through "poetic condensation" (2003, p.558). I was very taken with this idea as a way of expressing something about each participant that maybe I could not include in the original report. What follows, therefore, is an example of a poetic condensation for each participant that I hope evokes another aspect to their experience brought to life through the condensation of their narrative. I have preceded each poem with the original text for comparison and I hope that the reader feels, as I do, that the process of condensing the narrative into a poem allows a different reading to shine through.

Reference

Ohlen, J. (2003). Evocation of meaning through poetic condensation of narratives in empirical phenomenological inquiry into human suffering. *Qualitative Health Research*, 13, 557-566

Amanda

EGR ok so erm so you know I mean we've kind of covered this before but how do you feel then about your body since having your baby in comparison perhaps to these 2 other periods we've spoke, spoken about before during and after if you like [sniffs]

P2 umm well bizarrely enough I probably liked it the most when I was pregnant [EGR right yeah] umm [EGR can hear that yeah] yeah maybe because I, it, it, it sort of, I had a, I had an excuse, I had an excuse for looking the way I looked [EGR right] you know when you haven't had a baby [EGR yes] it's as though you know why are you not super fit and why have you got a bit of flab here and why have you d, you know and, and, and you haven't really got a good excuse cause I'm lazy and cause I don't go to the gym umm and you could say now you know he's 6 months old and many of the women in my group they go to the gym and you know I can see they're quite slim and they make an effort to get their body back I haven't really bothered with that I haven't really got an excuse for that but when I was pregnant it was like I have, I have to, you know I'm supposed to look like this it's healthy that I look like this it's right that I look like this [EGR yeah] I shouldn't be dieting or going to the gym or anything and so and so it's, it's almost like I had, I had permission [EGR yeah] to look the way I looked [EGR yeah] whereas any other time you know you can all, you can always think oh yeah I suppose I could go to the gym I suppose I'm a bit flabby I suppose I could try harder [EGR ok] umm so biz, so yeah so that was the reason why I quite liked [EGR right] the pregnant bit

How do I feel about my body
In comparison to before, during and after?

Well bizarrely enough
I probably liked it the most when I was pregnant

Maybe because I had an excuse
I had an excuse for looking the way I looked

When you haven't had a baby
It's as though, you know, why are you not super fit?

And why have you got a bit of flab here
And you haven't really got a good excuse

Cause I'm lazy and cause I don't go to the gym

Now he's six months old
And many of the women in my group

They go to the gym
And, you know, I can see they're quite slim

And they make an effort to get their body back

I haven't really bothered with that
I haven't really got an excuse for that

But when I was pregnant it was like
I have to, you know, I'm supposed to look like this

It's healthy that I look like this
It's right that I look like this

I shouldn't be dieting
Or going to the gym or anything

And so it's almost like I had permission
To look the way I looked

Whereas any other time

You can always think
Oh yeah I suppose I could go to the gym

I suppose I'm a bit flabby
I suppose I could try harder

So yeah so that was the reason why
I quite liked the pregnant bit

Emily

P3 umm leaking breasts [EGR right] in the middle of sexual intercourse [EGR ok] is not something that you're [EGR laughs] necessarily prepared for and err I might have been prepared for it but I'm not sure my husband was [EGR right] or is and you know [EGR laughs] all those things you know you've got to have a very very umm [baby gurgles] you've got to have a fantastic relationship [EGR ok] because how you deal with those, those situations you know do you laugh about it? Do you address it beforehand and say right this is gonna happen this may not happen this will happen you know and the baby may cry in the middle of it as well [EGR yeah right absolutely] umm but yeah the boob thing is for me probably the biggest biggest issue

EGR it, it almost sounds a bit like they've developed a life of their own [P3 well they have] in a way

P3 kind of taken over your life [EGR laughs] because they, they're doing this magnificent thing but you know [EGR yeah] [short pause] you know you sort of get given your list of things to take to the hospital and you see breast pads and you think ok well I'll need to put a breast pad in my bra [inaudible] ok well you don't really know until you start breast feeding what, what it's about really and leaking boobs was something I was not prepared for at all [EGR ok right] and maybe this is part of the whole body image thing I don't know but you know I am going to be away in the, over the summer [EGR right] and I'm, I shall probably still be breast feeding [EGR right] well it all gets much easier the breast feeding thing because your boobs calm down they sort of, I guess it, they get used to breast feeding I, I don't know [EGR ok] but you don't sort of fill up as much [EGR right] so you don't have this, these sort huge rock hard Pamela Anderson [EGR laughs] engorged things [EGR yeah] that you have in the early days [EGR ok] and they don't leak as much but you know I, my boobs still leak [EGR right] so I'm thinking how am I gonna manage on the beach? How am I gonna, you know I've sort of been asking people you know like what did you do? [EGR right] did you, did you wear breast pads in your bikini [EGR yeah] and you know what if you don't

Leaking breasts
In the middle of sexual intercourse
Is not something that you're necessarily prepared for
I might have been prepared for it
But I'm not sure my husband was

Or is

All those things, you know
You've got to have a fantastic relationship
Because how you deal with those situations?
Do you laugh about it?
Do you address it beforehand
And say right this is gonna happen
This may not happen
This will happen

And the baby may cry in the middle of it as well

But yeah the boob thing is for me probably the biggest, biggest issue
They have kind of taken over your life
Because they're doing this magnificent thing
But you sort of get given your list
Of things to take to the hospital

And you see breast pads

And you think
Ok well I'll need to put a breast pad in my bra
Well you don't really know
Until you start breastfeeding
What it's about really

And leaking boobs was something I was not prepared for at all

Maybe this is part of the whole body image thing
I don't know
But I am going to be away over the summer
I shall probably still be breastfeeding
It all gets much easier the breastfeeding thing
Because your boobs calm down

They get used to breastfeeding

You don't sort of fill up as much
So you don't have these sort of huge
Rock hard Pamela Anderson engorged things
That you have in the early days
And they don't leak as much

But you know my boobs still leak

So I'm thinking how am I gonna manage on the beach?
I've sort of been asking people
Like what did you do?
Did you wear breast pads in your bikini?

And, you know, what if you don't?

Helena

P4 but most, most of the time I'm ok you know, I just, I suppose in a sense it's more about what I think is going to happen than what has already happened, it's like aah this is the start of the aging process [EGR ok right] erm and you know, in common with most people I'm not very happy about getting old [EGR right yeah fair enough] erm and for the first time in my life, I don't think I would have my boobs done, but for the first time in my life I'm thinking you know, maybe I would have some plastic surgery [EGR ok] I don't know whether I'd ever go as far as a face lift but I might just be tempted to have me und, under here done and my eyes done [EGR yeah] you know [EGR right] it's very strange isn't it? And I think in a way maybe it's them, maybe because they, you know, they're so new to the world and they're just starting on their, their life's journey its reminded me that I'm you know, half way through mine [EGR ok] maybe that's and, umm, and now that I've got them you know, I'm very aware of the fact that the ne, next half you know, god willing I've got half left, but this next section of my life is gonna go fa, far faster [EGR right] than the last section of my life. [To baby] I know you're hungry. Do you mind if I just make their bottles?

Most of the time I'm ok, you know
I suppose in a sense it's more about what I think is going to happen
Than what has already happened,
It's like ah this is the start of the aging process
And in common with most people

I'm not very happy about getting old

And for the first time in my life
I don't think I would have my boobs done
But for the first time in my life

I'm thinking maybe I would have some plastic surgery

I don't know whether I'd ever go as far as a face lift
But I might just be tempted to have me under here done
And my eyes done
You know

It's very strange isn't it?

And I think in a way maybe it's them
Maybe because they're so new to the world
And they're just starting on their life's journey

It's reminded me that I'm half way through mine

And now that I've got them
I'm very aware of the fact that the next half
God willing I've got half left
But this next section of my life is gonna go far faster
Than the last section of my life

Sarah

P5 yeah and I think, it's partly because I think when you're breastfeeding you are hungrier and you don't rea, and you don't wanna be eating this much because you want to lose the weight but then you, you, you kind of, yeah so I eat you know more quantity-wise [EGR right] umm and you don't wanna be doing it [EGR yeah] because you, you want to start dieting and everyone says no no you can't start dieting so then well I'm just gonna have to do it through exercise [EGR ok yeah] umm yeah I will have to do it through exercise I think until I stop feeding her I think once I stop feeding her and then I, and if you come back to see me in 4 months time [EGR right] I'll bet you I would be much more negative

EGR it's an interesting thought I think that yeah and also I wonder if the kind of seasonal effect as well that if this was the summer [P5 yeah] whether that would have a diff, an, erm you know if we were already in June say and it was stinking hot outside and you didn't wanna be going out in lots of clothes and everyone's you know wandering around in skimpy tops [P5 skimpy tops] how that might be?

P5 yeah it would definitely be different cause I only wear skimpy stuff like you know in the house like, like yeah I wouldn't really wanna go out no I wouldn't I definitely would feel differently [EGR ok] I think that umm there are probably some people out there who are so into their body image that they wouldn't breastfeed for that reason [EGR ok yeah] I mean breastfeeding now is so encouraged that it's, it's almost a negative thing if you do not do it and that pressure on women umm is quite, it is, it is, yeah definitely it's, the, that pressure is there frankly I just think it's easier [EGR ok] umm but I'll bet you'll, you would find people who wouldn't do it because the wanna get rid of all that weight [EGR yeah] and all these stars I bet you they didn't do it

I think when you're breastfeeding
You are hungrier
And you don't want to be eating this much
Because you want to lose the weight
But then you, you, you kind of, yeah

So I eat, you know, more quantity-wise
And you don't want to be doing it
Because you want to start dieting
And everyone says no, no, you can't start dieting
So then well I'm just gonna have to do it through exercise
Yeah I will have to do it through exercise I think

Until I stop feeding her

I think once I stop feeding her
And if you come back to see me in four months time
I'll bet you I would be much more negative
I definitely would feel differently

I think that there are probably some people out there
Who are so into their body image
That they wouldn't breastfeed for that reason

I mean breastfeeding now is so encouraged
That it's almost a negative thing if you do not do it
And that pressure on women is quite
That pressure is there

Frankly I just think it's easier
But I'll bet you would find people who wouldn't do it
Because they want to get rid of all that weight

And all these stars
I bet you they didn't do it

Olivia

I don't know [short pause] its funny cause I go to France quite a lot my partner's French and, and their acceptable standards of slimness or normal, their normality is our sli, slim kind of thing [EGR right yeah] so it's funny there definitely things happen to my thinking when I'm there [EGR ok] but in a way it makes me feel more kind of, what's the word, sort of not defiant but I just think they've, I think there's something a bit wrong with that [EGR right yeah] that they, unless you're sort of bone thin [EGR right] you're fat in France and I think, I sort of, it, I don't know I kind of, I don't really wanna go there I don't wanna accept that as normality really [EGR ok] it just I think it's [short pause] I think it's a bit sad really I don't know a little bit sad and, and when people, I dunno I mean this is all sorts of kind of judgements and prejudices on my behalf but I think ah these women and their, their whole life is centred on what they look like when they're sitting in a café having a coffee and [EGR ok] ok well done you look really great and err have you got anything interesting to talk about? [EGR right] No maybe not maybe you do maybe you don't but we wouldn't know because you're so, you know I've got a very kind of anti-vain [EGR ok] do you know what I mean?

It's funny cause I go to France quite a lot
My partner's French

And their acceptable standards of slimness or normal
Their normality is our slim kind of thing

So it's funny there
Definitely things happen to my thinking when I'm there

But in a way it makes me feel more kind of, what's the word
Sort of not defiant but I just think there's something a bit wrong with that

That unless you're sort of bone thin, you're fat in France

And I think, I sort of, it, I don't know, I kind of
I don't really want to go there

I don't want to accept that as normality really
I think it's a bit sad really

I don't know, a little bit sad

And when people, I dunno
I mean this is all sorts of kind of judgements and prejudices on my behalf
But I think ah these women

And their whole life is centred on what they look like
When they're sitting in a café having a coffee

And ok, well done, you look really great

And err have you got anything interesting to talk about?

No maybe not

Maybe you do
Maybe you don't

But we wouldn't know
Because you're so, you know

I've got a very kind of anti-vain
Do you know what I mean?

