Transgressing the skin: a phenomenological study into the transition to motherhood

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Abstract

The aim of this study was to illuminate the experience of early mothering for a small group of first-time mothers from the South of England in 2001. Central to this were the detailed descriptions, as recounted by the women, of the way in which they gradually adapted to being mothers.

In this phenomenological inquiry seven women shared their stories with me. The interview took place at a time and place of the women's choosing and they were asked to describe, in as much detail as possible, the way in which they had experienced "becoming a mum". Each woman took a unique and circuitous journey to mothering and their narratives were rich and evocative, revealing the complexity of the transformative process.

The data were analysed using a descriptive phenomenological approach, which revealed seven constituents contained within a general structure. Although the women interviewed provided notably contrasting descriptions, underlying and uniting their individual experiences was the general structure. This can be summarised as,

"Becoming a mother for the first time introduced some fundamental changes into the woman's manner of being in the world. Essentially, this concerned the development of a new becoming-a-mother-change-of-body subjectivity in which the woman was required to re-order her way of being in all its existential dimensions. The new mother sought to integrate and authenticate this challenging life event within her biography – she manifested both an openness to the beloved child and a resistance to the truncation of her existential possibilities."

This is not to say that the women all experienced the phenomenon in the same way, instead there were particular essential constituents through which each woman negotiated her transforming journey into motherhood. Some women assimilated these changes to their embodied self with ease, others struggled and resisted, feeling assailed and overwhelmed.

The seven constituents are:

- Welcoming the intimate stranger
- Anxious loving
- The baby fills her vision
- Acceptance: from crisis to comprehension
- Exhaustion, recovery and the physical body
- Relationships: re-evaluation and conflict
- Isolation, ambivalence and tears

The data also challenged mainstream understanding of postnatal depression as a discreet, diagnosable illness. Becoming a mother is a transition that compels women to make radical re-adjustments to every aspect of their manner of 'being-in-the-world'. It would be extraordinary if this did *not* cause significant levels of distress, dis-equilibrium and a sense of chaotic disorganisation. I propose that distress in early mothering is understood as a normal reaction to a significant life-changing event. Implications for clinical practice and further research are also discussed.

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1.0 Introduction

Despite the fact that many women in the post-industrial developed world aspire to live a life very different from their mothers and grandmothers, it is still the case that womanhood is regularly conflated with motherhood. Furthermore, motherhood is seen as requisite and normative, in so much as women 'opting out' are still considered to be following an 'unnatural' lifestyle. Childlessness is only rarely assumed to be a lifestyle choice and a 'lack' of children is usually interpreted as an 'enforced' state due to infertility, unless a different explanation is offered by the woman. This is confirmed by Woollett (1991) in her discussion of childlessness and the way in which motherhood granted women access to **"a world of female knowledge and experience and enables them to share a common identity."** (p55). Implicit within the assumption that motherhood and womanhood are interwoven is the promise of fulfilment. This belief was investigated by Weaver and Usher (1997). They interviewed thirteen mothers, whose eldest child was aged between 1 and 3, about motherhood and whether their expectations had been unrealistic or not. Their conclusions were not unfamiliar in so much that they revealed the way in which women's expectations of motherhood are rarely matched by the reality,

"The women were therefore disillusioned on two counts: firstly by discovering that motherhood had overwhelmed, rather than enhanced, their identity as women; but secondly by finding that the dominant societal discourses of motherhood were misleading." (*ibid.* p60).

To provide a balanced over-views of their study, it is important to note the positive elements of motherhood: the joy experienced by the women of watching their children grow and develop. The authors commented on the way in which the women sometimes 'stumbled' over their words when trying to express this love and gratification. They speculated that this might be explained by the **"benefits of motherhood** (being) **less tangible than the costs."** (p59). These themes along with others will be revisited below in considerable depth.

Forty years of feminist-led social change have presented young women with what appears to be a multiplicity of choices – in lifestyle, career, relationships and parenting. We are no longer constrained by traditional constructions of womanhood but it could be argued that the price paid for this freedom is a lack of coherence and a sense of 'displacement'. One of the ways that this incoherence is revealed is the way in which certain pervasive idealistic ideas about motherhood as a role and an institution remain unchallenged.

Although they may eschew motherhood until a little later in life, or plan to initiate egalitarian parenting arrangements from the outset, 'modern' women are still, on the whole, unprepared for the profound changes to their life that motherhood brings about (Parker 1995, Benn 1998, Maushart 1999, Miller 2005). Furthermore, almost all of them unwittingly strive to perpetuate the 'myth of motherhood' that they have absorbed from a multitude of sources since childhood. The discrepancy between what is experienced by women and what is prescribed and disseminated about motherhood is often so

inconsistent it is no surprise that the majority of women experience the transition to motherhood as traumatic, vexatious, isolating, exhausting and boring (Parker 1995, Barclay & Lloyd 1996, Chesler 1998, Figes 1998, Aiken 2000). At the same time, the unconditional love of a child, the sense of profound connection to a new baby adds a further dimension to the experience – that of deepest joy and love.

Into this experience, unprepared and idealistic, countless women are thrown at the moment of birth. With all the panoply of midwifery, obstetric and health visitor advice as well as popular advice books, magazines and celebrity articles on how to mother and still maintain a spotless home, slim figure and satisfied husband, they invariably fail to adapt easily to their new role (Leach 1988, Marshall 1991, Leach 1994, Ford 1997). Instead they struggle with the disjunction of mothering as biological, natural and immutable and mothering as socially constructed, circumscribed by experts and resistant to re-interpretation.

However, although universal, motherhood is also distinctly personal. The aim of this study was to find out from a few women, in as much detail as they were prepared to provide, what it was like for them to become mothers. Furthermore, I sought to identify certain aspects of the transition to motherhood that were possibly experienced by all women (in the post industrialised developed world) becoming mothers for the first time – albeit with limitless variation and intensity. This was a tentative aim because success or failure did not depend on being able to establish immutable conditions within which the phenomenon of becoming a mother was circumscribed. Success was to be achieved by

immersing myself in the descriptions provided by the women and building up an accurate picture of their day-to-day lives with a new baby. They were not questioned about any particularities, for example whether they considered themselves to have suffered from postnatal depression (PND) or if having a baby had effected any sexual relationship they had. It was for them to guide the research process, to shape the narrative as they chose and through this process to reveal what was important to them in the process of transition rather than what was important to me, as a researcher.

The narratives were analysed using a descriptive phenomenological approach and the results of this (known as the 'general structure' of the phenomenon) contributed to further discussion and critical examination of the complex nature of becoming and being a mother. Alongside this, the status of PND and the efforts made to understand and resolve it are investigated and a new embodied theory is proposed that re-positions symptoms of PND as intrinsic to a normal transition to motherhood and not abnormal and requiring treatment. I should emphasise that at no point am I advocating a total rejection of traditional medical treatment for severe depression and/or puerperal psychosis.

As the study evolved and in order to 'delve deeper' into the women's embodied response to the birth of their first child, I turned to an ontological understanding of the way in which individuals dwell in the world and then struggle to articulate an authentic representation of their experiences – drawing particularly on the work of Maurice Merleau-Ponty and Medard Boss.

This study commences with a literature review, examining the history of our traditional understanding of the transition to motherhood as well as factors which are thought to make early mothering more difficult.

2.0 Literature review

2.1 Preliminary concerns

There can be little doubt that becoming a mother presents women with an array of emotional, physical and psychological challenges, which are in turn inextricably entwined with fundamental changes to their social and personal identity (Richardson 1993, Brown *et al.* 1994, Figes 1998, Woollett & Nicholson 1998). Affonso and Arizmendi (1986) declared that after the birth of her baby, a woman's whole being has to undertake inevitable adjustments that may have serious implications for her ability to function. All women who give birth to their first baby have to negotiate this transition and the range of reactions to motherhood varies immensely.

There seems to be general agreement amongst primary care providers and researchers that 10-15 percent of women will *not* maintain their mental health following childbirth (Pitt 1968, Manley *et al.* 1982, Watson 1984, Cox *et al.* 1987, Cox *et al.* 1993, Cox 1996, Holden 1996, Littlewood & McHugh 1997, Thorpe & Elliott 1998). In one of the earliest (and seminal) research projects, Pitt (1968) carried out a prospective study with a large random sample of women using questionnaires and interviews. The questionnaire was completed by 305 women, on or about the 28th week of pregnancy who were then followed up through to the late puerperium (period of time following the birth). Women whose scores suggested that they might develop depression were then interviewed as were a random sample of those whose scores did not indicate depression. The questionnaire addressed whether they became depressed after the birth and what differentiated those who became depressed from those that did not. The incidence of

depression in the 6-8 weeks after birth was found to be 10.8%, approximately six times greater than Pitt had expected. He also reported the depression as *atypical* in that neurotic symptoms (not usually seen in depression) were present such as irritability and anxiety but classic symptoms such as suicidal thoughts and worsening of depression in the morning were only present in *one* woman who was admitted to hospital for treatment. Otherwise the women did not report feeling suicidal or that their depression deteriorated when they awoke.