Claudia

EGR ok ok so erm how important would you say that your body image is to you?
P7 umm yeah I think it's, I think it is really important yeah definitely mmm
EGR so do you think that's changed at all since before the pregnancy during the pregnancy you know through, if we're thinking about before during and after
P7 yeah no I think it definitely has changed and I mean I think it's still very important to me but erm I think I used to erm, I used to spend a lot of time thinking about it [EGR right] umm which I don't anymore umm [short pause] I mean things like, you know, clothes and just your, just the way you look it was just so much more important to me [EGR right] before but again I think this is a t, I think this is a sort of, its, its, you know, it's somethi, a baby comes into your life and, and suddenly your priorities completely change and you can't be self obsessed anymore you can't be selfish anymore and so your energies are on there and then actually, I, I sort of sometimes catch us, catch a, a, a glimpse of myself in the mirror and I sort of see myself as, as older than I was before [EGR right] erm and I look at Amy and she's this beautiful little baby and I sort of have this image of me putting all of my energy into her into making her beautiful [EGR right] which does take away energy and, and beauty from yourself so I think it is, I think it's a, I think it's a balance I think you have to strike a balance erm I don't wanna be the sort of woman who, I mean there are cert, some women who you know, breastfeed for years and years and years and, and their hair starts to fall out and they start to get ill and you know, they look dreadful because th, their energy's basically been seeped, you know, sucked out by their child [EGR right] and I think that at th, but at the same, I, you know, I don't wanna become a woman like that

How important is body image?
I think it definitely has changed
I think it's still very important to me
I used to spend a lot of time thinking about it

Which I don't anymore

A baby comes into your life
And suddenly your priorities completely change
You can't be self-obsessed anymore
You can't be selfish anymore

Your energies are on there and then

I sometimes catch a glimpse of myself in the mirror
I see myself as older than I was before
I look at Amy and she's this beautiful little baby

I have this image of me
Putting all of my energy into her
Into making her beautiful

Which does take away energy and beauty from yourself

I think you have to strike a balance
Some women who breastfeed for years and years and years
Their hair starts to fall out and they start to get ill
They look dreadful
Because their energy's been seeped, you know, sucked out by their child

I don't want to become a woman like that

Eva

P8 [short pause] I felt weird, I've been into work a couple of times and I feel weird about that [EGR ok] I feel like I'm a totally different person I go in there and you know, it's a relatively big office and I was running a team of 15 or 20 people there [EGR right] umm and I went in when Thomas was [phone rings] about 6 weeks old umm and I just really felt totally not part of the office [EGR right] and I sort of felt I was exuding an aura of motherishness [EGR laughs ok] that was not part of my persona there for [inaudible] [EGR yes] [answer-phone starts] [both laugh] I'll just see who this is [man's voice speaking in German on answer-phone] hang on [to partner upstairs] I think its John on the phone [pause] hang on [to partner: do you want to talk to John? Answers phone....] sorry

EGR I was quite relieved he was talking in a foreign language so that

P8 oh its gone off now [EGR ok] umm yes [inaudible]

EGR [laughs] so you felt different when you, when you got back?

P8 yeah I, well a) I felt uninvolved in the work and b) I felt I totally didn't care about any of it but I felt like this kind of soft kind of motherish person and totally unsuited and unfitting in this kind of slightly harsher [EGR yeah] work environment and [EGR yeah right] you know and I had to find a place to breastfeed my baby in my office [EGR right] I thought oh gosh you know, collea, yeah colleagues, male colleagues, I would feel very uncomfortable breastfeeding in front of male colleagues because I think [short pause] breastfeeding really it's a real, it's a real stamp of motherhood isn't it and of, you know, you can't do anything else while you're doing it and it's like a bond between you and your baby and I dunno I love breastfeeding I think its great but totally yeah it just totally doesn't gel with anything of my experience of work and my relationship with my colleagues and [EGR yeah] you know I, err you're also quite vulnerable aren't you when you've got your breasts exposed and that's something [EGR well its quite an intimate moment really isn't it] yeah its an intimate moment and a moment of gentleness and, and over[exhales], its kind of giving yourself and exposing yourself which is something I don't want to do in front of people who in, in my previous life I was their boss and I needed if, if necessary you know, you need to be able to be strict with people and to, and to be firm and [inaudible]

EGR right so a very different role again isn't it

P8 yeah cause what I found when I became a manager was that your relationship with your former colleagues has to change, that you have to stop being their friend and build a wall between you and them so that if need be you can discipline them [EGR yeah] or instruct them or lead them or whatever it is [EGR yeah] and if you're sitting there with your breasts out you can't do that [both laugh]

I've been into work a couple of times and I feel weird about that
I feel like I'm a totally different person

I go in there and it's a relatively big office
I was running a team of 15 or 20 people there

I went in when Thomas was about six weeks old

I just really felt totally not part of the office
I sort of felt I was exuding an aura of motherishness
That was not part of my persona there

I felt uninvolved in the work
I felt I totally didn't care about any of it
I felt like this kind of soft kind of motherish person

Totally unsuited and unfitting in this kind of slightly harsher work environment

And I had to find a place to breastfeed my baby in my office
I thought oh gosh colleagues, male colleagues
I would feel very uncomfortable breastfeeding in front of male colleagues
Because I think breastfeeding, it's a real stamp of motherhood isn't it?

You can't do anything else while you're doing it
It's like a bond between you and your baby
I dunno, I love breastfeeding I think it's great
But it just totally doesn't gel with anything of my experience of work

And my relationship with my colleagues

You're also quite vulnerable aren't you when you've got your breasts exposed
It's an intimate moment and a moment of gentleness
It's kind of giving yourself and exposing yourself
Which is something I don't want to do in front of people
Who in my previous life I was their boss

You need to be able to be strict with people and to be firm
Cause what I found when I became a manager
Was that your relationship with your former colleagues has to change
That you have to stop being their friend
And build a wall between you and them
So that if need be you can discipline them
Or instruct them or lead them or whatever it is

And if you're sitting there with your breasts out, you can't do that

Anna

everything else has gone back, completely gone back to normal apart from my ridiculous boobs [both laugh] [EGR ok] which have just become the centre of my world which is unfortunate really cause I've never been that fond of them I mean the standing joke when I was pregnant was that I've carried them around for 35 years and if I can't breastfeed I'll be bugged [laughs] cause I've got to have had them for a reason [EGR yeah right] they have been the bane of my life erm [EGR ok] but erm [short pause] but we had various problems kind of when we hit uh I suppose about 8 or 9 weeks we had various kind of umm breastfeeding problems and so my boobs really hurt and, and if they weren't, you know, they were bigger than ever anyway and then they hurt and they just became, it was like you might as well have put them here, like in front of my nose [EGR right] cause they just became the centre of everything and feeding him

was difficult and [EGR ok] and it just yeah everything seemed to revolve around these really hurty boobs erm

EGR how was it for you to have the hurty boobs? [P9 erm] sort of, having problems as well with the breastfeeding?

P9 I was just in enormous amounts of pain but I was absolutely determined to carry on [EGR right] erm and, and we kind of, we muddled through for about 6 weeks and, until he started losing weight cause he, cause I was in pain and he wasn't getting what he needed [EGR right] and it was just horrible and he's always been a really happy little boy so he wasn't complaining he was just [EGR ok] not, not eating very much [EGR right ok] umm and then we sought help from a fantastic breastfeeding co, counsellor who just got us back on track and since then its been fabulous he's piling on the weight I'm pain free [EGR ok] and really enjoying it again so I have a much more positive relationship with me than I did kind of before and the whole breastfeeding thing is working like clockwork [EGR yeah] and its like ok this is how it was supposed to be

EGR so it sounds like it was quite frustrating for you initially [P9 yeah] with it not working out very well

P9 yeah erm and just yeah and, and it makes you wonder whether actually you can do it and [EGR right] you know it's like and because it's, it's such, breastfeeding's such a mind trick anyway [EGR right] because you can't see it, nothing, you know, you can't measure it [EGR right] you don't know, you have to believe that your baby is getting [EGR the milk] enough to eat [EGR right] and there's no way of knowing apart from, you know, ok, if they're putting on weight but then babies do at different rates and if they're going on putting on weight which he always did like a trooper [EGR laughs] don't you, and you still do don't you my love? Erm so [EGR ok] but umm but you just don't know and as soon as something, and its such a, you have to just have the confidence that it will work and that it does [EGR ok] umm but if it, if your confidence gets shaky and to be honest friends of mine have been together having children, have had children at the same time [EGR right] but if your confidence shakes then you just believe you can't do it and its much more difficult the whole thing is much more difficult and you're much more tense about it and [EGR right] the milk projection is more difficult erm so once we'd sorted that out [EGR ok] we've ju, we haven't looked back

Everything else has completely gone back to normal
Apart from my ridiculous boobs
Which have just become the centre of my world
Which is unfortunate really

Cause I've never been that fond of them

I mean the standing joke when I was pregnant
Was that I've carried them around for 35 years
And if I can't breastfeed I'll be bugged
Cause I've got to have had them for a reason
They have been the bane of my life

But we had various problems

I suppose about eight or nine weeks
We had various kind of breastfeeding problems
So my boobs really hurt
They were bigger than ever anyway
And then they hurt
It was like you might as well have put them here
Like in front of my nose

Cause they just became the centre of everything

Feeding him was difficult
Everything seemed to revolve around these really hurty boobs
I was just in enormous amounts of pain
But I was absolutely determined to carry on
We muddled through for about six weeks
Until he started losing weight
Cause I was in pain
And he wasn't getting what he needed

It was just horrible

He's always been a really happy little boy
So he wasn't complaining
He was just not eating very much
And then we sought help from
A fantastic breastfeeding counsellor
Who just got us back on track

And since then it's been fabulous

He's piling on the weight
I'm pain free
And really enjoying it again
So I have a much more positive relationship with me
Than I did kind of before
And the whole breastfeeding thing
Is working like clockwork

It's like ok, this is how it was supposed to be

It makes you wonder whether actually you can do it
Breastfeeding's such a mind trick anyway
Because you can't see it
You can't measure it
You don't know
You have to believe that your baby is getting enough to eat

And there's no way of knowing apart from if they're putting on weight

But then babies do at different rates
And if they're going on putting on weight
Which he always did like a trooper
But you just don't know
You have to just have the confidence
That it will work
And that it does
But if your confidence gets shaky

Then you just believe you can't do it

And it's much more difficult
The whole thing is much more difficult
You're much more tense about it
The milk projection is more difficult
So once we'd sorted that out
We haven't looked back

Part 2

Professional practice:

Advanced case study

The Use of Cognitive Behavioural Therapy in the Treatment of Binge Eating Disorder: A Case Study

Elena Gil-Rodriguez, City University.

Part A – Introduction and the start of therapy

Introduction and rationale for the choice of case

I have chosen to present this particular case as I feel that it is a good example of how a case formulation may be used to enable a shared understanding of the client's difficulties and maintaining processes in addition to guiding the application of theory to clinical practice. I found the process of formulating particularly useful in this instance to assist in treatment planning and guide the selection of appropriate interventions. Furthermore I feel that this case reflects my own process in terms of my development as a trainee and working with a supervisor of a different orientation.

Summary of theoretical orientation

The theoretical orientation employed for this case is the cognitive behavioural approach which proposes that emotional disturbance arises largely from an individual's interpretation and evaluation of events, rather than the events themselves. It considers that an individual's thoughts influence their emotions and behaviour, with distorted negative thinking creating and maintaining emotional disturbances and maladaptive behaviours (Beck, 1995; Curwen, Palmer & Ruddell, 2005). The model distinguishes between thoughts and the underlying beliefs from which they arise. These beliefs can be inferred from a person's thoughts and are often derived from early experience (Woolfe, Dryden & Strawbridge, 2003).

Binge eating disorder (BED) is characterised by episodes of binge eating as with Bulimia nervosa (BN), however, individuals with BED do not engage in compensatory behaviours such as self-induced vomiting, the misuse of laxatives or fasting (Dingemans, Bruna & van Furth, 2002). Individuals with BED tend to evaluate their self-worth almost exclusively in terms of their ability to control their eating, weight and shape and this is believed to be fundamentally important in maintaining the disorder. Binge eating is thought to be a consequence of attempts at strict dietary restraint where the response to even minor lapses is bingeing behaviour (Fairburn, Cooper & Shafran, 2003).

It has been suggested that one or more of four additional maintaining processes may also be present in some instances. These are thought to interact with the core mechanisms of maintenance for BED and may impede improvement. These processes are core low self-esteem, severe perfectionism, mood intolerance and interpersonal difficulties. Resolution of these issues is thought to facilitate change (Fairburn, Cooper, & Shafran 2003).

BED appears to be prevalent in obese individuals seeking weight loss treatment; however, obesity is not a criterion for BED. Treatment for obesity tends to focus on weight reduction, neglecting underlying behavioural or psychological disturbances. In obese individuals with BED, binge eating is likely to continue or even worsen if it is not addressed directly. Cognitive behavioural therapy (CBT) is the most widely investigated treatment for both BN and BED and is the treatment of choice for both disorders (Dingemans, Bruna & van Furth, 2002). For these reasons CBT was the therapeutic method of choice for this client.

The referral and context for the work

Lucinda¹⁰ was referred by her GP to the Voluntary Sector Counselling Service where I have my placement. The referral stated that Lucinda was a 33 year old Italian woman who was morbidly obese with a Body Mass Index (BMI) of over forty who needed “help with bingeing”.