O'Hara & Swain's (1996) meta-analysis of 59 studies of PND, which included 12,810 women, found an average prevalence rate of non-psychotic PND of 13%. Included within their meta-analysis were women assessed by validated psychiatric interviews and self-reporting questionnaires. However, the widespread use of this figure of 10-15% both within academic papers and popular articles conceals the dissension and contradictory positions and arguments defended by researchers investigating the postpartum experience. Distress after childbirth is usually divided into three categories: the 'blues', PND and puerperal psychosis. However these classifications can lack clarity and PND seems to have become the blanket term utilised by maternity care providers and 'lay-persons' alike to explain all female discontent after childbirth (Ussher 1989). According to Nicolson (1998), PND no longer needs to be defined or explained as, even without a coherent definition or clear aetiology, it has become an accepted part of female life.

In his major work on motherhood and mental health, Brockingham (1999) advised that the scientific value of the concept PND be treated with scepticism. He scrutinised the

many divergent reactions to motherhood and concluded that the psychopathology of the postpartum period takes many forms, of which he delineated twenty different disorders. These were discussed in detail under the headings: psychoses of early onset, the 'maternity blues', stress reactions, anxiety, obsessional disorders and depression, with a further complete chapter examining puerperal psychosis (*ibid.* p135-284). Aside from disagreements about definition and classification of postpartum distress, there is lively interdisciplinary debate regarding the way in which women react to the birth of their baby. Frequently posed questions are: is the cause of PND (used as a blanket term at this point) hormonal, a consequence of obstetric intervention, social inequalities, lack of support and isolation, a continuation of low antenatal mood or a symptom of the endemic discrimination experienced by women in society? Or is it a realistic response to the life event of birth and to the stress of being a mother? Is it possible to predict who is at risk and how sensitive are the available screening tools? What is the most effective 'treatment' – medication, social support or psychiatric/psychotherapeutic input or should women be 'taught' that becoming a mother is a tumultuous time and a degree of low mood is to be expected? Before expanding on and critically appraising these arguments, it will be useful to understand the context of mothering and a necessarily selective history of the research into how women adapt to their new role.

In English speaking countries, motherhood occupies a contradictory position within the national psyche (Homans 1994, Kitzinger 1994, Barclay *et al.* 1997, Roiphe 1997, Benn 1998). On the one hand it is *not* a role that is held in high esteem as it represents a withdrawal of social and economic status for women (Lewis & Nicolson, 1998).

Government policy aimed at encouraging both parents to work (Working Family's Tax Credit, extended school hours and holiday clubs) does little to contradict the belief that a woman who is 'just a mum' is not contributing anything of quantifiable value to society. On the other hand, motherhood is seen as obligatory and synonymous with achieving both full adult status (Woollett 1991) and the purest form of feminine expression and completion. Women are expected to be **"carers and nurturers"** rather than **"producers and achievers"** and motherhood is fundamental to this assumption (Ussher 1990, p77). Society is inundated with idealised images of perfect mothers and idyllic mothering – in literature (particularly popular fiction but also in 'advice and guidance' books) on television, in the media and in the arts, resulting in many women struggling to untangle the myth from the reality and lamenting their failure to achieve impossibly high standards of mothering (Oakley 1980, Barclay & Lloyd 1996).

2.2 New parenting as a 'crisis' event

In many ways, contemporary women are as unprepared for motherhood as they were fifty years ago when LeMasters (1957) concluded that new parents experienced the birth of their first child as a *crisis*. The idea of crisis within the context of parenting was based upon Hill's (1949) theory that the addition of a family member was experienced by married couples as a crisis in their relationship. A crisis point was defined by Hill (1949) as a moment of profound change, when established ways of behaving are suddenly found to be deficient and new attitudes and responses are urgently required. The parents in this early research spoke of feeling unprepared and being 'taken in' by unrealistic romantic images of motherhood and family life. Reflecting on informal conversations I have had

with other mothers prior to this study, a sense of shock and *unpreparedness* is often discussed, as well as being present in contemporary research and mainstream books and articles (Nicholson 1988, Brown *et al.* 1994, Parker 1995, Chesler 1998, Figes 1998, Maushart 1999, Aitken 2000).

LeMasters (1957) conducted unstructured, joint interviews with a non-probability sample of forty-six urban middle-class white couples whose first child had been born within the last five years. A five-point Likert-type scale was devised to measure the extent to which parents experienced the birth of their first child as a crisis: 1) no crisis, 2) slight crisis, 3) moderate crisis, 4) extensive crisis, 5) severe crisis and the appropriate designation was arrived at through discussion between the researcher and interviewees. In the light of modern day standards, the paper appears to lack detail. There is a paucity of explanation as to the process of developing the Likert-type scale, the way the crisis scores were reached and how any differences between the women and their husbands were reconciled. There was a high risk of bias as the hypothesis was proposed by the author who then carried out the research with his wife's assistance. However, putting aside these limitations, and in the light of more contemporary research, it is important to consider these findings carefully. Eighty-three percent of couples were found to have experienced "extensive" or "severe" crisis in adjusting to parenthood with mothers identifying the following problems: chronic tiredness and sleep deprivation, relentlessness of caring for a baby, loss of job and curtailing of social contact, extra housework as well as an overall decline in the standards they considered they maintained, and concern about their physical appearance.

Dyer (1963) sought to replicate this research with a non-probability sample of 32 urban middle-class white couples whose first child had been born within the last two years. A Likert-type crisis scale was used and items for the scale were drawn from aspects of family life upon which the birth of a baby might be expected to have the greatest impact (Dyer 1963). Crisis scores were calculated as the average of the summed items for each couple and then plotted on a five-point continuum to represent their level of crisis (see LeMasters 1957, above). Dyer's results were similar to LeMasters but overall reported a reduced degree of crisis. The majority of the couples (66%) in Dyer's study (1963) experienced either moderate (38%) or extensive crisis (28%). A total of 87% of the women reported one or more severe problems including exhaustion, feeling unable to fulfil the maternal role and that mothering was an 'anti-climax'.

The omission of minority ethnic groups and working class women from studies of 'ordinary' life experiences may have been partly deliberate. The reason may have been because minority groups were not thought capable of providing examples of *typical* behaviour (Phoenix 1991, Phoenix & Woollett 1991) or perhaps because academics have been known to rely on samples of opportunity. For example, Phoenix (1990) suggests that in the past the women who were invited to take part in research lived in pleasant housing relatively close to academic institutions, were home during the day and not averse to having researchers in their home. These factors often resulted in an over representation of white middle class mothers in early research.

Later research produced notably less negative responses. Hobbs (1965) carried out research similar to LeMasters (1957) with a random sample of 53 urban lower and middle-class couples whose first child had been born recently (mean age 9.8 weeks). Items on the checklist were selected mainly from LeMaster's (1957) report of difficulties described by new parents, as well as some input from other health professionals' suggestions. Results indicated that 70% of the women and 91% of the men were *more* satisfied in their relationship with their partner since the birth of the baby and none of the couples had experienced "extensive" or "severe" crisis – the majority (86%) described periods of "slight" crisis and the rest moderate.

It seems to be the case that discussion of the disparity between Hobbs' (1965) results and LeMaster's (1957) are conducted in a cautious tone with Hobbs expressing frank surprise that his results did not mirror those of LeMaster's. Hobbs suggests that the disparity may be caused by the timing of the research [his couples were questioned during the **"baby honeymoon"** (*ibid.* p371), before the elation has deteriorated to crisis. Or possibly, parents were reticent about expressing negative feelings towards their new baby]. Class differences were also considered but a sub-analysis of the results of the 13 couples in which fathers were college graduates did not indicate an increased level of crisis. He concluded by advising a **"return to the drawing board"** (*ibid.* p372) and his 1968 paper refers to his initial investigation as *failing* to support the hypothesis that adjusting to the first child was experienced as a crisis. To verify his results he repeated his research in 1968, administering both the 23 item check list and a structured interview to a random sample of 27 couples (mean age of child 23.8 weeks) and following these results wrote

with greater confidence that **"neither checklist nor interview data indicated that beginning parenthood was a severely stressful experience as earlier studies suggested"** (*ibid.* p417). In this second study (Hobbs 1968) the 23 point checklist was enhanced by the addition of interview material rated by independent judges using a four point scale ('extensive crisis' having been omitted to increase the discrimination of the judges). The results confirmed a low level of crisis with 18 of the women reporting slight crisis and the rest moderate. Mean crisis scores by the checklist were almost identical in the two studies, although when classified according to interview data, five of the mothers demonstrated 'severe' crisis. However as Hobbs pointed out, over 20 mothers experienced no more than 'moderate' crisis regardless of whether checklist scores or interview ratings were employed.

In their 1976 paper Hobbs and Cole reviewed relevant research and concluded that the transition to parenthood may not present new parents with as many difficulties as at first anticipated. They then repeated Hobbs' (1965) research with 65 couples completing the same questionnaire. Overall, mean crisis scores were nearly identical to Hobbs (1965) and in searching for variables related to difficulties adjusting to a first child, none were statistically significant for women.