Initial impressions – appearance and behaviour

Lucinda was a well presented woman who maintained excellent eye contact with an open body posture and was very articulate. Her spoken English was of a reasonable standard and she was tearful at times when recounting painful material.

Biographical information and family history

Lucinda was a chef who had moved to London from Italy four years previously. She was single and had no children. Lucinda was born and raised in Italy. Her parents were still together and she had a sister who was two years older. She recounted a difficult childhood with her parents separating on and off throughout. She described her father as

¹⁰ All names have been changed to maintain confidentiality.

having numerous affairs and being violent towards her mother with constant arguing, both of which she often witnessed.

Around ten years ago, Lucinda's parents decided to split up once and for all, however, her mother had a health scare and this prompted them to change their minds. Lucinda reported that this seemed to change their relationship for the better and from then on things improved enormously. She described her relationship with her father now as being vastly improved with him being "a changed man".

Lucinda's problems with her weight started at an early age and she remembered starting to gain weight at around six or seven years old, being referred to a dietician and put on a strict diet. This marked the beginning of her bingeing behaviour which persisted from then on.

The presenting problem

Lucinda told me that despite losing nearly two stone in the previous summer when on an NHS diet and exercise programme ("Fit for Life") prescribed by her doctor, she had regained the weight and more since finishing the programme. She felt that her problems with food and overeating were deep rooted and wanted to gain a better understanding of her relationship with food, stop bingeing and lose weight. Lucinda had never had any counselling before.

The contract and therapeutic aims

Issues of confidentiality were addressed with Lucinda, along with supervision, notes and consent to tape. On discussion of the therapeutic aims, Lucinda's main concern was to overcome her bingeing and we agreed that we would work towards that goal. Our contract was for twenty four sessions as decided in Lucinda's assessment with a senior counsellor at the service before being accepted for therapy. This was considered an adequate contract length for her problems given the constraints of the service and waiting lists. We were to meet weekly for sessions of 50 minutes.

Formulation of the problem

An initial formulation was developed in order to assist my understanding of Lucinda's problems in cognitive terms and to guide the therapy. This was continually refined and updated as therapy progressed and more information about the client came to light

(Curwen, Palmer & Ruddell, 2005; Persons, 1989). It was constructed over the first three sessions and was done so in a collaborative manner with Lucinda.

Lucinda wanted to have an in-depth look at the origins of her BED in order to gain insight into her “relationship with food”. This was an important goal for her and I reasoned that collaboratively constructing a detailed formulation of the development and maintenance of her problem might facilitate a greater understanding of this. In addition it would help provide a framework for the therapy, engage Lucinda with the model, provide the opportunity for psychoeducation to the cognitive behavioural approach to BED and allow her the opportunity to tell her story thus helping to develop our rapport and therapeutic alliance.

A diagrammatic summary of our formulation of the development and maintenance of Lucinda’s problem, including her core beliefs, can be seen in Figure 1 found in Appendix A.

A significant predisposing factor for Lucinda’s current difficulties was her traumatic childhood resulting from a turbulent home environment. In addition to her parents’ marital difficulties, her mother worked full-time running her own business and Lucinda reported that as a rule she was usually late collecting her from school or other engagements. This meant that Lucinda was often left waiting for her mother for anything up to an hour which left her feeling unimportant and abandoned.

Lucinda described her sister as “the good child” while she was “the black sheep of the family”. On exploration it became apparent that these were family labels arising from the comparison of Lucinda to her sister. She reported her sister as being studious and successful at school, well behaved, serious and mature with herself not doing so well at school, frequently “getting into trouble” and having problems with her weight from an early age. She described feeling responsible for her parents’ arguments which she attributed at the time to her poor performance and “trouble-making behaviour” at school and home and her weight problems.

As a result of this Lucinda appeared to have developed core beliefs about herself and others which included: “I’m unimportant”; “I’m not good enough” and “Others are unreliable and not to be trusted”. We also identified several rules and assumptions such

as: “I must be perfect”; “if I am not successful at everything I try then I am a failure” and “If I fail then I am not good enough”.

The critical incident that seems to have precipitated Lucinda’s problems with overeating was when she “realised what was happening in my family” at the age of six or seven when her father left for the first time. At this point she started overeating, gained weight, was referred to a dietician and put on a strict dietary regime that persisted for the rest of her childhood.

Lucinda’s behavioural response to this imposed dietary restriction was to find inventive ways to gain access to the foods that she liked. She would spend all her pocket money on food, swap her healthy food for more fattening options with other children at school, steal food and even persuade local shopkeepers into giving her food “on tick” which her mother would have to pay for later. Lucinda reported “eating to cope” and told me that “food was her only friend” throughout this time. She described secret bingeing, often when no-one else was at home, that persisted from childhood until the present day.

Lucinda was bullied and felt socially excluded at school as a result of her obesity when she was a teenager. She described feeling “empty inside”, ashamed of her body and guilty that she “had let her mother down” by secretly eating when her mother had tried so hard to help her regulate her diet. At around fourteen or fifteen Lucinda reported vomiting after her binges. This persisted for one year and then she continued to binge without purging. Her bingeing behaviour, in response to dietary restriction had therefore been present for most of her life.

In terms of Lucinda’s current problems, she reported that her life was focused on her dietary control and her weight. I felt that this demonstrated a dysfunctional system for evaluating self-worth as she judged herself in terms of her ability to control these aspects. Lucinda also reported trying to abide by specific and restrictive dietary rules, as she had for most of her life. She would then respond negatively to the inevitable breaking of these rules, with even minor transgressions being viewed as stark evidence of her lack of self-control. Her response to this trigger would invariably be to temporarily abandon her dietary restraint therefore resulting in a binge.

Lucinda described a distinctive pattern of “good” (dietary restraint) eating behaviour interspersed with bouts of “bad” (binge) eating behaviour. The bingeing would amplify her concerns about her ability to control her eating and weight and this in turn led to increased dietary restraint, which in turn increased the risk of bingeing, and so on. A further maintaining process for Lucinda was her tendency to be highly self-critical. She would reproach herself fiercely when she failed to meet her demanding standards relating to the control of her eating and weight. This would result in negative self-evaluation which would lead to her redoubling her efforts to control her eating. Thus a vicious circle maintained the cycle of restraint and bingeing (Fairburn, Cooper & Shafran, 2003; Pike, Devlin & Loeb, 2004).

As we investigated this pattern it became apparent that Lucinda’s binges were not happening at random but were firmly connected with stress, particularly in the working environment. Fairburn, Cooper and Shafran (2003) note that binges are likely to occur in response to acute changes in mood, typically adverse mood states, which hinder dietary restraint. As binge eating can temporarily counter these mood states it is reinforced as a useful behaviour in these circumstances.

Part B – The Development of the Therapy

The pattern of therapy

Lucinda was committed, engaged and enthusiastic from the outset with excellent timekeeping and attendance. We quickly developed a good rapport and I felt that we maintained a strong therapeutic alliance throughout the period we worked together. She worked hard, spending a considerable amount of time reflecting on both the sessions and her process and doing her homework between sessions. She was articulate with excellent eye contact and played an active role in the planning of her therapy and homework assignments.

The therapeutic plan and main techniques used

As the focus of the report is on the processes that were maintaining Lucinda’s problem, the therapeutic plan and main techniques used may be found in Appendix B.

Key content issues, the therapeutic process and difficulties in the work

The cognitive behavioural theory of eating disorders suggests that treatment for BED should not concentrate exclusively on binge eating but should also focus on maintaining

factors (Fairburn, Cooper & Shafran, 2003; Pike, Devlin & Loeb, 2004). It was evident from the outset that Lucinda's efforts to overcome her binge eating were hampered by various maintaining factors and these were therefore where the focus of treatment ultimately lay.

Adverse mood states are known to trigger binge eating (Fairburn, Cooper & Shafran, 2003) and it became evident early on that there was a complex relationship between Lucinda's emotional state and her bingeing. It was apparent from her diaries that she found it difficult to accept and cope appropriately with adverse mood states such as anxiety, anger and sadness. It seemed that for Lucinda bingeing served the purpose of modulating her mood and had become a habitual means of doing this (Fairburn, Cooper & Shafran, 2003; Pike, Devlin & Loeb, 2004). We therefore focused on helping Lucinda develop alternative ways of responding to her negative mood states, such as using mindfulness techniques and meditation (Kristeller & Hallett, 1999; McKay, Wood & Brantley, 2007).

Lucinda's perfectionist tendencies and low self-esteem were clearly identifiable from the initial formulation and her core beliefs. They were further demonstrated in therapy by a consistent bias towards failure in her evaluation of her performance at work or with controlling her bingeing. She was constantly hypervigilant to even minor lapses in achieving her standards or goals and even when she had been successful she would typically discount this and view it as "a one off". I also noted that she found it extremely difficult to accept positive feedback on her achievements or progress from me.

Lucinda also brought issues to therapy regarding a poor work-life balance that was impacting upon her close relationships. A closer exploration of this problem confirmed that Lucinda defined her self-worth largely in terms of accomplishment (e.g. at work or controlling her eating) and any aspect of her performance that fell short of her expectations was judged as a failure (Corrie, 2004). Anticipation of such a failure at work caused Lucinda great anxiety and drove her to refuse to delegate tasks to others and work excessively long hours.

Lucinda's low self-esteem appeared to be sustaining her perfectionist standards and these were applied to her attempts to control her eating and weight as well as her performance at work. An improvement in these additional processes is suggested to

facilitate change (Fairburn, Cooper & Shafran, 2003) so I decided to use the work-life balance problem as a framework for working on these issues with Lucinda. As Lucinda's bingeing was often in response to stress at work I also hoped that any improvement in this area of her life would impact her BED.

We began by exploring diagrammatically (please see Figures 2 and 3 in Appendix C) the maintaining processes for both (Corrie, 2004; Fennell, 1998). In terms of her self-esteem, Lucinda identified links between her anxious predictions and maladaptive behaviours (Figure 2) and how these operated together in the work situation to maintain her anxiety which would confirm her core belief. She also recognised that her high standards often originated from her tendency to over-generalise and think in all-or-nothing terms coupled with her core belief (Figure 3). Moreover, she identified cognitive biases in the standards she set for herself which often included the need for perfection, again reflecting all-or-nothing thinking (Shafran, Cooper & Fairburn, 2002).

A cost-benefit analysis (Leahy & Holland, 2000) of holding such rigid and perfectionistic standards at work allowed Lucinda to see that striving for perfection increased her levels of stress and resulted in her overworking. She felt, however, that to lower her standards was risky and predicted disaster if she did so. In order to test her fears regarding the introduction of more flexible standards we developed a series of behavioural experiments. These were designed to test her negative predictions and support her in deciding whether her initial interpretation, that perfect standards are required at all times, was accurate or needed revising (Corrie, 2004; Fennell, 1998; Shafran, Cooper & Fairburn, 2002).

Lucinda, therefore, intentionally lowered her standards at work to "good enough" and observed the outcome. She delegated tasks to other staff and left work on time regardless. Contrary to her catastrophic predictions she still performed to a high standard and work did not "fall to pieces". In fact she discovered that her changed working practices enabled more effective functioning both at work and at home and led to a greatly improved mood. The experiments also served to gradually undermine and diminish the underlying dysfunctional assumptions and beliefs that were driving Lucinda's low self-esteem and perfectionism and dictated the standards she set herself at work in order to avoid the pain associated with her core belief (Fennell, 1997; Fennell 1998).

Following the development of the new formulations (please see Figures 2 and 3 in Appendix C), and behavioural experiments, Lucinda was able to see that her assumptions were unhelpful and would continue to prevent her from feeling happy with her achievements. She decided to implement new rules for living such as “I am always good enough, regardless of my performance” and “a good enough standard at work is sufficient”. We explored how these would be operationalised in her everyday life (Corrie, 2004; Fennell, 1998).

As a result of this work, Lucinda was able to examine her low self-esteem and perfectionism within the context of eating and weight control. Over time she became more proficient at recognising negative predictions and self-critical thoughts and questioning them. She was also able to formulate more realistic and helpful alternatives to these and challenge her dysfunctional assumptions and beliefs around the control of her eating and weight (Shafran, Cooper & Fairburn, 2002). As a result of this I noticed a dramatic reduction in Lucinda’s self-criticism and negative self-evaluation particularly when she did have a lapse in her dietary control. She was much more compassionate towards herself in these circumstances and was able to appreciate her achievements and her progress nonetheless. I felt that this was a great achievement in terms of her process.

Further evidence of Lucinda’s improved self-esteem was manifested through her interpersonal relationships. During the time that we worked together she was able to discuss personal and family issues more openly with both her parents and her sister – something that she had always avoided for fear of being dismissed before engaging in therapy. I also noticed that Lucinda was more assertive in an intimate relationship that she both initiated and finished during therapy. She told me that, after a number of dates, she felt that the man in question was not right for her, did not treat her with the respect she felt she deserved and that she did not want to “settle for second best”. I felt that this was a clear example of Lucinda valuing and prioritising herself more in the context of intimate relationships and indicated good progress.

Within the context of Lucinda’s issues with low self-esteem and perfectionism, which had no doubt arisen from early interpersonal experiences, I was also aware that the therapeutic relationship would be of central importance (Corrie, 2004). I realised that the presence of these two underlying issues might lead Lucinda to be sensitive to signs

of disapproval from me and even anticipate rejection based on her performance in therapy. I felt that it was important to offer her a supportive space where it was clear that approval was not in any way dependant on her therapeutic success. I also encouraged her to explore any anxieties that she might have about my expectations for her progress or achievements. I hoped that an open and unconditional atmosphere within the context of the therapeutic relationship would provide a reparative experience for her and counter any potential negative predictions that she might make regarding my view of her (Corrie, 2004).

Throughout the course of therapy I encouraged Lucinda to focus on the gradual process of therapeutic change (Corrie, 2004) when she became frustrated with her perceived lack of progress. As therapy continued she gradually became more able to reflect on her improvement and achievements and began to evaluate her progress in a more global manner than on a session-by-session basis reflecting a move away from all-or-nothing thinking. I also attempted to model a non-judgemental stance to my own as well as her performance in therapy by encouraging her to express frustrations and disappointments with therapy. I hoped that this would convey that approval was not dependent on everything being perfect.

I was also aware that the pattern of therapy regarding Lucinda's timekeeping, attendance and homework performance may have been driven by her perfectionism and low self-esteem and we were able to explore this aspect of her behaviour, and how it related to these, within the context of several times when she was late or had not done all of her homework. I took care in these situations to explore the link between her negative predictions, feelings and behaviour whilst maintaining an unconditional stance to her performance. I hoped again to show her that my approval was not contingent on her being in any way perfect.

Part C – The conclusion of therapy and the review

The therapeutic ending and an evaluation of the work

By the end of therapy Lucinda had overcome her bingeing to a considerable degree. She was increasingly able to address triggering mood states using mindfulness and other techniques and showed a significant improvement in her self-esteem and perfectionist tendencies. This in turn increased her flexibility in terms of standards and demands she made on herself and enhanced her ability to be more compassionate towards herself

when she did make a dietary slip. The upshot of this was a decreased vulnerability to bingeing and I felt that this was a good therapeutic outcome given her longstanding history.

Lucinda did not, however, make any real progress regarding weight loss throughout the twenty four sessions that we worked together. Clinical experience with BN indicates that a goal of normalising eating patterns is often incompatible with that of attempting weight loss. A CBT approach to BED therefore prioritises the cessation of bingeing with weight loss being deferred until these goals are at least in part achieved (Pike, Devlin & Loeb, 2004). Lucinda and I addressed this within the framework of her perfectionism and self-esteem issues using her lack of weight loss as material to help her accept a less than perfect (in her view) therapeutic performance and appreciate what she had achieved in terms of gaining control over her bingeing behaviour and improving her self-esteem and perfectionism. As part of her therapy blueprint (Beck, 1995; Sanders & Wills, 2005) Lucinda and I discussed how she might move forward in terms of weight loss in the future.

From the beginning of our work together it was apparent to me that the therapeutic relationship was influenced by Lucinda's attachment style. From our detailed exploration of her family history and childhood I suspected that Lucinda may have an internal working model of attachment that is ambivalent and I noted from the beginning a tendency to display "care-seeking" behaviour (Liotti, 2007, p.145). This manifested itself in Lucinda freely expressing vulnerable emotions (e.g., distress, emotional pain) coupled with a desire to be soothed. I felt on occasion that she idealised me as her rescuer from past and present suffering and I noticed in myself at these times a feeling of protectiveness towards her and a desire to look after her. I was struck by the strength of my reaction and discussed this at length in supervision.

I realised on reflection that in these moments we were shifting from collaborative movement towards the shared therapeutic goals to "an attachment-caregiving type of interaction" (Liotti, 2007, p.145). On the one hand I felt that this was helpful to Lucinda in that it clearly demonstrated to her that I was a safe, reliable support and source of validation. I hoped that this would be containing, particularly given her history. On the other hand, however, I was concerned that she would become dependent upon me and this would negatively impact our alliance and the therapeutic process. I was acutely

aware that I needed to maintain a delicate balance between giving appropriate soothing and validating responses without becoming overprotective. I hoped that this might foster a reparative relational experience and more secure attachment in Lucinda whilst trying to regain a collaborative alliance that was moving toward the therapeutic goals. I was also aware that it was very important that I did not respond in a way that might confirm her negative expectations about such interactions, such as through rejecting her or being inconsistent, given her experiences as a child.

Throughout our time working together I took great care to try and maintain this delicate balance. With the support and guidance of my supervisor, I endeavoured to demonstrate to Lucinda that I was there for her, but also offered help in a concrete and consistent way. I encouraged her to develop her coping abilities through improving her response to turbulent emotions, her self-esteem and perfectionism. As time progressed I noticed that Lucinda was gradually more able to soothe herself and manage her difficult emotions more effectively. This in turn seemed to give her a sense of mastery and I gradually noticed that she had less need of reassurance or soothing from me. I felt that she had made good progress on this front.

The true test of this element of our work together was the end of therapy. Lucinda still found it difficult to finish and was very concerned that she “would not be able to cope” without our sessions. By way of preparation we spent considerable time exploring her feelings of loss and fears for the future. In a more concrete vein we prepared a therapy blueprint that comprehensively reviewed the work that we had done, planned how Lucinda might continue her self-development and what she might do in the event of a relapse.

What I learned about psychotherapeutic practice and theory

Apart from the obvious learning in terms of the treatment of eating disorders and working with low self-esteem and perfectionism I found this case invaluable in strengthening my ability to formulate a client’s difficulties in a collaborative manner in session. Moreover, while the model for eating disorders is reasonably straightforward, the information that Lucinda brought to therapy was more complex and confusing. I felt that the process of formulating helped me apply the theoretical model to my clinical practice in this instance without feeling overwhelmed by the complex nature of her problem. It allowed me to develop specific explanations and hypotheses that applied to

Lucinda's case. This was particularly useful within the context of working with a supervisor of different orientation as it helped me stay on track, articulate my thoughts and ideas and thus be flexible enough to incorporate my supervisor's alternative view into my working practice within a CBT framework. Furthermore, I felt that it enabled Lucinda to take a step back from her BED and understand more clearly how it was maintained, possibly for the first time.

Another issue that arose for me in this case, and that I felt I gained significant learning from, was where the focus of treatment should lie. Although perfectionistic themes were apparent in Lucinda's initial formulation, it was not clear at the start of therapy to what extent these played a role in maintaining her BED. It seemed reasonable to focus on Lucinda's bingeing behaviour initially; however, it became increasingly obvious that her therapeutic progress was hampered by these perfectionist tendencies in conjunction with her core low self-esteem (Fairburn, Cooper & Shafran, 2003). This led to a collaborative reformulation of the problem as it became evident that these underlying themes needed to be addressed in order for Lucinda to move forward. A further learning point from this was an increased understanding of the various models and how they might interrelate in a case of eating disorder. I am sure this will be of great use when I am next presented with an eating disordered client.

Making use of supervision and learning from the case about myself as a therapist

This case has stimulated reflection on the supervisory relationship and process with this particular supervisor and my journey as a trainee therapist.

It has been suggested that a trainee therapist benefits from and prefers a supervisor that shares the same orientation whereas more experienced therapists find this less important (Dryden & Thorne, 1991; Fortune & Watts, 2000). I have been working with my supervisor at this particular placement for two years and she is of transpersonal orientation having originally trained in and used a person-centred approach for many years. My preferred orientation is cognitive behavioural although I also work within a person-centred framework.

I had attempted to use CBT with a client early on in this setting, however, I was inexperienced at the time and found my efforts to formulate and discuss client issues within a CBT framework left me feeling isolated and incompetent as my frame of

reference had limited overlap with that of my supervisor. While the supervisory input from a transpersonal slant did facilitate my understanding of the client and the process I found it difficult to translate this into practical strategies within the CBT model. In particular, at the time, I felt I was struggling with a lack of guidance relating to the use of techniques. I often felt we were talking at cross purposes and felt increasingly anxious and unsupported as the work progressed although the outcome was successful in the end.

The experience was enough to discourage me from using the model again within that setting and with this supervisor. I went back to using a person-centred approach and found another placement with a supervisor of CBT orientation with whom I developed my knowledge and skills. When presented with this client, eighteen months after my initial and difficult foray into supervision of a different orientation, I felt that I had developed as a CBT therapist with increased confidence in my abilities to use the model competently. This therefore supported my decision to use CBT in this setting as it is the treatment approach most widely investigated and recommended for this problem (Dingemans, Bruna & van Furth, 2002). I felt that I no longer needed so great a level of technical advice and was keen to try and make better use of supervision in a different orientation than my first, rather disastrous for me at the time, attempt. I hoped it might be a reparative experience.

Whilst working with my supervisor on this client I was struck by how different the experience was to before. I found that I was more able to relate and integrate my supervisor's transpersonal formulation of the problem to my CBT guided ideas. Her input regarding the therapeutic relationship and the impact of Lucinda's low self-esteem and perfectionism on this was invaluable, as was her advice and guidance in encouraging Lucinda's spiritual growth through a more "holistic" approach to mood regulation in the form of mindfulness and meditation.

I realised that I had found it very difficult to accept input from a supervisor who looked at things from such a different perspective at that time in my development as a therapist, however, my progress was such that now I felt much more able to use the differences in perspective to enhance and assist my work. I had the feeling that the individual contributions of the two orientations and the interplay between them gave extra insight and were synergistic. It seems therefore that, consistent with research, I have found it

less important to have a supervisor of the same orientation as I have gained experience and perhaps confidence in my abilities (Dryden & Thorne, 1991; Fortune & Watts, 2000).

In terms of my development as a therapist, this experience has stimulated me to examine my expectations around supervision, what I believe I should get from it, and to reflect on my process in this area. I have come to realise that in some sense Lucinda and I have followed a parallel process: throughout the course of our therapeutic work she was able to develop a stronger sense of self and through working with her, and my supervisor of a different orientation, I have gained the insight that I have developed a stronger sense of myself as a CBT therapist over the last two years of training.

Part D – Reference and appendices

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Appendix A

Figure 1: The Initial Formulation

Early Experiences
Traumatic childhood: parental marital difficulties; domestic violence; mother often late to pick Lucinda up from school and other engagements.
Unfavourable comparison of self to older sister: “black sheep of the family”; not as well behaved; not as good at school; lack of praise.
Weight problems started at 6/7 years old: put on a strict diet at this age; bullied and excluded at school for being obese.



Core Beliefs and Rules/Assumptions
SELF: I’m not good enough; I’m unimportant
OTHERS: People are unreliable and not to be trusted
I must be perfect
If I am not successful at everything I try it means I am a failure
If I fail then I am not good enough



Critical Incident
Started overeating at age 6 or 7 when father left for the first time and Lucinda “realised what was happening in my family”



Beliefs and Rules Activated



Low Self-Esteem

Over evaluation of eating and weight control

“I must control my eating”
“I must lose weight”
“I must not gain weight”



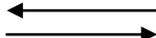
Strict dieting and rules about eating

“I must eat a low fat, low carb diet”
“I must not treat myself to fattening foods”
“I must eat the bare minimum”



LIFE
Difficult relationships at work

Mood intolerance
Affect: anxious, stressed, angry, depressed



Binge eating



(Fairburn, Cooper & Shafran, 2003)

Appendix B

The therapeutic plan and main techniques used

Sessions one to six – the beginning:

- Formulation of the development and maintenance of Lucinda's problem (Curwen, Palmer & Ruddell, 2005; Persons, 1989; Fairburn, Cooper & Shafran, 2003).
- Psychoeducation to the cognitive behavioural approach to BED and its treatment (Pike, Devlin & Loeb, 2004).
- Assessment of the current state of Lucinda's BED: Eating patterns were assessed through the use of a food diary (Powell, 2000) which also included the assessment of thoughts and feelings around episodes of overeating in order to identify and highlight the link between negative mood states and bingeing (Fairburn, Cooper & Shafran, 2003; Pike, Devlin & Loeb, 2004).
- Monitoring of mood, verbal exploration of attitude to weight and shape and exploration of interpersonal functioning (Fairburn, Cooper & Shafran, 2003; Pike, Devlin & Loeb, 2004).
- Initial work on identifying and expressing emotions (Bourne, 1995) and identifying and describing negative automatic thoughts (NATs) (Leahy & Holland, 2000).