Hobbs and Wimbish (1977) used the same methodology and examined the transition to parenthood for 46 black couples and also generated comparable results to Hobbs (1965, 1968, 1976). In all these studies the majority of couples experienced a "slight" crisis -

although the mean crisis score for the women was consistently higher than that of their partners'.

The disparity between the results is interesting and raises questions as to the suitability of a crisis model for research into parenting experiences. I would argue that a crisis framework was restrictive in its approach to the subject. One would have to consider the possibility that the interviewees would have been influenced by what they perceived as the researcher *suggesting* that new parenthood was experienced as a crisis. Hobbs (1976) concludes that it may be time to move from a crisis orientation to a more comprehensive approach and instead investigate parent's *experiences* with their first child. Had the interviewer in the earlier research asked the question, "How did you experience becoming parents?" then the respondents may still have chosen to use to word 'crisis', or perhaps a different concept all together. It is also possible that middle class parents were not able to rely on a local extended family and that they found the birth of their first baby more disruptive than parents from different social groups. When the research was repeated a decade later, it is possible that parents had developed more realistic expectations. However, descriptions of crisis-like situations *are* still present in much contemporary research into women's experiences of mothering, as will be demonstrated below.

2.3 'Transition' to parenthood instead of 'crisis'

In her structural analysis of the parental role cycle Rossi (1968) proposed that **"the time is ripe"** (p28) to discard the concept of 'normal crisis' and replace it with the notion of a

"transition to parenthood". She maintained that the idea of a 'normal crisis' is incongruous, **"If the transition is achieved and if a successful reintegration of personality or social role occurs, then crisis is a misnomer."** (*ibid.* p28). She continued with her argument, that this concept of 'normal crisis' implies successful outcome, thus diverting attention from **"the deviant instances when failure occurs"** (*ibid.*). She proposed a conceptual system, based upon the stage-task concepts of Erikson, which can accommodate both successful and unsuccessful transitions to parenthood..

2.4 Relationship tension following parenthood

Tomlinson and Irwin (1993), Belsky and Kelly (1994) and Hock *et al* (1995) found that the demands of parenting caused considerable stress to both women and men and that parents reported a marked deterioration in their relationship. However, Feldman & Nash (1984) carried out a short-term longitudinal study involving 31 middle-class firsttime mothers and their husbands. They were interviewed during their pregnancy and again when the baby was six months old. They completed a variety of self-assessment instruments and a lengthy interview. Although the interviewees acknowledged significant stress levels, this did not detract from their overall optimism and enthusiasm for parenthood. The women's expectations of parenthood were inconsistent with their experiences as parents. They thought they would be 'very good parents' and that the baby would cause only minor disruption. Tomlinson and Irwin (1993) collected data from 16 first-time mothers during pregnancy and then at four months, one year and four years. They used both standard measures and an intensive semi-structured interview to assess patterns of family adaptation following the birth of a first child. Spanier's Dyadic

Adjustment Scale (Spanier & Thompson 1982) was used to measure marital satisfaction and over the four years was shown to be significantly ($p < .001$) reduced and closely resembled scores achieved in distressed marriages (*ibid.*). The authors make the point that a causal relationship should not be assumed as the results suggest a complexity of factors impacting on the couple's ability to adapt successfully to being parents. They concluded that new mothers face a multiplicity of problems, only one of which is adapting to their new role. The stress they experience is mediated in part by gender and marital role and exacerbated by unemployment, financial worries and their partners' "anti-social behaviour".

Traditional gender roles seem to become more polarised following the birth of a baby, thus potentially leading to further conflict and considerable frustration on the part of the woman. Gjerdingen and Chaloner (1994) carried out a longitudinal study to investigate the changes in the division of household labour as well as the emotional and practical support offered to new mothers. Questionnaires were completed by 436 married, recently employed first time mothers at one, three, six, nine and 12 months postpartum and results indicated that women assumed primary responsibility for household tasks and that their husband's contribution was perceived to significantly diminish as time passed ($p < .05$ to $.001$). Women who returned to work relatively quickly believed their husbands demonstrated greater willingness to perform household tasks than those women who remained at home. These findings support the earlier work by Pridham and Zavoral (1988) who interviewed 49 mothers about the support they received with childcare and housework during pregnancy and three months postpartum. They discovered a reduction

in assistance provided by both the baby's father and the grandparents. Rexroat and Shehan (1987) carried out a cross-sectional study of 1618 couples comparing the divisions of labour in households with and without children. The male partners in the childless group spent more time performing household tasks while those with children contributed the least (reducing further as the children grew older). Conversely, the women devoted more time to housework as the children grew older (23-33hrs compared to 18hrs per week).

2.5 Maternal adaptation and role attainment

It is frequently acknowledged by mothers, social scientists and researchers alike, that early motherhood can be stressful, exhausting, chaotic, frustrating and overwhelming as new mothers are forced to confront enormous psychological and social upheaval. This results, at least temporarily, in a loss of self (Mercer 1986, Ruchala & Halstead 1994, Sethi 1995, Barclay *et al* 1997). Furthermore there is the surrendering of personal freedom and individual identity as well as a re-defining of both the women's social role and inter-personal relationships (Percival1990, Gjerdingen & Fontaine 1991).

The thirty-six women who took part in Lewis and Nicolson's (1998) study (see above) into women's experiences of mothering and the transition to motherhood, spoke clearly of their sense of *loss* of their identity and independence. Suddenly being defined in relation to their children, they felt as though they had become invisible to family and friends, as well as society at large (*ibid.* p184). The results of two studies were discussed concurrently to demonstrate the way in which medical/clinical discourse on PND sets the

parameters within which women struggle to organise their subjective experience of motherhood. In one study women were interviewed several times during their pregnancy and up to six weeks postnatally and in the second study, mothers were interviewed and asked to reflect upon their experience of mothering. What became clear was the way in which the women rejected the notion of PND as inappropriate as it was thought by some of the women to imply a significant problem, whereas the difficulties they experienced were 'every day' problems and were dealt with within that context. The women described experiences that revealed the failings of the predominant discourse on mothering - the idealised, non-problematic version of motherhood they had been expecting as compared to the reality. They also described the way in which motherhood precluded them from the public world of work and confined them to the private sphere of the home where motherhood was generally considered to be synonymous with a loss of power and status.

Rubin (1967a, 1967b, 1975) developed a theory of maternal role attainment to better understand the psychological processes through which women successfully acquired a particular adult role and become, in this case, 'competent' mothers. The study design was that of **"biological field studies of function in living organisms"** (Rubin 1967a, p237) and took place in two American university hospitals. Primiparas (first time mother) and multiparas (women with subsequent babies) were observed to assess their maternal skills and behaviour as well as participating in one or two interviews during their pregnancies and the postnatal period, while five primiparas and four multiparas took part in multiple interviews. Rubin concluded that this process of **"taking into herself the task and**

process of becoming a mother" (*ibid.* p239) required the women to reorganise their interpersonal relationships, 'construct' a new identity and acquire a higher level of maturity and that this was achieved in four developmental stages. This began with a successful outcome to the pregnancy and birth, followed by the baby being welcomed and nurtured by significant others. The third stage was 'binding into' the baby and finally giving of herself to the child.

Mercer (1981, 1985, 1986) also used the phrase "maternal role attainment" when examining the many new tasks mothers needed to accomplish to enable them to respond to their baby's needs, as well as restructuring their relationships with significant others, thus enabling them to 'receive' a new family member. Two hundred and ninety four women were recruited to take part in her study to determine the process of maternal role attainment over the first year of motherhood and were grouped according to their age (15 to 19yrs, 20 to 29yrs and 30-42yrs). Subjects met with the researcher four times, during which both questionnaires and a semi-structured interview were completed. Mercer described maternal role attainment as the **"...process in which the mother achieves competence in the role and integrates the mothering behaviours into an established role set, so that she is comfortable with her identity as a mother."** (Mercer 1985, p198). This sense of a psychological 'journey' can provide an interesting starting point for research into the postnatal experience. The women had to move from learning what is expected of them as mothers, to seeking advice from professionals and role models, developing their own sense of appropriate behaviour within the mothering role, to finally feeling confident in relying on their own competency. These adjustments are both

physically and emotionally demanding, and are exacerbated by the women struggling to recover from the physical demands of the birth (Mercer 1986). The challenges that were most frequently referred to by the new mothers were their lack of personal time, feelings of incompetence, interrupted sleep patterns and the perpetual responsibility of a baby. At the third interview conducted when the baby was eight months old a new difficulty arose: the mothers reported feeling less competent in their role and experienced more negative feelings towards the baby which coincided with the child manifesting problematic infant behaviour.

Fowles (1998) examined the relationship between postpartum depressive illness and maternal role attainment. One hundred and thirty six first time mothers living in Illinois returned questionnaires 9-14 weeks after birth. PND was measured using the Edinburgh Postnatal Depression Scale (EPDS) (Cox *et al.* 1987). Three scales of maternal role attainment were also used. Elevated scores on the EPDS, signifying that the women may be at increased risk of PND, demonstrated a significant negative relationship to all measures of maternal role attainment. Fowles (1998) concluded that all women should be screened for PND as accurate diagnosis and swift treatment could improve women's ability to communicate effectively with their babies and enhance the mother's self image.

2.6 Emotional well-being in mothers

It is not unusual for studies examining the emotional wellbeing of new mothers to focus on depression or poor emotional wellbeing, in other words, 'problematic' reactions to mothering rather than 'normal' mothering (Ussher 1989, Thorpe & Elliott 1998). A considerable majority of this research used quantitative methodologies in which standard

assessments of mental health, or more recently, screening tools *specifically* designed to identify those at risk of PND, were administered. These were usually in a questionnaire or structured interview format. Research related to PND will be examined in greater detail below but before turning to this section it is important to consider certain factors that have been found to influence the way in which women respond to motherhood. Overall these factors are covered by one of two theoretical perspectives – the psychoanalytical perspective that emphasises the individual and their internal character traits as being of primary significance and the social perspective that takes greater account of the socio-political framework and the way in which this has defined the mothering role.

There is growing evidence to suggest that women's emotional wellbeing during their pregnancies may be predictive of their state of mind after the baby is born (Green 1990, Evans *et al.* 2001, Josefsson *et al.* 2001, Austin & Lumley 2003). Green (1990) recruited 825 women for her study investigating the possibility of correlations between antenatal and postnatal mood. They were asked to fill in a questionnaire four weeks before their babies were due and then six weeks after the baby was born. Questions to assess emotional wellbeing were based on the EPDS. She concluded that antenatal mood is a significant determinant of postnatal emotional wellbeing (as well as women's subjective reports of their labour). However, the women's social/economic status was not relevant to dysphoric mood. Evans and colleagues (2001) also carried out a longitudinal study, using prospectively gathered data from 13799 women (all women resident in Avon, due to give birth during a specific time period). The women completed the EPDS as part of a series

of postal questionnaires, administered at 18 and 32 weeks of pregnancy and at 8 weeks and 8 months postnatal. Their results revealed that the women had higher scores on the EPDS in pregnancy than postnatally and they concluded that depression is no more likely after childbirth than during pregnancy. Buist (2003) agreed with this and declared that, although it must not be considered in isolation, the most powerful predictor of PND is current antenatal depression. In Green and Murray's study (1996), approximately 9000 women were assessed using the EPDS at 18 and 32 weeks gestation and 8 and 32 weeks postpartum. Of the women who had scored above the cut-off point of 12 on the EPDS antenatally (and were therefore considered to need formal assessment for depression) 38% had fallen below the threshold postnatally (at eight weeks). The authors concluded that whilst the birth of a baby *may* precipitate the onset of depression in some women, birth can also be experienced as a positive, life-enhancing event that can lift the new mother out of a depressed state. However, there is a strong correlation between antenatal and postnatal mood and although the former may predict the latter, it is also of interest and concern in its own right (Green & Murray 1996).

2.7 Personal characteristics and adapting to motherhood

The way in which women respond to being pregnant and becoming mothers may be influenced by their personal characteristics (Pitt 1968, Playfair & Gowers 1981, Percival 1990, Younger 1991). Thorpe and Elliott (1998) reviewed seven papers examining the relationship between scores on standardised assessments of personality and the emotional wellbeing of mothers in the first year postpartum. A consistent finding was that women who attained high scores for neuroticism and/or trait anxiety were more likely to

experience depression after childbirth. Younger's (1991) study of 101 mothers of six to eight week old babies used several assessment scales to measure parenting stress. She confirmed that 'personality strength' was protective in stressful situations, including becoming a parent. The prospective study carried out by Boyce *et al.* (1991) involved 141 non-depressed women, expecting their first baby and in a secure relationship, completing two personality assessment questionnaires - once antenatally, and several times postnatally. The results found that women who had a high level of neuroticism had a three-fold increased risk of suffering from PND and women with high interpersonal sensitivity had a tenfold increased risk of suffering from PND.

2.8 Implication of social factors in the transition to motherhood

Brown and Harris' (1978) study into the social origins of depression involved a large sample of women living in a south London community and concluded that women from lower economic groups are more liable to suffer from depression and low self esteem. However, research that enquired into a possible relationship between social circumstances and *maternal* dysphoria has provided inconsistent results. Studies that supported the hypothesis that social disadvantage (in several guises) was associated with women suffering from PND were sometimes tentative in their claims (Playfair & Gower 1981, Feggetter & Gath 1981, Thorpe *et al.* 1991, Seguin *et al.* 1999) and have been challenged by studies that found no association (O'Hara *et al.* 1984, Green 1990).

Playfair and Gower (1981) aimed to identify possible risk factors that might predict PND. They recruited 618 women for their study who were interviewed four times during

pregnancy and afterwards by their family doctor. They concluded that the most important risk factor associated with PND was external stress in the immediate postnatal period – particularly marital difficulties, housing problems and maternal ill-health. Arguably, women from disadvantaged backgrounds are more likely to struggle with these factors. Seguin and colleagues (1999) recruited 68 primiparous women into their longitudinal study to assess the impact of stressful life conditions on the onset of PND. Questionnaires were administered to assess depressive symptomatology, social stressors, social support and how the women perceived their babies' behaviour. They were administered antenatally and at three and nine weeks and six months postpartum. At six months postpartum, 38.2% of the women were found to be screening positive for depression and the authors concluded that **"chronic stressors and inadequate social support have a clear association with late postpartum depressive symptoms."** (p160).Moreover, first time mothers, with low socio-economic status were more likely to be depressed at six months postpartum than at two.

Feggetter and Gath (1981) carried out a two stage cross-sectional community study in which mothers of one year old babies in Oxford (n=820) were screened using the General Health Questionnaire. The second stage was the interviewing of a sub-sample of 71 with probable psychiatric disorder and 71 probable non-cases. The overall prevalence of non-psychotic psychiatric disorder a year after birth was estimated to be 19.7% and possible aetiological factors were being a single parent, being young and of lower social class. Thorpe and colleagues (1991) in a sample of 13,135 women, five years after the birth of a child, found that women in social class IV and V were twice as likely to report depressive

symptoms than women in higher social classes. O'Hara and colleagues (1984) followed a sample of 99 women from pregnancy until nine weeks after the birth. Their psychological wellbeing was assessed using a variety of psychometric measures. Although a history of depression, antenatal depression, obstetric risk factors and childcare difficulties were implicated in the diagnosis of postnatal depression, social disadvantage was not found to be a risk factor. The authors did acknowledge that this was at odds with other research into contributory factors for PND.

O'Hara & Zekoski (1988) undertook a meta-analysis of thirteen research papers on PND, only two of the papers reported any relationship between social status and PND. However, when research findings seem to be incompatible, differences in methodology, definition and timing may have been the cause. For example, the ways in which social status was assessed, whether by the woman's occupation, her educational achievements or her partner's occupation, the timing of the study and the size and composition of the group of women studied would have been key factors in effecting the results (Thorpe & Elliott 1998). As women negotiate motherhood, certain obstacles that were initially experienced as insurmountable are often overcome and as such, become less important and less likely to be recalled during the research interview. So the timings of the interviews and whether they are one-off or repeated are particularly pertinent. Likewise, the way in which emotional well-being is defined and who defines it (the woman or the interviewer) and how it is measured – by the administration of a questionnaire or an interview; either face to face, by telephone or by post - will influence the findings.

2.9 Life events

Critical 'life events' such as the death or serious illness of a partner or significant other, accidents, moving home and bad news precipitate the experience of depression (Brown & Harris, 1978). Of interest is a consistent body of research demonstrating an association between such events and reduced emotional wellbeing after childbirth (Playfair & Gowers 1981, Cutrona 1984, Thorpe *et al.* 1992a, 1992b, Thorpe & Elliott, 1998). Combining these findings with the fact that women living in poor housing on low incomes, possibly as unsupported single parents (Kitamura *et al.* 1993, Webster *et al*, 1994) are arguably more vulnerable to the life events outlined above, as well as being more likely to suffer poor physical health (Graham 1984), one can see why they are at a greater risk of suffering from depression and poor emotional wellbeing, both generally and after the birth of a baby. Webster and colleagues (1994) screened 206 European and Maori women in New Zealand for PND at four weeks postpartum (specific numbers of Maori and European women are not specified). Their results revealed that single women, less than 20 years old, in a dysfunctional relationship were more likely to screen positive. Maori women were found to be at greater risk of depressive symptoms and the authors highlight this group's social and educational disadvantage.

One could speculate that women from more affluent social groups might have access to material resources to cushion the impact of negative life events with varying degrees of success. However, this is not to suggest that middle class professional women are less likely to struggle with the transition to motherhood, rather that their problems may have different contributory factors, which will be discussed in greater detail below.