Sessions seven to eighteen – the middle:

- Development and implementation of a meal plan to regulate eating, establish a more normal eating pattern and displace the tendency to binge (Pike, Devlin & Loeb, 2004).
- Review of thought journals, diaries and eating patterns in conjunction with the formulation.
- Identification of points in the cycle where Lucinda could intervene when she had the urge to binge and activities that she could pursue instead of bingeing (Pike, Devlin & Loeb, 2004).
- Development of other behavioural strategies to support the cessation of bingeing such as using a list when going food shopping, avoiding certain aisles in the supermarket (e.g. biscuits aisle) and not going food shopping when hungry or emotionally disturbed (Pike, Devlin & Loeb, 2004).
- Reformulation of low self-esteem and perfectionistic tendencies (Corrie, 2004; Fennell, 1997; Fennell, 1998).

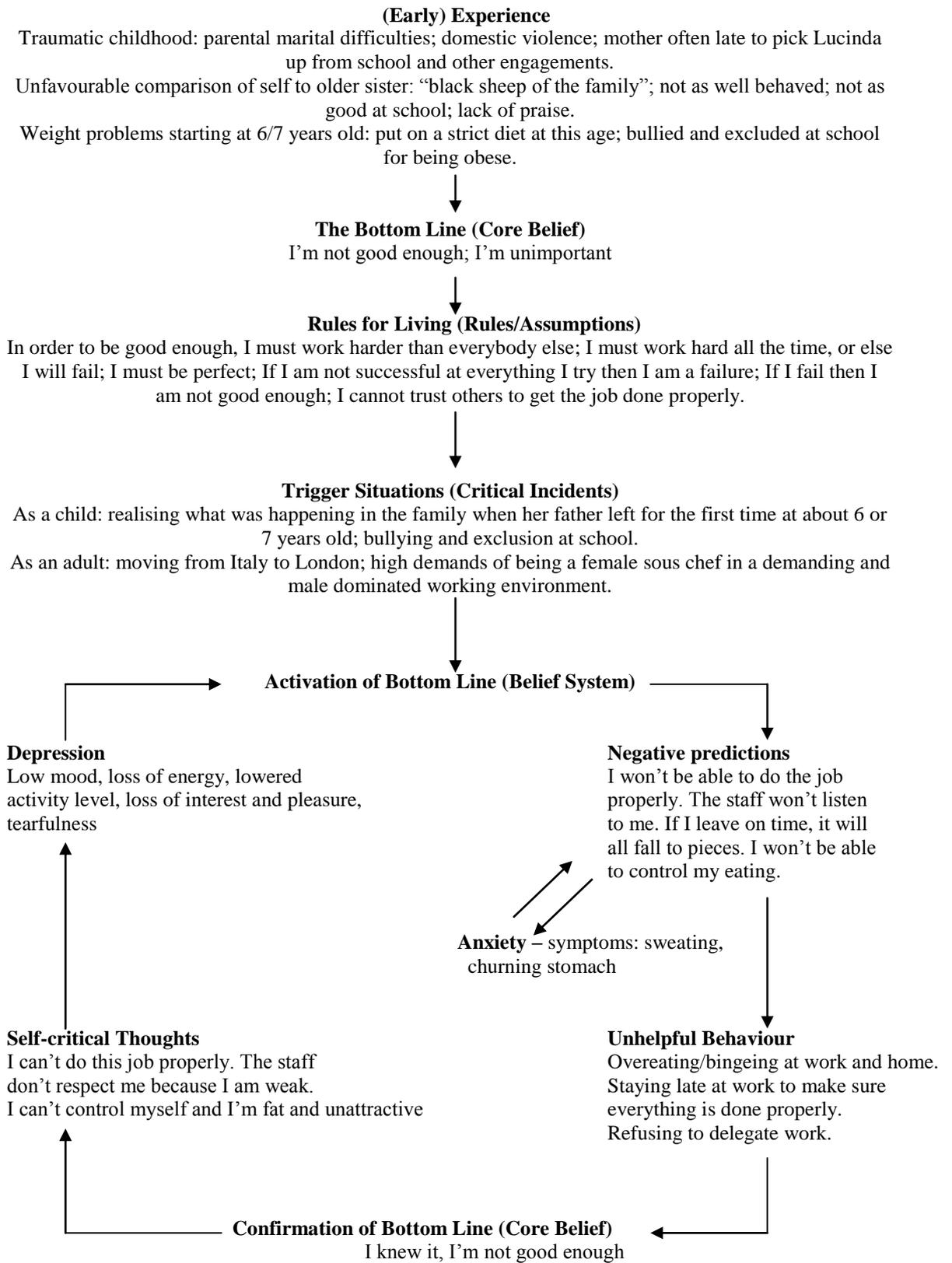
- Use of collaboratively devised behavioural experiments in order to support work on Lucinda's low self-esteem, perfectionism and binge eating (Corrie, 2004; Fennell, 1998; Shafran, Cooper & Fairburn, 2002)
- Improvement in emotion regulation instigated through the use of mindfulness techniques such as daily meditation practice, mindful walking and mindful eating (Kristeller & Hallett, 1999; McKay, Wood & Brantley, 2007).
- Introduction of the dysfunctional thought record (DTR) along with psychoeducation regarding cognitive distortions to identify and challenge negative thinking in order to improve mood and therefore assist in managing bingeing (Cuwen, Palmer & Ruddell, 2005; Pike, Devlin & Loeb, 2004)

Sessions nineteen to twenty four – the end:

This phase of therapy involved consolidating all the techniques introduced thus far. A therapy blueprint (Beck, 1995; Sanders & Wills, 2005) was collaboratively devised during the last month of treatment in order to help Lucinda focus on how she might maintain the changes that she had made, how future problems or setbacks might be handled and to support her being her own therapist in the future (Pike, Devlin & Loeb, 2004).

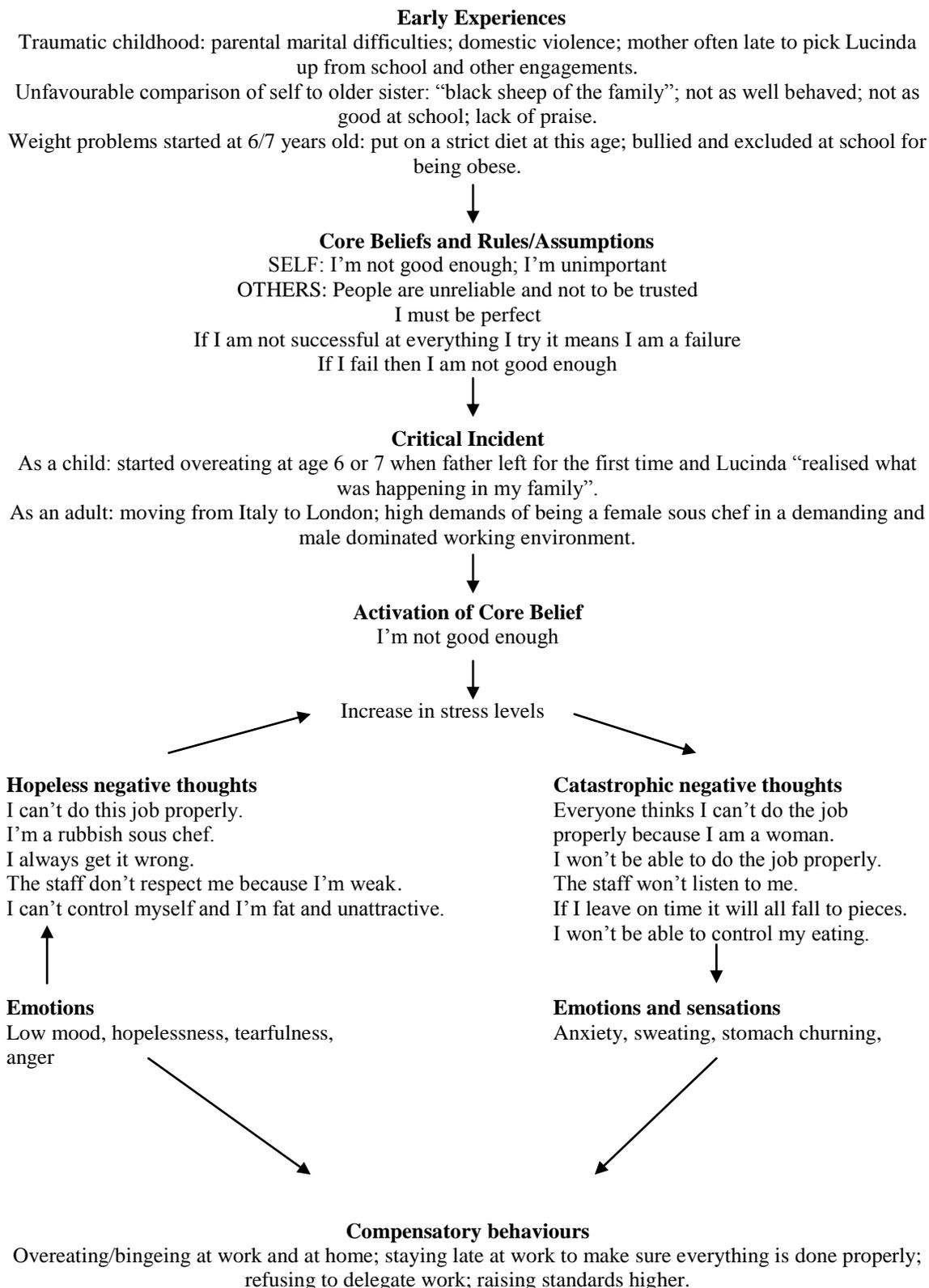
Appendix C

Figure 2: Low Self-Esteem Formulation (Map of the Territory)



(Fennell, 1998)

Figure 3: Perfectionism Formulation



(Corrie, 2004)

Part 3

A critical review of the literature

Body Dysmorphic Disorder: A counselling psychology perspective

Introduction

The topic for this critical review of the literature is Body Dysmorphic Disorder. This links to the overarching theme of body image that is found throughout the portfolio due to the disorder's integral ties to body image disturbance (Neziroglu, 2008).

Body dysmorphic disorder (BDD) is a comparatively common and yet under diagnosed psychological disorder occurring in many cultures (Phillips, 2004). It is often significantly disabling for the individual and is associated with high morbidity and distress (Foster & Veale, 2007; Phillips & Hollander, 2008). The disorder is characterised by a preoccupation with an imagined defect in physical appearance or grossly excessive concern about a minor physical abnormality. This preoccupation must cause significant distress and impairment of social, occupational or other functioning, and not be better accounted for by any other psychological disorder, in order to fulfil the diagnostic criteria for DSM-IV-R (American Psychiatric Association [APA], 2000). BDD frequently presents with comorbidity, in particular with depression, social anxiety, obsessive-compulsive disorder (OCD) and substance use (Phillips, Menard, Fay & Weisberg, 2005).

The aim of this review is to explore the phenomenon of BDD from the perspective of counselling psychology, with particular reference to the clinical features of BDD, prevalence, the comorbidities presenting with BDD and treatment. The review will reveal the hidden nature of BDD and will argue that it is necessary for counselling psychologists to have an awareness of the issues presented so that we may identify this under recognised and under reported disorder should we encounter it in our client work.

There are some topics related to BDD that are considered outside the scope of this review and therefore will not be discussed in detail. The author accordingly acknowledges that the review will not examine in-depth the pathophysiology of BDD (see Feusner, Yaryura-Tobias & Saxena, 2008, for a review); the role of BDD in cosmetic surgery or dermatological treatment (see Sarwer & Crerand, 2008, for a review); psychopharmacological treatment of BDD (see Phillips & Hollander, 2008, for a review); issues relating to the current classification of BDD (see Castle & Rossell, 2006; Phillips, Pinto et al., 2007 and Phillips & Stout, 2006); delusional versus non-delusional BDD (see Castle & Rossell, 2006 and Phillips, Menard, Pagano, Fay &

Stout, 2006, for a review) and BDD and cognition (see Castle & Rossell, 2006, for a review).

Historical Aspects of BDD

BDD was first described over a century ago by an Italian psychiatrist, Enrico Morselli. He named the disorder “dysmorphophobia” which literally means “fear of ugliness” (Morselli, 1891, as cited in Phillips, 1991, 2004), although the modern term is Body Dysmorphic Disorder (BDD). BDD was described by other European psychiatrists at the turn of the century, including Kraepelin (1909-1915, as cited in Phillips, 1991) and Janet (1903, as cited in Phillips, 1991). Janet held that the syndrome was reasonably prevalent, emphasising the intense shame experienced by sufferers (1903, as cited in Phillips, 1991).

Dysmorphophobia is also found in the psychoanalytic literature, with the classic example being the Wolf-Man analysed by Freud and Brunswick. This patient had BDD relating to his nose (Brunswick, 1928, as cited in Phillips, 1991). BDD is referred to in the literature between 1930 and 1950 with terminology such as: “one who is worried about being ugly”, “beauty hypochondria” and “dermatologic hypochondriasis” (Phillips, 1991, p.1139).