2.10 Social support

Perhaps not surprisingly, a dependable, supportive social network is believed to be important in ameliorating the negative aspects of adapting to life with a new baby. Family and significant others can significantly reduce the practical burden during this time. Seguin and colleagues (1999) found that a supportive social network could alleviate to some degree, the depressive symptoms experienced by new mothers from low socio-economic backgrounds. Webster and colleagues (2000), in their study involving 901 pregnant women, sought to investigate the impact of social support during pregnancy, on symptoms of postnatal depression, as measured with the EPDS. Their results revealed that women with low social support in pregnancy were more likely to report poorer health postnatally ($p<0.001$) and to be more depressed ($p=0.0001$). However, Thorpe and Elliott (1998) highlight the crucial distinction between social *network*, defined as the availability of social contact and functional support, and social *support*, whereby women have access to their close friends and family with whom they can share experiences, disclose their problems and seek advice. Morrell *et al.* (2000) aimed to measure the effect of providing postnatal support by a maternity support worker (MSW), based on a Dutch model of care. During this randomised control-led trial 623 newly delivered women (numbering 623) were offered ten visits lasting up to three hours per day in the first 28 days postnatally. The MSW could help with household tasks, chat with the mother and provide care for the baby and siblings. The control group of women were not offered this support. The research hypothesis was that such support could reduce the risk of PND and encourage women to continue breastfeeding. Although the women spoke highly of the service, there

was no evidence of any health benefit at the six week or six month follow-up and no differences in the use of NHS services. It is interesting to note that the intervention appeared to have a negative effect on the women's assessment of their partner's involvement in the postnatal period.

This study appeared to illustrate the way in which providing *functional* support alone failed to satisfy the needs of new mothers. Sympathy and understanding from a caring partner, friend or relation with whom they could simply 'be themselves' appeared to provide women with some protection and relief from the negative aspects of new motherhood and promoted their emotional wellbeing (Cutrona 1984, Brown *et al.* 1994, Parr 1996). Parr (1996) identified the woman's partner to be the most significant source of emotional support particularly when families are geographically dispersed. In Brown and colleagues (1994) extensive study (see below) the women who took part spoke with resignation and exasperation about the lack of practical, home-based support provided by their partners. Partners who did take a more equal part in childcare and housework were appreciated by the women and felt to contribute to a reduction in their dysphoric mood.

2.11 'Working' mothers

The 'absence' of 'working mothers' from the traditional setting of the home is often portrayed by certain factions of the national press and by conservative social commentators, as contributing to delinquency in children. Many mothers, on their return to paid employment report increased self-esteem, personal gratification and fewer symptoms of depression. However, they remain, on the whole, largely responsible for

running the home and arranging childcare and are often sidelined for promotion and struggle with feeling of guilt at not being at home, a lack of time and exhaustion (Cowan & Cowan 1992, Brown *et al.* 1994, Maushart 1999). In Aiken's (2000) book about 'surviving' PND, some of the women who shared their stories spoke clearly about the value of returning to work,

"Although I was still suffering from postnatal depression at this time, the hours away from my 'real life' helped me on to the road of recovery and gave me back some much needed independence and mental stimulation." (*ibid.* p136).

In the extensive study undertaken by Brown and colleagues (1994) 790 women completed questionnaires when their babies were seven to nine months old and out of those, 90 women took part in in-depth interviews when their babies were approximately two years old. The aim of this study was to obtain a representative picture of what women living in Victoria, Australia thought about maternity care as well as their experiences of pregnancy, birth and motherhood. Forty-three of the 90 women were in paid employment at the time of the home interviews and 18 others had been employed at some time since the birth. The majority of the women described working as improving their self-esteem, confidence and sense of identity and it was clearly a crucial part of their lives. However, the extracts revealed that the women frequently struggled with accepted ideas of the 'good' mother who devoted all her time to her children, while at the same time enjoying increased emotional wellbeing when they have time away. Just under a third of the women who had returned to paid employment expressed considerable

ambivalence about being separated from their children, **"Well, I love the work. When I get there I love it. The only negative aspect of working is leaving the kids...I just worry about them."** (*ibid.* p217). However, only three of the 43 women who were employed said they would rather be at home so it would appear on balance that the positive aspects prevailed.

2.12 Hormonal influences in the postnatal period

Dalton (1980, 1984, 1985) has, over the years vigorously defended her position that PND is caused by hormonal fluctuations during pregnancy and the puerperium. She argued that progesterone is of paramount importance and following the expulsion of the placenta the supply of this hormone is abruptly suspended. She speculated that certain women are particularly sensitive to sudden fluctuations in hormone levels and are consequently at risk of developing PND. She identified several risk factors that predisposed women to suffer from PND. These were, immediate female relatives who have suffered with PND, being between 20 and 30 years old and already suffering from premenstrual syndrome and/or PND after a previous birth and feeling 'on a high' and in excellent heath as the pregnancy comes to an end, particularly if the pregnancy had threatened to miscarry. She (1980) advanced the theory that PND may develop into premenstrual syndrome in some women and could then persist until the menopause.

Dalton's recommended treatment involved the administering of varying doses of progesterone from birth until two months postnatal, or until the resumption of menstruation. Progesterone can also be used in conjunction with anti-

3.0 Postnatal depression: some thoughts on definition

Brockington (1999) in his comprehensive review of motherhood and mental health, argued that the psychiatry of childbirth is probably more complex than any other human situation.

"Childbirth is a complex event, packed with somatic and psychological incident. It is a period of rapid biological, social and emotional transition. It is a social and psychological crisis, requiring intrapsychic adaptation and interpersonal reorganisation, especially after the first child." (*ibid.* p138).

It is interesting to note that Brockington (1999) used the word 'crisis' in the above quote but unlike LeMasters' (1957) paper it is not the principle defining concept of childbearing but instead is one of several, utilised to evoke the tumultuous nature of the transition.

Brockington (1999) suggested that approximately half of newly birthed women will experience a transient phase of emotional lability or sadness a few days after parturition, known as the 'blues'. At the other extreme, some women, especially those with their first baby might possibly develop severe anxiety, which he called 'puerperal panic' or if they had suffered severely during the birth they might possibly suffer from post-traumatic stress disorder, although the evidence for this was very limited. For example, Green *et al.* (1988) found that the wellbeing of women following the birth was *not* related to the

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intervention itself but instead to their perception that the 'right' things had happened, along with an appropriate explanation as to the reasons behind the decision/advice. Cartwright and Murray (1993) concluded that overall, a traumatic birth was not related to PND although a previous history of obstetric intervention *did* increase the risk of PND after a current pregnancy and birth.

Approximately 1/1000 women will be diagnosed with puerperal psychosis with an onset during the first two weeks and this will manifest as manic or cycloid disorders. Other mothers develop melancholia or delusional depression. Thus postnatal depression includes a portfolio of about twenty different disorders and may envelop the new mother temporarily or for many months following the birth (Brockington 1999).
Although the refined classifications outlined by Brockington (1999) provide essential diagnostic detail, 'postnatal depression' (PND) has become a universally recognised label. It has come to be defined very broadly - as depression that occurs after birth, during the first twelve months of motherhood, a definition that is now so familiar it has entered the vernacular and is used by midwives and other providers of primary care, researchers, feminist academics, the media and of course mothers (Pollock *et al.* 1980, Hopkins *et al.* 1984, Whiffen 1992, Nicolson 1998).

Hopkins *et al.* (1984) took issue with the apparent failure of the scientific community to adequately distinguish between maternity blues, postpartum affective psychoses and mild to moderate postpartum depression. However, they did conclude that PND was a **"relatively common and clinically significant disorder...worthy of additional**

research."(*ibid.* p503). In a wide ranging review of research current at the time, they concluded that the methodological and conceptual limitations of current research had resulted in inconsistent findings and thus there was no coherent theoretical framework for explaining the aetiology, development and effective treatments for PND. Pollock *et al.* (1980) referred to the lack of agreement about definition and disputed the efficacy of studies of PND as they were **"...beset by methodological problems such as problems in the definition of depression itself."** (p1). However, Nicolson (1998) identified the way in which the concept of PND encapsulated a variety of meanings for the interest groups that utilised the term and that far from being a limitation, could be viewed as ratifying their interest in and concern about the experiences of new mothers. Women need to be able to name and legitimise their negative response to motherhood and **"...primary care workers...need to find a diagnosis which describes and explains the symptoms such as tiredness, unhappiness or the inability to cope with the demands of childcare that many new mothers present to them."** (p2).

The symptoms of PND are the same as other dysphoric mood states and include sadness, anxiety, irritability, self-reproach, pessimism, taciturnity, reclusion, insomnia and loss of vitality. Brockington (1999) highlighted the need for an epidemiological association, thus indicating some specific causal factors to distinguish PND from depression generally. His detailed analysis of case registers, studies in general practice, surveys, follow-through studies and case control studies led him to conclude that far from being an easily identifiable condition, PND is indistinguishable from the generally high levels of

depression identified in women during their reproductive lives albeit with an increase in *brief* episodes of depression within the puerperium.

Cox (1996) discusses the disinclination of the World Health Organisation (WHO) to provide postnatal mental disorders with their own distinct classification. It was only in 1992, with a new edition of the International Classification of Diseases (ICD-10) that a psychological disorder was reluctantly 'allowed' to be categorised as puerperal, only if the condition could not otherwise be classified and the mental disturbance had occurred within six weeks of the birth. Clinicians were clearly discouraged, within the text of the publication, from using this diagnosis, and although I have grave reservations about PND, paradoxically, I am reluctant to discard the term immediately. Cox (1996) argues that PND is a user-driven term and that victims regard PND as different from other depression. Their experiences and suffering needs to be acknowledged and named. Furthermore, telling a woman who is struggling to adjust to being a mother that her depression is unconnected to having a baby may be tantamount to telling her that there is nothing really wrong with her, that it is all in her imagination. In many ways this debate forms one of the central threads through this thesis and will therefore be revisited in considerable detail and depth.

3.1 How many mothers are suffering from PND?

Brockington (1998) examined forty studies into PND, both from the UK as well as Europe and the USA, in which there were at least 100 subjects. A variety of definitions, measures and thresholds were used and the studies were carried out at different time

intervals after birth. All results confirmed that depression after childbirth is a common problem. However, the majority of the results suggested a prevalence for PND of between 10 and 20%, although eight studies reported rates of less than 10% and ten found rates of PND to be higher than 20%. (Brockington 1998, p171-2). Shakespeare (2001) in her comprehensive evaluation of screening for PND, conducted a meta-analysis of 59 studies into PND and found an average prevalence rate of 13%. This meta-analysis included studies using validated psychiatric interviews and self-reporting questionnaires. The majority of cases develop within 3 months with 4-6 weeks being the time of the highest rate of occurrence. It is of note that the incidence of depression is not significantly different from that in women who have *not* recently given birth.

Case registers provided an insight into the postnatal psychiatric wellbeing of a large number of women, albeit with minimal accompanying detail. Brockington (1999) examined case registers and studies in general practice from several cities. Southampton (Nott 1982), Camberwell (Kendell *et al.* 1976) and Edinburgh (Kendell *et al.* 1981, Kendell *et al.* 1987) provided information for the review but results were limited in that only first psychiatric contact and hospital admissions were recorded. Although the data on which these studies are based is approximately thirty years old, they do provide an interesting historical perspective on our understanding of PND. The Edinburgh based studies reported on the prevalence of new mothers admitted to a psychiatric hospital. The first involved 35,729 births over a seven-year period (Kendell *et al.* 1981) and the second, 54,087 births over an eleven-year period (Kendell *et al.* 1987). Excluding psychosis, between 2-4/1000 mothers were admitted to a psychiatric hospital during the

two years after the birth. The other case studies collated first psychiatric contact, and this was also examined in the second Edinburgh study for a two-year period only. Relying solely on psychiatric referral, only 1-3% women suffered postpartum illness but although the numbers are very low, there is an increase in hospital admissions following birth compared with those preconceptually and in pregnancy (Brockington 1999). Studies in general practice (Ryle 1961, Tod 1964, Pitt 1968) produced combined results indicating a rate of 2-3% of newly delivered woman requiring psychiatric referral.

However, there are obvious limitations to all these studies. Many women who are struggling to adapt to motherhood fail to access psychiatric services for several reasons. There is still a stigma associated with mental illness (Richards 1991) and they may feel ashamed or anxious as to the repercussions of admitting they are 'ill', even fearing that their baby will be taken into care. They may not be aware that they are experiencing anything other than normal feelings and it is also possible that they recover before accessing any medical assistance. It is also possible that, were health visitors and midwives rather than doctors identifying the women with emotional problems the numbers may have been higher.

Longitudinal studies have been inconsistent in their findings regarding the incidence of PND. Rees and Lutkins (1971) found that 10% women were depressed both before and after the birth. Knight and Thirkettle (1986) found only a slight rise in rates of depression amongst postpartum women. A large study in Oxford that followed through 483 pregnant women until a year postpartum (Cooper *et al.* 1988) concluded that the prevalence of

psychiatric disorder as defined by the presence of five Present State Examination (PSE) (developed by Tress *et al.* 1987) symptoms was 6% during pregnancy. This increased by less than 3% for the first six months after the birth and had reduced to 5.2% by the time the infant was a year old.

However, other studies have indicated that there *is* an increase in rates of depression for postpartum women. Elliott *et al.* (1983) studied 128 London women and found that ten women developed depression in the first six weeks postpartum with a further thirteen new cases during the first year. Kumar and Robson's study (1984) involved 119 primiparous London women who were interviewed several times during their pregnancies and until their babies were a year old (all participants had at least three interviews, with some being interviewed more times depending on clinical evaluation during the research process). A semi-structured clinical interview was used. The incidence of depression rose by 10% in the first trimester and 14% postnatally, with the results suggesting that the women in the sample were either depressed before the birth or afterwards, but not both.

The authors robustly defended their study as providing evidence that "**childbearing *per se* does have a particular and deleterious effect on the mental health of a substantial proportion of first-time mothers.**" (p45). This comment was made in the context of Brown and Harris' (1978) study and Paykel and colleagues (1980) study which both suggested that it was women's poor social, economic and educational status that caused them to be depressed and that motherhood was an "**additional stress in tenuous**

situations", (Paykel *et al.* cited Kumar & Robson 1984, p45) and not a specific cause of depression.

One might assume that women who have recently given birth would present with a *higher* incidence of depression, thus validating a diagnosis of depression linked to having a baby. O'Hara *et al.* (1990) compared the moods of nearly 200 pregnant and non-pregnant women in Iowa and found no significant difference in the number of women reporting depressive symptoms after the birth. Likewise, Cox *et al.* (1993) studied 232 women six months after the birth, matched with a control group of women who had not recently given birth. The results showed an almost identical occurrence rate of depression of just under 14% for both groups. However their results demonstrated an increase *frequency* of new postpartum episodes of depression (22/238 in the first nine weeks) and it was noted that these were relatively short in duration. O'Hara *et al.* (1990) confirmed that the mean duration of PND was 3.3 weeks in the Iowa study. However Elliot *et al.* (1983) studied the mood of 128 postpartum women over a year and provided precise data on the duration of their depression in the 29 women identified. Just fewer than 10% of the women taking part experienced depression that lasted at least six months. Cooper *et al.* (1988) also examined the period of PND experienced by women and found that 15% were depressed for at least six months.

Attempting to summarise these contradictory findings presents obvious difficulties. However, this is not a reason to abandon the notion of PND. The concept serves to validate women's difficulties in adapting to their new role as mothers and legitimises the

notion of PND in the media and popular culture. Nicolson (1998), in her detailed account of the postpartum experiences of 24 women, argued that rejecting the notion of PND, **"...risks further marginalising the evidence of women's experience of the transition to motherhood and associated emotional responses"** (p108). PND can also be utilised as a political tool to exert pressure on government agencies and primary care providers to supply more effective, responsive and consistent support for new mothers. To 'flesh out' our understanding of PND, there is a need for further qualitative research projects that address women's lived experience. Rather than counting symptoms, a more 'textural' analysis of the *experience* of mothering would be valuable so that a realistic understanding of the impact of a new baby on women's lives can be developed.

3.2 Postnatal depression and child development

Evidence is increasing to support the supposition that dysphoric mood affects the quality of the mother-child relationship. It has been suggested that children of depressed mothers are more likely to be diagnosed as having behavioural difficulties and delayed cognitive development, but research findings are not conclusive. Caplan and colleagues (1989), in their study with 92 first-time mothers, reported that at four years old, children with depressed mothers were more likely to be described as having behavioural problems. Low cognitive abilities in the children were also associated with behavioural difficulties by their mothers but overall, the authors concluded that PND alone was not a convincing explanation and that women who have a discordant, hostile relationship with their partner are more likely to have children with behavioural problems. Deave (2005), in her study on the associations between women's attitudes to pregnancy and motherhood and child

development used, amongst other measures, the EPDS both antenatally and postnatally. She concluded that, after **"taking account of antenatal depression, no association was found between postnatal depression scores and child development at 2 years."** (p72). She acknowledged that this finding contradicted that of other studies (Cox & Holden 1994, Green 1998). Murray and Cooper (1997) in their comprehensive review of accumulated research in this area, concluded that PND *was* implicated in a range of unfavourable cognitive and emotional outcomes in infants, particularly boys. Furthermore, they alleged that it was not the depressive symptoms themselves that were influential in the child's emotional and cognitive development, rather it was the way in which the dysphoric mood adversely affected the interaction between mother and child that impaired development. Milgrom and colleagues (2003) in their detailed guide for health care practitioners on the treatment of PND, advised caution when discussing this issue as it abounds with contradictory findings. Although current research suggests that many women suffering from PND are less engaged, less responsive and less accepting of their infants (Field *et al.* 1985, Murray 1988), some depressed mothers are very caring and sensitive towards their infants (Milgrom 1991). Some may be withdrawn and taciturn and others intrusive and overbearing and this in turn may depend on the baby's gender (Cox 1988a, Murray 1988). Milgrom and colleagues (2003) suggested that in some cases, socio-economic factors may not have been accounted for in explaining both the depression and the inadequate interactional behaviour. Aiken (2000), in her first person account of her own PND, speaks movingly about the repercussions of her 'illness' on her family.