Interestingly, dysmorphophobia was not included in the World Health Organisation ICD until the 10th revision (World Health Organisation, 1992), in spite of its existence in the European literature for around a century. As ICD-10 subsumes the disorder under hypochondriacal disorders, however, no specific diagnostic criteria are defined (Foster & Veale, 2007). Infrequently referred to in the American literature, it was also not included in the American Psychiatric Association’s DSM as the discrete disorder of BDD with a separate diagnostic status until DSM-III-R (APA, 1987) (Castle & Rossell, 2006; Phillips, 1991). The DSM-IV-R includes BDD under somatoform disorders and lists specific diagnostic criteria (Foster & Veale, 2007).

Diagnosis of BDD

This section of the review will explore the problem of diagnosing BDD and the consequent implications for counselling psychology. BDD is described as being a hidden disorder, even though it is relatively common (Phillips, 2004). The reason for this is that it is notoriously difficult to diagnose and often missed by clinicians. This is

because many sufferers are too embarrassed and ashamed to divulge their symptoms for fear that their worries will be deemed narcissistic or petty (Grant, Won Kim & Crow, 2001; Phillips, 2004; Phillips & Hollander, 2008).

BDD sufferers are more likely to self-refer to cosmetic surgeons and dermatologists than mental health professionals due to their excruciating feelings of shame and humiliation (Phillips, 1991). A significant proportion therefore seek nonpsychological treatment for their BDD (Crerand, Phillips, Menard & Fay, 2005). They may even avoid visiting their GP due to the dread of having a physical examination (Veale, 2004a). It has also been reported that sufferers feel so ashamed of their symptoms that they conceal them from clinicians who have treated them for years (Phillips, 1991).

Participants in studies of BDD have reported that unless specifically asked by their clinician, they would not volunteer any information about their BDD symptoms due to the agonising shame that they feel (Grant et al., 2001). Thus unless information regarding BDD symptoms is explicitly solicited, the diagnosis may well be overlooked. Misdiagnosis can lead to clients feeling more isolated and misunderstood and may lead to inappropriate, and thus ineffective, treatment (Phillips, 2004). It is therefore important to specifically diagnose and target BDD with regard to treatment (Phillips & Hollander, 2008).

There is a possibility, therefore, that clients may only disclose associated anxiety, depression or suicidal ideation unless specifically questioned, and there are a myriad of misdiagnoses that could be made: agoraphobia or social phobia as a result of social anxiety and isolation arising from BDD; panic disorder due to panic attacks that may occur, for example in social situations or when looking in the mirror; depressed patients may have BDD which is not diagnosed; BDD is frequently misdiagnosed as OCD due to its obsessions and compulsions; delusional BDD could be identified erroneously as schizophrenia or psychotic depression (Phillips, 2004).

For this reason, suitable screening questions that may enable the identification of BDD in clients are of importance to counselling psychologists. The questions listed below are taken from Foster and Veale (2007, p.177) and reflect the criteria in DSM-IV-R (APA, 2000):

1. Do you think a lot about your appearance? What feature(s) are you unhappy with? Do you feel your feature(s) are ugly or unattractive?
2. How noticeable do you think your feature(s) are to other people?
3. On an average day, how many hours do you spend thinking about your feature(s)? Please add up all the time that your feature(s) are on your mind and make the best estimate.
4. Do your feature(s) currently cause you a lot of distress?
5. How many times a day do you usually check your feature(s)? (Include looking in a mirror or other reflective surface, such as a shop window, or feeling it with your fingers).
6. How often do you feel anxious about your feature(s) in social situations? Does it/do they lead you to avoid social situations?
7. Have your feature(s) had an effect on dating or an existing relationship?
8. Have your feature(s) interfered with your ability to work or study, or your role as a homemaker?

BDD is diagnosed if a client is concerned about an appearance flaw that does not exist or is minimal, are preoccupied with the defect in that they think about it for at least an hour a day or longer, and experience impaired functioning and significant distress as a result (Phillips, 2004).

This discussion around the diagnosis of BDD has a bearing on counselling psychologists as there is a need to be vigilant to the potential presence of BDD in clients presenting with social anxiety, depression and suicidal ideation. Other warning signs may include substance abuse (Phillips & Hollander, 2008), unnecessary cosmetic surgery or dermatological treatment or excessive expenditure and time spent on beauty treatments and grooming. Other indicators may include clients who are housebound or avoidant of work, school and social activities, those who have referential thinking and the presence of compulsive or safety behaviours relating to appearance (Otto, Wilhelm, Cohen & Harlow, 2001; Phillips, 2004; Phillips & Hollander, 2008).

The age of onset of BDD is generally in adolescence (Phillips, Menard, Fay & Weisberg, 2005), however individuals with BDD are commonly formally diagnosed 10-15 years after onset (Phillips, 1991; Phillips & Diaz, 1997). It is therefore also important that counselling psychologists are aware of client groups that may be vulnerable and of

the warning signs that may alert to this secretive and hidden disorder. Other factors regarding prevalence of BDD in particular client groups and comorbidities will be further discussed in the course of the review.

Clinical Features of BDD

An understanding regarding the clinical features of BDD is argued to be of relevance to counselling psychologists. An awareness of the clinical characteristics exhibited by sufferers may be useful in identifying the disorder.

Individuals with BDD are fixated with the idea that there is something wrong with the way they look. They tend to believe that one or more of their features are deformed, ugly or unattractive. This is despite the fact that the supposed imperfection is in reality minimal or even non-existent. Fixations may concern any part of the body, however are most commonly focused on the face and head. They may include a preoccupation with skin, hair, eyes, eyelids, nose, lips, mouth, jaw, chin or even head size. There is often a problem with multiple areas of the body simultaneously (Phillips, 2004; Veale, 2004b).

Preoccupations typically include facial flaws (whether real or perceived), acne, wrinkles, scars, complexion problems (excessive whiteness or redness), issues with hair (thinning hair, excessive body or facial hair), asymmetry and body features that are experienced as out of proportion. Complaints may be precise or general. In addition, preoccupations may change over time and shift from one area to another (Veale, 2004b; Phillips & Hollander, 2008). Sufferers' preoccupations may take up to an average of three to eight hours of their time a day and are very difficult to refrain from, or keep in check. These preoccupations are commonly coupled with shame and low self-esteem, fear of rejection and feelings of embarrassment and low worth (Phillips, 2004; Veale, 2004b).

Most individuals with BDD are convinced that their view of their appearance is accurate and real. They usually have very little insight and are generally unable to recognise or accept that their appearance-related beliefs originate from a psychological problem (Eisen, Phillips, Coles & Rasmussen, 2004; Phillips, 2004). This has implications for treatment as poor insight may mean that clients are reluctant to accept and complete therapy. Studies have found insight to be significantly lower in BDD than OCD (Eisen et al., 2004). Sufferers may also be delusional and delusions of reference are common.

Individuals may believe that others particularly notice their imagined defect and are talking about it, staring at it, making fun of it or horrified by it (Phillips, Menard, Pagano, Fay & Stout, 2006).

The majority of sufferers perform time consuming, repetitive, BDD-related compulsive or safety behaviours. These can continue for hours a day and are hard to resist or keep under control. They are carried out to examine, improve, disguise or hide the defect. The aim is to reduce distress associated with thinking about perceived defects (Phillips & Hollander, 2008). These behaviours may include mirror gazing, comparing self with others, excessive grooming, camouflaging the perceived defect, skin picking, reassurance seeking, dieting and even seeking cosmetic or dermatological treatment (Phillips, 2004; Veale, 2004b).

Suicidality, psychosocial functioning and quality of life

Studies have also shown that the prevalence of suicidal ideation and suicide attempts is high among individuals with BDD. Suicidal ideation has been reported at rates of up to 78% (Phillips, Coles et al., 2005). High rates of suicide attempts have also been reported, for example, Veale, Boocock et al. (1996) found a rate of 24% and Phillips, Coles et al. (2005) found a rate of 27.5%. An arguable problem with these studies, however, is that they are retrospective and based on self-report data. Phillips and Menard (2006) conducted a prospective study of BDD's course and investigated suicidality in 185 patients over four years. They found suicidal ideation reported by 58% of participants per year with a mean of 3% attempting suicide per year and 0.3% (two participants) completing suicide per year. The authors conclude that, although these findings are preliminary and comparisons should be made with caution, the suicide rate is manifestly high compared to the US average and most other psychiatric disorders.

Psychosocial functioning and quality of life have both been found to be impaired in BDD (Phillips, 2000; Phillips, Menard, Fay & Pagano, 2005). A comparatively recent study by Phillips, Menard, Fay and Pagano (2005) looked at the psychosocial functioning and quality of life relating to mental health of a sample of 176 individuals with BDD recruited from both clinical and non-clinical populations. They found these were manifestly and persistently worse than published norms for the general US population and patients with depression, an acute medical condition such as recent

myocardial infarction or a chronic medical condition such as type II diabetes. The study used standard measures with good reliability, validity and well-established norms. A combination of self-report and semi-structured interview measures was administered and a statistical comparison was performed with the published norms. Despite efforts at rigour, there are nonetheless a number of limitations to the study. These include the use of norms for comparison rather than controls or actual individuals with a medical or psychological disorder and that the sample was not randomly obtained. This compromises generalisability as the sample is unlikely to be truly representative of the general population.

The most recent and only prospective study examining psychosocial functioning in BDD is that of Phillips, Quinn and Stout (2008). This is in fact a three year longitudinal and naturalistic follow-up of participants involved in Phillips, Menard, Fay and Pagano (2005). The authors went to great lengths to ensure the rigorous administration of a number of self-report and interview assessed measures. Again all the measures used are well-established with good reliability and validity. They found that, consistent with previous studies, BDD sufferers had poor psychosocial functioning. This remained the same over time with few participants achieving remission in functioning over the duration of the study. It was also demonstrated that, as would be expected, more severe symptoms of BDD resulted in significantly worse psychosocial functioning. Limitations of this study include the high attrition rate before the third follow-up and that the sample was a convenience sample from a particular region of the US thus limiting generalisability.

In conclusion, the high rate of suicidality, poor psychosocial functioning and quality of life for these individuals further underlines the extreme suffering associated with BDD.

Prevalence of BDD

The prevalence of BDD is a contentious issue that is of relevance to counselling psychologists as they tend to work in a wide variety of settings. An understanding of the incidence of this hidden disorder is therefore argued as important as it is possible that therapists may encounter BDD in either a clinical or community setting. This type of epidemiological study may also give an indication of which client groups could be at increased risk of BDD through providing information regarding its prevalence in particular populations.

It has been suggested, however, that an accurate estimation of the prevalence of BDD is problematic for two reasons. Firstly, BDD sufferers are more likely to self-refer to cosmetic surgeons and dermatologists than mental health professionals, particularly as insight is limited, and because of the secretive nature of the disorder. Secondly, there may possibly be a high rate of subclinical BDD present in the general population where symptoms are present but do not give rise to a substantial impairment in functioning. (Altamura, Paluello, Mundo, Medda & Mannu, 2001). The question of subclinical BDD will be discussed later.

Studies that have been conducted regarding the prevalence of BDD can be broadly divided into four categories: clinical populations consisting of psychiatric inpatients and outpatients, and non-clinical populations consisting of student and community samples. The studies indicate that BDD occurs reasonably frequently in all populations, although there are conflicting data that will be discussed below.

Prevalence is particularly pertinent when considering how common it is for BDD to be under reported and under diagnosed (Phillips, 2004). Evidence to support this comes from studies conducted in clinical populations: two outpatient studies (Zimmerman & Mattia, 1998; Phillips, Nierenberg, Brendel & Fava, 1996) and two inpatient studies (Grant et al., 2001; Phillips, McElroy, Keck Jr., Pope Jr. & Hudson, 1993) found that BDD had been missed by clinicians in every case identified by the researchers. Grant et al. (2001) investigated the prevalence of BDD in a psychiatric inpatient setting and found that 13% (95% CI = 6.9-19.3%) of a sample of 122 inpatients had previously undiagnosed BDD. The authors found that all of the participants identified as having BDD reported not revealing their symptoms to their clinician unless explicitly asked due to feelings of shame. A more recent inpatient study by Conroy et al. (2008) assessed prevalence in 100 patients consecutively admitted to a general adult psychiatric unit. Sixteen percent (95% CI = 8.7-23.3%) were found to have current or lifetime BDD, consistent with the findings of Grant et al. (2001). Strikingly, these patients were found to have revealed their BDD symptoms to only a fraction of previous clinicians and only one of the sixteen had revealed their symptoms to their current clinician. The most common reasons for this were embarrassment and fear of negative judgement (Conroy et al., 2008).

These studies are particularly pertinent to counselling psychologists as they further underline a probable reason for why BDD is under diagnosed. Participants in both studies reported feeling so ashamed of their problems that they were reluctant to initiate a discussion or reveal symptoms related to appearance concerns unless asked. This clearly highlights the issue of shame and humiliation in BDD and the importance of specifically screening for BDD. It suggests that without clinicians being alert and vigilant to the possibility of this distressing and debilitating disorder, it may well go unnoticed.

In psychiatric outpatient settings, prevalence studies also indicate that the rate of BDD is relatively high. There is also a high rate of comorbidity with other psychiatric disorders. For example, a sample of 80 outpatients with atypical depression had a rate of BDD of 13.8% (Phillips et al., 1996). Among outpatients with anxiety disorders, rates of BDD of 11% (Brawman-Mintzer et al., 1995) and 12% (Wilhelm, Otto, Zucker & Pollack, 1997) have been found in social phobics and 8% in patients with OCD (Brawman-Mintzer et al., 1995; Wilhelm et al., 1997).

Prevalence studies in non-clinical populations are highly relevant to counselling psychologists as many work in community settings. Studies conducted in this area have focused on student and community samples and estimate varying rates of BDD in the general population. For example, a non-clinical sample of 133 German college students revealed a prevalence of 5% for BDD (Bohne, Wilhelm et al., 2002). This is similar to the rate of 4% found in a sample of 101 American students (Bohne, Keuthen, Wilhelm, Deckersbach & Jenike, 2002). Notably, both of these rates are considerably higher than the rates found in the community samples discussed below. This may indicate the need for increased vigilance to the possibility of BDD in this client group. On the other side of the coin, however, it is likely that both findings are subject to a lack of generalisability due to sampling from exclusively student populations. In addition, the German sample had a high percentage of female participants (74%) and was comprised entirely of psychology students from one particular German University. This is likely to seriously limit the generalisability and utility of the data (Bohne, Wilhelm et al., 2002).

In terms of community samples, a study conducted in Italy found a one-year BDD prevalence of 0.7% in 673 participants (Faravelli et al., 1997). The five cases of BDD identified in the mixed sex sample were all women, although the age range is unknown.

Another study conducted in the USA also found a prevalence of 0.7% in a community sample of 976 adult women aged between 36 and 44 years (Otto et al., 2001). The similarity between the findings of these two studies is striking, however, Otto et al. (2001) caution that their study may well have underestimated the rate of BDD as the sample age was relatively high. It is possible that a younger sample may have demonstrated a higher rate as the age of onset of BDD is usually in adolescence (Veale, 2004b) and a higher rate is found in studies of student populations (e.g., Bohne, Wilhelm et al., 2002).

Another issue of note is that the two studies used different criteria to rate the prevalence of BDD in their samples. Faravelli et al. (1997) used DSM-III-R criteria (APA, 1987) and Otto et al. (2001) used DSM-IV criteria (APA, 1994). The difference between the two is that the former did not include significant distress or functional impairment as one of the diagnostic criteria (Bohne, Wilhelm et al., 2002). This suggests that a direct comparison between the studies is compromised. Another criticism that could be levelled at the study conducted by Otto et al. (2001) is that it did not examine the prevalence in men, who are also known to frequently suffer from BDD, thus limiting generalisability to the general population (Phillips, 1991).

Two other studies have assessed the rate of BDD in a sample of the general population: in the USA, Bienvenu et al. (2000) found a prevalence of 3% in a sample of 73 participants. In addition, 1% of 300 first degree relatives of this sample also demonstrated a life-time prevalence of BDD. In the Netherlands, however, DeWaal, Arnold, Eekhof and van Hemert (2004) found no cases of BDD in over 1000 consecutive general practice patients assessed with structured interviews. The latter study has been criticised by Veale (2004a), however, who raises concerns regarding the exclusion of participants under 25 years old, where most cases of BDD are found, and that the screening tools and the interview used were inadequate for identifying BDD. Veale (2004a) also highlights the importance of using open questions, as discussed earlier, to specifically screen participants or clients for BDD due to issues of shame leading sufferers to conceal their BDD. This once again emphasises the need to be alert to the possibility of hidden BDD in community-based clients and supports the need for robust epidemiological data in order to better assess treatment needs.

The most recent and definitive community study is that of Rief, Buhlman, Wilhelm, Borkenhagen and Brahler (2006). This is the largest study to date, using a sample of 2552 participants with an age range of 14 to 99 years old. The sample was recruited country-wide in Germany and in a manner that retained the typical characteristics of the population in terms of age and sex. A prevalence rate of 1.7% for current BDD was found (95% CI = 1.2-2.1%). Limitations acknowledged by the authors include that fact that the data was self-report. This is not as reliable as structured interview data and sufferers of BDD with poor insight may not classify themselves using such measures thus leading to an underestimation of prevalence. On the other hand, self-report measures provide a certain amount of anonymity that could mean individuals would be more comfortable disclosing symptoms than in an interview. The authors conclude that further investigation of the best way of obtaining information for prevalence studies is warranted. Another problem was due to a restrictive exclusion criterion. This meant that a large amount of women with concerns regarding body weight were excluded in an effort to separate out eating disorders. This may also have led to an underestimation of prevalence. Finally, it would have been of interest to assess comorbidities but this was not included.

In summary, it is apparent that estimates of the prevalence of BDD in the general population demonstrate a wide range from 0% (De Waal et al., 2004) to 3% (Bienvenue et al., 2000), with rates of up to 5% being found in student populations (Bohne, Wilhelm et al., 2002). There are a number of problems with the majority of these studies, however, limiting the utility of this information. Studies reporting higher rates tend to be in groups that might be expected to demonstrate greater prevalence, such as female college students. In addition, these samples are unlikely to adequately represent the general population thus limiting generalisability of the findings.

The use of self-report measures in a number of studies could mean that results are unreliable compared to those studies using structured interviews such as Faravelli et al. (1997) and Otto et al. (2001). Both of these studies had relatively small sample sizes in terms of power, however, and both recruited from particular regions thus limiting generalisability (Rief et al., 2006). Of all the studies, Rief et al. (2006) was probably the most comprehensive, although this also had limitations. Clearly, there is a need for further studies to elucidate the prevalence of BDD in the general population. A better understanding of the prevalence of this so-called secret disorder in the community at

large could assist in an improvement in rates of diagnosis, thus allowing more sufferers to access treatment.

In terms of gender, Phillips (1991) found the ratio in reported cases of BDD to be around 1.3 females to 1 male. Some studies have reported high rates of women to men in samples with BDD: Rosen and Reiter (1996) found 72% of 82 participants were female; Veale, Boocock et al. (1996) found 76% of 50 participants were female and Rief et al. (2006) found 59% of 42 individuals identified with BDD from a large community sample were female. Other studies, however, have found a marginally higher proportion of men among BDD participants: Phillips et al. (1993) found 57% of 30 participants were male and Perugi et al. (1997) reported 59% of 58 participants were male. Notably, all these samples of BDD sufferers are small in size and, except for Rief et al. (2006), all clinical samples of convenience. This means that they are likely to be subject to biases and are therefore not an accurate representation of the gender ratio of BDD in the general population.

Phillips and Diaz (1997) reported on a larger group of 188 participants with BDD, of which 51% were male, however this was also a clinical sample. More recently, Phillips, Menard and Fay (2006) reported 68.5% of 200 BDD sufferers as female. This particular sample was recruited from a variety of sources so may be marginally more representative. It is clear therefore that further epidemiological studies are required to elucidate a less speculative estimate of the female to male ratio in BDD, particularly in the general population. In terms of gender differences, more similarities than differences have been found. For an interesting and comprehensive review of data pertaining to gender similarities and differences please see Phillips, Menard and Fay (2006).

Clinical and Subclinical BDD

There is also a question regarding at which point BDD differs from a typical concern with physical appearance. As concern with physical appearance is not uncommon, particularly in adolescence, the boundary between abnormal and normal concerns may be unclear (Phillips, 1991). When does a resulting preoccupation become so intrusive in life that it becomes BDD?

The symptoms of BDD appear to occur along a continuum with some individuals able to maintain jobs, families and a social life. This, however, is often a struggle and these

individuals commonly experience a poor quality of life as a result. At the other end of the continuum are those individuals with severe BDD, unable to maintain a job or any relationships (Sarwer, Gibbons & Crerand, 2004). The symptoms must be severe enough to cause significant distress or impairment in daily functioning to qualify for a diagnosis of BDD according to DSM-IV-R (APA, 2000), but how many people are there with symptoms that are just below this level of impairment? Conroy et al. (2008) make the point that judgement on the level of impairment may be easy to make in more severe cases but could be difficult in mild cases of BDD; much of this depends on how the criterion is operationalised. The region of overlap between normal and abnormal concern is therefore indistinct and further research is needed to provide clarity (Conroy et al., 2008; Phillips, 1991). Furthermore, Conroy et al. (2008) argue that it may not be clear cut as to whether the perceived defect is actually imagined or slight. For example, acne or other minor defects may demand a “subjective aesthetic judgement” (Conroy et al., 2008, p.71) which could be quite variable.

Altamura et al. describe those BDD sufferers exhibiting the principal symptoms of BDD, but not demonstrating a significant impairment in functioning, as “subclinical” (2001, p.105). The researchers conducted a study to examine the similarities and differences between BDD and subclinical BDD in a sample of non-psychiatric participants found at cosmetic surgery centres in Italy. BDD was found at 6.3% and subclinical BDD at 18.4% in their sample of 478 participants. The authors, however, caution that the generalisability of these results is poor due to the nature of the sample. They argue that the participants were likely to have a higher incidence of BDD as they were recruited from cosmetic surgery centres and BDD sufferers have poor insight and are more likely to self-refer to dermatologists and cosmetic surgeons than mental health professionals. Other limitations of the study include the absence of a validated instrument to define and identify subclinical BDD; the researchers classified subclinical BDD according to reduced scores on an established measure, however this procedure is not validated. In addition, the greater representation of women in the total sample (76%) may have introduced a bias, as with the relatively small sample sizes of 30 BDD sufferers and 88 subclinical BDD sufferers. Subclinical BDD was also reported as being associated with a lifetime comorbidity of OCD (22%) and it was found that 12% of the subclinical BDD sufferers reported lifetime suicidal ideation (Altamura et al., 2001).

In spite of its limitations, the study highlights an interesting question regarding the existence and prevalence of the possibly underestimated condition of subclinical BDD. Further research into a milder and less debilitating form of BDD would no doubt be of value. This is of relevance to counselling psychologists, who could potentially encounter this less severe type of BDD in their practice, which could also be complicated by comorbidity and suicidal ideation. In addition to this, subclinical BDD may be a precursor to clinical BDD. Finally, in support of Altamura et al. (2001), it is of interest that Rief et al. comment that their community sample of 2552 participants confirmed that “many people have concerns about unattractive body parts, although only a few of them fulfil the criteria for BDD” (2006, p.882). It is not inconceivable that some of this population could meet criteria for subclinical BDD.

BDD and Comorbidities

Studies indicate that BDD has high comorbidity with other psychological disorders and most commonly with certain Axis I disorders (Phillips & Stout, 2006). An understanding of the comorbidities that tend to present with BDD is of value to counselling psychologists as BDD may be hidden or masked by comorbidity, but still present to some degree. This carries implications for treatment which may not be fully effective if directed only at the Axis I disorder and not at comorbid BDD. For this reason, knowledge of the comorbidities that present with BDD is of importance (Allen & Hollander, 2004).

A great variety of conditions are found to be comorbid with BDD, for example, mood disorders, anxiety disorders, psychotic disorders, substance use disorders, eating disorders and others such as trichotillomania (Gunstad & Phillips, 2003). The review will focus on the most common comorbid Axis I disorders, however, which have been found to be major depression, social phobia (SP) and obsessive-compulsive disorder (OCD) (Gunstad & Phillips, 2003; Phillips, Menard, Fay & Weisburg, 2005; Phillips & Stout, 2006). These are particularly relevant to counselling psychologists as they are disorders that may frequently be encountered in the course of their clinical work in a variety of settings.

Varying rates of these comorbidities have been found in different studies. This is attributed to the different settings and populations used for the studies. For this reason, the current review will briefly examine a selection of the more recent and influential

studies that have been published, with the results summarised for ease of reference in Table 1 below. The largest published study investigating comorbidity in BDD was that conducted by Gunstad and Phillips (2003). The study used a sample of 293 participants with BDD and identified a great variety of comorbid disorders. It was found that major depression was the most common comorbidity, with a rate of 76%. SP followed this at 37% and then OCD with a rate of 33%. The limitations of the study acknowledged by the authors are a lack of control group, which sheds doubt on the specificity of the findings to BDD, and the inclusion of some participants from a drug treatment study, the exclusion criteria of which may have introduced biases. In addition, all participants were recruited from a setting specialising in BDD. These factors imply that the results may not be generalisable to a community or a non-speciality setting (Gunstad & Phillips, 2003).