"Georgina ...is currently having individual therapy for obsessive, compulsive hand washing disorder...My eleven year old daughter has taken on a very maternal role towards me and says she feels as if she is my mother as opposed to me being hers...Tasha...cuddles up to me and tries to assure me that everything is going to be OK." (p8).

Although not always in agreement, current research seems to tentatively support the belief that the long-term outcome for children whose mothers suffered from symptoms of depression after the birth appears to be compromised. This is most obvious in mother-child interaction and less clear in assessment of cognitive development in children.

3.3 Identifying postnatal depression

A problem that must be addressed if we are to establish an effective support service for women who are struggling to come to terms with life with a baby, is the sensitivity and accuracy of primary care teams to identify those women who require assistance. Seeley (2001) asked the question, **"How good are we at finding postnatally depressed women so we can offer support and treatment?"** (p16). Briscoe (1986) evaluated the accuracy of health visitor diagnosis of PND when they relied upon their 'gut instinct' or professional judgement. The study revealed a combined misdiagnosis rate of 40%. Seeley and colleagues (1996) carried out a similar investigation and produced similar findings. Seeley (2001) goes on to advocate the use of the Edinburgh Postnatal Depression Scale (EPDS) to more accurately detect women who *may* be suffering from PND.

3.4 Screening and treating postnatal depression

It is not possible to discuss and evaluate every screening tool that has been used to assess whether women are at risk of suffering from PND. Likewise, I cannot evaluate all interventions and treatments. Instead I have concentrated on a selection of screening tools that are most relevant to my study as well as examining in detail one programme of treatment that seemed to be successful in alleviating some of the symptoms of PND. My conclusions will be utilised to reflect upon the way in which PND is viewed within a traditional positivistic framework and how this might be improved upon.

3.5 The Edinburgh Postnatal Depression Scale

Probably the best-known and most extensively validated PND screening instrument is the Edinburgh Postnatal Depression Scale (EPDS) developed by Cox and colleagues in 1987. Prior to the EPDS there was no questionnaire to screen for depression that had been designed specifically for use during the postnatal period. Researchers were forced to rely upon more general rating systems that were often unsuitable for the particularities of PND – for instance questions about loss of libido, inability to sleep and weight gain/loss were not felt to be useful as 'markers' for this condition. The EPDS is a ten item self-reporting scale that can be completed in 5-10 minutes. Women are asked to respond to each statement, allocating a score of between 0-3 with three being the strongest response. The EPDS is presented as follows:

In the past 7 days:

1. I have been able to laugh and see the funny side of things -

As much as I always could
Not quite so much now
Definitely not so much now
Not at all
And the other nine items are (with four choices of response each):
2. I have looked forward with enjoyment to things -
3. I have blamed myself unnecessarily when things went wrong -
4. I have been anxious or worried for no good reason -
5. I have felt scared or panicky for no good reason -
6. Things have been getting on top of me -
7. I have been so unhappy that I have had difficulty sleeping -
8. I have felt sad or miserable -
9. I have been so unhappy that I have been crying -
10. The thought of harming myself has occurred to me -

The EPDS has been validated extensively for use in research (Cox *et al.* 1987, Harris *et al.* 1989, Boyce *et al.* 1993, Murry & Carothers 1990, Jadresic *et al.* 1995, Zelkowitz & Millet 1995, Wickberg & Hwang 1996, Ghubash *et al.* 1997, Lee *et al.* 1998, Clifford *et al.* 1999, Eberhard *et al.* 2001) but not in clinical practice, and is considered by many to be generally efficacious and accessible within the research setting. However, recently problems of administration have been identified as well as ethical concerns and it is no longer universally acclaimed (Guedeney *et al.* 2000, Shakespeare 2001, Shakespeare *et al.* 2003). The EPDS failed to meet the criteria of the National Screening Committee who advised against its use except to

"... Serve as a checklist as part of a mood assessment for postnatal mothers, when it should only be used alongside professional judgement and a clinical interview. The

professional administering it, should have training in its appropriate use, and should not use it as a pass/fail screening tool". (National Screening Committee, 2004).

However the EPDS *is* recommended for use by "The Scottish Intercollegiate Guidelines Network for PND and Puerperal Psychosis" (this is intended to be a national clinical guideline) (SIGN 2002) and the "English National Service Framework for Mental Health" (Dept of Health 1999). Therefore it is clear that the EPDS is considered to be acceptable and reliable by government bodies as a screening tool for PND. Guedeney and colleagues (2000) discussed in detail three false negative cases identified by the EPDS of major depressive disorder following childbirth. Eighty-seven women took part in the study – of these 23 of them were depressed and 20 were correctly identified using the EPDS. The predominant feature of the false negatives (cases where the EPDS score suggested that the women were not at risk of developing PND but further psychological evaluation revealed they were in fact suffering from depression following the birth of their child) were 'psychomotor retardation' – both observed and subjective. The authors argue that the EPDS was conceived of as a screening tool for 'anhedonic' depression (depression with a high level of 'mental pain', sadness and anxiety) to the detriment of depressive psychomotor retardation (apathy, poor concentration and memory loss). Therefore women displaying the latter 'symptoms' may fail to be detected by the EPDS.

Shakespeare *et al.* (2003) conducted a study to explore the acceptability of the EPDS to women, as used by their health visitor. This study will be discussed in detail as it represents a timely intervention in this debate, and is unique in its focus - highlighting the

opinions of the users – in this case the *women* rather than the health professionals. Shakespeare *et al.* (2003) undertook interviews with 39 women (interviewing continued until data saturation was reached), all of whom had been offered the EPDS at eight weeks and eight months postnatally and some of whom had 'listening visits' with their health visitor following the EPDS. Analysis was carried out using the constant comparative method. This study took place within the context of a more extensive multidisciplinary initiative in Oxford called, 'The Oxford City Postnatal Depression Strategy' (McClarey & Stokoe, 1995).

The women were asked a general question to begin the interview, inquiring about 'how they had felt' in the first three months since the baby had been born. Only if they did not refer to the screening process were they asked about is administration. If their response was negative, then it was deemed to have been an 'unacceptable' intrusion. Twenty-one of the 39 women responded negatively to the use of the EPDS and two women had declined to complete it. The researchers acknowledge that this overwhelmingly negative response was unexpected. Moreover, this study demonstrates that **"...the EPDS needs to be properly evaluated in routine clinical practice...the cost, effectiveness and acceptability of screening with the EPDS needs to be compared with an alternative..."** (Shakespeare *et al.* 2003, p619). Women who resented the use of the EPDS clearly demonstrated their strength of feeling in the depth and breadth of their responses whereas women who found the process broadly acceptable offered sparse comment about the experience. Administration of the screening tool at the baby clinic was considered to be unacceptable due to lack of privacy and time restrictions. I would

suggest health visitors were surprisingly insensitive in administering a screening tool to assess mental wellbeing in a public situation, a concern expressed by one of the women **"...to have it filled in and then talked about in front of everybody else was just terrible."** (p616) The home is a much more appropriate setting.

Three major themes were identified by Shakespeare *et al.* (2003) as being problematic. These were the screening process, the personal intrusion and the potential stigma from a negative result. Although some women described the process as quick, easy and providing a means to *avoid* having to discuss the issue of PND face-to-face, women who resented the screening process found the EPDS to be **"transparent, simplistic, "daft" "** (p616). Closed questions, non-disclosure of PND by 'lying' and a lack of opportunity to discuss their feelings, **"have a coffee and a chat"** (p616) were mentioned. Women also described feeling anxious, ill-prepared and ignorant as to what, if any follow-up care was available should it be required. Likewise, the attitude of the health visitors was commented upon and some of the women expressed gratitude that s/he engaged with their feelings about the EPDS. However, a large minority described the way that a 'reassuring' EPDS result ostensibly prevented any further discussion of psychological difficulties and that health visitors often seemed rushed and reluctant to pursue a conversation about emotional problems. Some of the women put their distress down to a difficult social situation and therefore found the EPDS to be intrusive, **"patronising"** (p618) and **"pointless"** (p617). Being 'diagnosed' with a mental illness can be experienced as stigmatising and many of the women in this study expressed their concern that women with PND were, by definition, not good mothers. Some were frightened that

their baby would be removed by social services if their score indicated that they were depressed and so they provided inaccurate information when screened, as an interviewee explained, **"It's obvious from the questions what the answers should be, if you want to be seen as a good mother."** Shakespeare and her colleagues (2003) concluded that although their study has some minor limitations, it clearly demonstrated that the EPDS is not as suitable as generally considered by researchers and health professionals. The health visitors administering the test received **"as good as possible"** (p628) training within the available resources although it is apparent that limitations of time and space prevented many of the women feeling at ease and encouraged to reveal their true feelings. Possibly health visitors need to be freed from the restriction of filling in questionnaires and instead encouraged to talk with their clients and listen to their stories – however this would require longer visits in women's homes and time restraints often make this impossible. There is an urgent requirement, if the EPDS is to be relied upon nationally, to improve training so that the inadequacies identified in this paper are addressed. Within the context of my research, what Shakespeare and her colleagues have demonstrated is that screening tools are quite probably an inappropriate and inadequate response to an ill-conceived notion of what qualifies as an abnormal transition to motherhood. The potential pathologisation of a traumatic but fundamentally normal transition is liable to be resisted, distrusted, undermined and subverted by a majority of the women it was designed to support.