The second largest published study by Phillips, Menard, Fay and Weisberg (2005) reported on a sample of 200 participants with BDD recruited from a variety of sources. They found major depression at 74%, SP at 38% and OCD at 33%. Although the sample is more diverse than usual, the authors still acknowledge that it is a sample of convenience and as such subject to biases limiting its generalisability. Phillips and Diaz (1997) primarily investigated gender differences. However, in their sample of 188 participants with BDD, the authors found the most common comorbidity to be major depression at a rate of 82%, followed by SP at 38% and OCD at 30%. Interestingly, it was found that major depression and social phobia occurred with similar frequency between genders, although they tend to be more common in women than men in the general population.

Another study by Perugi et al (1997) was also investigating gender-related differences, but found that 41% of a sample of 58 participants had comorbid major depression, 41% had comorbid OCD and 12% had SP. A limitation acknowledged by the authors was possible bias introduced through referral patterns and selection criteria. The sample was also from a general psychiatric setting, and thus may have automatically had a high rate of comorbid disorders, particularly mood disorders. The only British study reviewed is that of Veale, Boocock et al. (1996). This was a study of fifty cases of BDD and found strikingly lower rates of all the comorbidities, with major depression at a rate of 36%, SP at 16% and OCD at 6%. The reason for the reduced rates of SP and OCD is not clear. Finally, a study by Zimmerman and Mattia (1998) investigated 16 participants

diagnosed with BDD from a sample of 500 patients in a psychiatric outpatient clinic. The study found rates of 69% for major depression and SP and 38% for OCD.

More recently, a study by Coles et al.(2006) investigated the relationship between BDD and SP by scrutinizing correlates of SP comorbidity in a large sample of 178 BDD patients. The authors found that 34% of the sample had current comorbid SP. This finding is strikingly consistent with the comorbidity studies of Gunstad and Phillips (2003) and Phillips and Diaz (1997). The authors suggest that comorbid SP may be more common than comorbid OCD, supporting previous studies. The limitations of the study cited by the authors are that around 60% of the sample was receiving mental health treatment and this may limit the generalisability of the findings to the general population. In addition, there was no direct comparison with SP controls.

Table 1: Comorbidity Rates (%) in Six Published Studies of BDD

Study	N	Major Depression	Social Phobia	OCD
Gunstad & Phillips (2003)	293	76	37	33
Phillips, Menard, Fay & Weisberg (2005)	200	74	38	33
Phillips & Diaz (1997)	188	82	38	30
Perugi et al. (1997)	58	41	12	41
Veale, Boocock et al. (1996)	50	36	16	6
Zimmerman & Mattia (1998)	16	69	69	38

In summary, the picture regarding the prevalence of comorbidities is mixed, although there does appear to be a trend indicating that depression is the most common, followed by SP and then OCD. Further studies are warranted to clarify this trend and elucidate a fuller picture. Onset data from these studies suggests that BDD tends to precede comorbid major depression but typically has its onset after the development of SP. Whether clients may develop depression as a result of their BDD, and whether SP gives rise to a predisposition to BDD, remains unclear. This data is retrospective and self-reported, however, and so should be treated with caution. Further research into this area would be of interest and have implications for counselling psychologists in terms of the

prognosis in cases of BDD and SP and the likelihood of the development of comorbidity.

Treatment of BDD

Over the last decade, both psychological and pharmacological treatments for BDD have been evaluated. Psychological therapies that have been investigated are behaviour therapy (BT) and cognitive behaviour therapy (CBT). BT tends to encompass exposure and response prevention (ERP) with no cognitive component (Williams, Hadjistavropoulos & Sharpe, 2006). CBT includes the elements employed in BT but also uses cognitive techniques. These techniques include the identification and modification of appearance-related automatic thoughts, distorted cognitions and beliefs (Williams et al., 2006). The UK National Institute for Health and Clinical Excellence (NICE) recommends that standard treatment for adults with BDD should include CBT with ERP and/or treatment with serotonin reuptake inhibitors in a stepped care approach (National Institute for Health and Clinical Excellence, 2008).

In their recent meta-analysis, Williams et al. (2006) examine the efficacy of treatments for BDD, evaluating the effectiveness of both psychological and drug therapies. They included a variety of different types of studies such as those using individual therapy (e.g., McKay et al, 1997; Veale, Gournay et al, 1996); group therapies (e.g., Rosen, Reiter & Orosan, 1995); randomised controlled trials (RCTs) (e.g., Veale, Gournay et al., 1996); case series (e.g., Neziroglu, McKay, Todaro and Yaryura-Tobias, 1996); and case studies (e.g., Geremia and Neziroglu, 2001).

Investigations into drug therapies have concentrated on serotonin reuptake inhibitors (SRIs) with various studies being conducted. It has been generally concluded that SRIs help to improve insight and reduce compulsive behaviours and distress experienced by sufferers (Williams et al., 2006). A more in depth discussion of drug treatment, however, is outside the scope of the current review and therefore will not be debated. For a more recent review please see Phillips and Hollander (2008).

Williams et al. (2006) examine effect sizes and directly compare all drug and psychological treatments investigated between 1994 and 2003, including both published and unpublished studies that were available, such as doctoral dissertations. As such, they have made great efforts to be as comprehensive as possible in examining the

efficacy of BDD treatments and in comparing the effectiveness of both pharmacological and psychological therapies. This meta-analysis could therefore be argued as particularly pertinent to counselling psychologists.

The meta-analysis included fifteen eligible studies, of which nine investigated psychological treatments and six investigated drug treatments. Effect sizes were calculated for the typically measured variables of BDD symptom severity and depression. Other comorbidities were not reported for the majority of investigations, giving rise to a lack of data that could have been very valuable in providing additional information (Williams et al., 2006). The authors concluded that BDD and associated depression improve with treatment. Large effect sizes were found for RCTs and case series, which the researchers argue demonstrates treatment effectiveness for BDD symptom severity and co-morbid depressive symptoms. The authors contend that the differences between studies, such as heterogeneity of duration of symptoms and age of participants for example, could have reduced the combined effect size so that this result is even more promising (Williams et al., 2006).

The study also reports that psychological therapies were more effective than drug therapies in decreasing symptom severity in BDD. In addition, it is maintained that CBT gave larger effect sizes than drug therapies, suggesting that it is more effective. This outcome was not found with BT however (Williams et al., 2006). These results have implications regarding counselling psychologists' role in the treatment of BDD. Working in a variety of settings, counselling psychologists are well placed and have the correct skills and knowledge to offer what appears to be the optimal treatment of CBT for this disorder.

The authors discuss several limitations of the meta-analysis, including a lack of generalisability of the results due to the small number of studies available for analysis and their small sample sizes. In addition, they are aware of the likelihood that unsuccessful studies would not be published, thus introducing bias to the results. In order to minimise this as far as possible, however, they did include unpublished dissertations (Williams et al., 2006). Another complicating factor relates to participants in psychological intervention studies who are also taking medication. This was not always reported and Williams et al. (2006) assert that this information is essential to consider the bearing of concurrent medication on response to therapy. Further research

in this area would be invaluable. More wide-ranging studies would also be worthwhile, particularly examining other comorbidities. In addition, larger, well-controlled RCTs would be helpful to support and expand upon existing data.

Long-term follow up studies would also be of value in order to investigate the maintenance of treatment gains given the chronic nature of BDD. Comparison studies of group versus individual therapy would also be informative, in order to ascertain possible benefits of group interaction in the treatment of BDD. In addition, it has been suggested that the use of an established treatment protocol would contribute to the elimination of inconsistencies in treatment approaches. This would allow for a more direct comparison of studies (Sarwer et al., 2004).

Despite Williams et al. (2006) evident effort to produce a rigorous meta-analysis of the available data there are several likely caveats. Firstly, although acknowledged by the authors, the studies that are included in the analysis are heterogeneous on many levels (e.g., duration of BDD symptoms, proportion of males to females, average age of participants and populations from which the samples were drawn). This makes them difficult to combine, introduces bias and may influence the conclusions drawn (Andersson, 2000). Secondly, it is not possible to know how many studies have not been published due to null results (the “file drawer” problem), and therefore not included in the meta-analysis, although the authors did go to considerable lengths to safeguard against this. In addition, we do not know if alternative therapies work because they have not been evaluated. Finally, meta-analysis, although useful in informing us how well particular treatments work overall, does not tell us how to treat the individual client who may respond differently (Lau, Ioannidis & Schmid, 1998). For recent reviews of treatment models and clinical considerations please see Neziroglu, Khemlani-Patel and Veale (2008); Rabinowitz, Neziroglu and Roberts (2008) and Buhlmann, Reese, Renaud and Wilhelm (2008).

The NICE recommendations for treatment of BDD, the meta-analysis and current accepted diagnosis and treatment approach are firmly set within the medical model and the positivist paradigm. As such, it could be argued that cognitive and behavioural therapies are promoted in this case as they are more in line with this epistemological standpoint and amenable to testing via RCTs and meta-analytic methods. Counselling psychology, however, has its roots in a more humanistic underpinning philosophy of the

human sciences (Strawbridge & Woolfe, 2003). This could be argued to be at odds with the medical model and more clinical viewpoint found throughout published material relating to BDD.

Fundamentally, these issues relate to inherent tensions in the relationship between research and practice (Lane & Corrie, 2006), particularly within the context of evidence-based practice as a central tenet of policy in the NHS (Goss & Rose, 2002). This is particularly pertinent for counselling psychologists who may at times find the marrying of science and practice within a single model epistemologically counterintuitive. Scientists and practitioners essentially have different assumptions and priorities. For example, they have different interests regarding knowledge: rigorous, objective and generalisable for the former and subjective, holistic and applicable to the individual for the latter (Lane & Corrie, 2006). A counselling psychologist may therefore experience a conflict, and need to find a balance, between practitioner interests in terms of tailoring therapy to the individual and scientific interests in terms of evidence-based practice and the provision of services.

Having said this, the research reviewed in the meta-analysis has originated from practitioners with a significant proportion taken from case studies and case series. As such it could be said, therefore, to adopt a bottom-up approach and relate to practice. What is conspicuously absent, however, from all the studies and papers reviewed is a sense of the individual experience of a BDD sufferer. Even the case studies reporting on treatment approaches tended to be clinical in orientation and gave no sense of what it is like to experience BDD or to be engaged in treating a client with BDD.

Phillips (2005) has written a very accessible and comprehensive guide to BDD containing information, stories and anecdotes that give some idea of the day-to-day realities of living with BDD. This, however, is aimed at sufferers and their families. The current author would therefore nonetheless suggest that there is a gap in the clinical literature. Qualitative studies could perhaps bridge the gap between the more particular aspects of BDD and the universal that is already known. Studies of this nature could provide valuable insight into BDD sufferers' experience of their condition and in-depth case studies could also provide an alternative view into clinicians' experience of working with these individuals.

Summary and Conclusions

The review has considered various topics relating to BDD that are argued as relevant to counselling psychology. Clients with BDD are likely to conceal appearance concerns and symptoms unless specifically asked by clinicians. They are also likely to be isolated and may well experience considerable distress, poor psychosocial functioning and quality of life. In addition, they are particularly at risk of suicidal ideation and rates of completed suicide seem manifestly high (Phillips, Coles et al., 2005; Phillips & Menard, 2006). They are therefore a particularly vulnerable client group at risk of serious morbidity and mortality.

The high shame component of BDD, coupled with its seeming prevalence in community and clinical populations and frequent comorbidity with other psychological disorders, point towards a definite need to check for appearance concerns and screen specifically for BDD. Counselling psychologists practice in a variety of settings and with a variety of client groups from both clinical and non-clinical populations. They are therefore well placed to raise awareness of this hidden disorder. Furthermore, comorbidities may mask BDD, complicating its diagnosis and treatment. It is of significance that the most common comorbidities found with BDD are disorders that counselling psychologists may frequently encounter in the course of their clinical work.

There is also the possibility of therapists encountering clients with subclinical symptoms of BDD who do not satisfy the criteria for a diagnosis, despite experiencing a poor quality of life as a result. It is argued that a good understanding of BDD is therefore necessary in order that counselling psychologists may be equipped to identify and treat symptoms of BDD in appropriate clients. Current treatment recommendations are CBT as the therapy of choice and drug treatment with SRIs. As counselling psychologists are liable to be involved in the treatment of BDD, and have suitable training and skills, they are well placed to offer the appropriate therapy for this disorder.

There is, however, a noticeably positivist emphasis throughout the literature with an approach to BDD firmly based on the medical model. Counselling psychology has an underpinning philosophy more allied with the human sciences and is therefore interested in subjective experience. Further studies of a qualitative nature would add to existing research in providing insight into BDD sufferers' experience of their condition and therapists' experience of working with these individuals.

In conclusion, this review has endeavoured to present a coherent argument supporting the need for counselling psychologists to be aware of and consider the hidden and secretive disorder of BDD in both clinical and non-clinical populations. Counselling psychologists have the opportunity to practice in varied settings, with diverse client groups and a wide range of mental health problems. Given the material discussed in the current review, it is not beyond the bounds of reason that they might encounter BDD in their practice at some point. For this reason, it is advisable for counselling psychologists to have an understanding of BDD.

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