Others studies have also indicated that some women are reluctant to accept further assessment or treatment for PND following a raised score in initial screening. Whitten

and colleagues (1996a, 1996b) sought the views of women who had been screened using the EPDS and then undergone psychiatric assessment – more than half of the participants disagreed with the diagnosis of depression, claiming that their symptoms were not serious enough to warrant the label. Robinson and Young (1982) reported that the refusal rate for psychiatric referral was 50% amongst women who had been screened as 'at risk' of PND. One could postulate that the women preferred to contextualise their experiences within their own biographies, rather than within the framework of a clinical condition. Milgrom and colleagues (2003) had greater success in persuading women to attend their clinic for treatment (70% agreeing to come) by presenting the EPDS as a normative process and providing nurses to respond to the women's **"erroneous assumptions about what it means to accept treatment."** (*ibid.* p53). Although presented by Milgrom and colleagues (2003) as something to be sensitively 'overcome', the disinclination and discomfort of some women to be labelled as depressed is an important factor to take into account when developing frameworks to assist women in making the transition to motherhood.

As an adjunct to the above comment, that women would prefer health visitors to talk with them rather than administer questionnaires, Holden (1996), in her discussion of preliminary use of the EPDS in clinical practice, argues that this screening tool *does* assist health visitors in detecting PND. Her rational for this is as follows: when comparisons are made between the number of women identified by health visitors as depressed after childbirth and the number of women scoring above the threshold on the EPDS, the health visitors classified a *lower* number of women as requiring extra help.

Consequently the EPDS is more accurate because it found that *more* women were screened as being depressed. Likewise Thome (1991) who evaluated the EPDS in Iceland discovered that nurses were failing to identify up to 50% of depressed postnatal women and Holden (1996) goes on to detail several other studies that came to similar conclusions. Whilst accepting that it is possible that the greater numbers of depressed women identified by the EPDS might indicate its greater accuracy, one should not dismiss the possibility that screening tools are yielding an excess of false positives. It is interesting to note that women who scored high in Thome's (1991) study did not consider their distress to be **"mental disturbance"** and neither did the nurses who cared for and supported them. Holden (1996) acknowledges that the nurses in Thome's study **"admired some mothers for their strength in living through very difficult life situations and not showing more distress then they actually did."** (p130). However, Holden (1996) also highlights the relief expressed by some of the respondents in her earlier study on the use of the EPDS (Holden *et al.* 1989) on being told they were depressed. They found it beneficial as it provided an explanation for their feelings and legitimised their emotional struggle. It is also noteworthy that Elliott and Leverton (2000) discussed in detail the problems of an improper understanding of the EPDS by health professionals and their managers. Some of the earlier shortcomings may be attributable to its administration rather than the screening tool itself. The EPDS is not a diagnostic test and is not as accurate as a psychiatric interview. It is also not designed as **"back-up in cases of uncertainty"** (p300). It is a primary screening device to avoid missed cases of PND. Likewise, its implementation should not replace health visitors' competence in detecting the antecedents of PND even if the woman scores below the threshold during

screening. Elliott & Leverton (2000) continued to scrutinise and respond to many of the criticisms levelled at the EPDS, although they do not discuss its acceptability amongst postnatal women.

Elliott (1996) discusses the role of health visitors and is sympathetic to their predicament in so much as they are expected to provide a universal service to families with children under five years old, their principal aim being health promotion and screening. **"They are not a treatment agency although pressure of work, combined with the unavailability of secondary care health professionals, often finds them operating a crisis intervention or treatment service."** (p229). She points out that the EPDS does not provide a differential diagnosis and as such health visitors have to rely on secondary services that are often over-subscribed with limited resources. This further increases their workload because unless the service provision is appropriate, health visitors still feel that responsibility for the woman's wellbeing remains with them (Cullinan 1991, Reading & Allen 1997).

3.6 The Hospital Anxiety and Depression Scale

Although the use of screening questionnaires are a popular means to access and evaluate psychological wellbeing, both after childbirth and generally, a study by Lavender and Walkinshaw (1998) that sought to assess the efficacy of postnatal debriefing demonstrated some startling findings when the control group of women were screened. One hundred and twenty postnatal women were randomised to receive the postnatal debriefing. The main outcome measure was the Hospital Anxiety and Depression scale

(HAD) (Zigmond & Snaith 1983) and what is particularly relevant to this discussion is the very high number of women in the control group who were found to be over the threshold scores for anxiety, depression or both. The level of positive screening results in this group was over 50%, which the authors refer to as 'worrying'. They do discuss the factors that might have contributed to this level of distress/depression, acknowledging that HAD might not have been an appropriate screening tool, as it has not been validated for postnatal women (although it has been validated in a variety of clinical settings). However their rationale for using it is its potential for subgroup analysis and they robustly defend their findings. My response to their study is a certain surprise that the authors did not further scrutinise the screening results – although I am aware that reviewing levels of distress after childbirth was not their primary aim. Lavender and Walkinshaw's study is valuable both for its contribution to the debate regarding the benefit of postnatal debriefing and for its tacit suggestion that distress after birth is a *normal* part of a complex, challenging transition rather than a condition that requires pathologisation. Arguably, efforts to differentiate between postnatal women who are anxious, unhappy or depressed and those who are not is spurious as *all* new mothers need to be prepared for the way in which having a baby will drastically change their lives and supported through the process of interpersonal, emotional and social transition. Wessely (1998) in his commentary following this paper speculated that Lavender and Walkinshaw (1998) were identifying transient postnatal dysphoria rather than depression. In other words 'postnatal blues' which, Wessely (1998) argued, does not require any treatment, just support and explanation.

3.7 The Postpartum Depression Screening Scale

There is a considerable variety of screening questionnaires for general depression and a much smaller selection designed specifically for PND. As has been discussed, the EPDS is the most familiar and most frequently utilised in clinical evaluations but there are other screening tools being developed and evaluated in clinical trials. Beck and Gable (2000, 2001a, 2001b) have designed the Postpartum Depression Screening Scale (PDSS) based on Beck's qualitative studies on postpartum depression (Beck 1992, 1993). They argue that there is a **"pressing need for psychometrically sound postpartum depression screening instruments"** (Beck & Gable 2001a, p155) and that all postnatal women should be screened routinely to prevent late detection and delayed treatment of PND. It is a thirty-five item Likert response scale consisting of seven dimensions, each of which contains five items. The PDSS was founded on the conceptual definition of PND as a deterioration in mood, starting any time within the first year of the baby's birth, **"Loss of control of emotions, thought processes, and actions is the basic problem of this experience"** (Beck & Gable, 2001b, p243). They go on to explain that this may manifest as some or all of the following, **"...withdrawal of positive emotions, inability to concentrate, insecurity, loneliness, anxiety, difficulty in sleeping and/or eating, guilt and/or shame, obsessive thinking, emotional roller coaster and contemplating harm."** (*ibid.*)

Preliminary psychometric testing involved 525 women who were approximately six weeks postnatal. The authors discussed in detail their careful analysis of the PDSS (Beck & Gable 2001a) and concluded that, based on sensitivity, specificity and predictive value,

the cut off score for screening for major PND should be 80. This provided higher levels of validity than those reported by Cox and colleagues for the EPDS (1987). They continued to compare the PDSS with the EPDS's development and implementation and to find in favour of the PDSS (Beck and Gable 2001b). They point out that the EPDS was initially assessed with a sample of eighty-four women and that the sample was biased as seventy-two of them had already been identified by their health visitors as manifesting symptoms of possible depression. Citing the example of the question about problems sleeping, Beck and Gable (2001b) emphasised what they considered to be a fundamental weakness in the EPDS – the items were not 'motherhood-specific' and therefore it was not reliable as a distinctive measure of PND. Murray and Cox (1990) described this as advantageous during a study to screen pregnant women for depression, **"Fortunately, the EPDS contains no specific references to the postnatal period so none of the items had to be altered for this study."** (p100). It is of interest that Cox (1996) does refer to the matter of sleep difficulties being linked to depressed mood in his paper discussing the origin and development of the EPDS. Although he acknowledged the complexity of distinguishing depressive sleep disorder from interrupted sleep due to babycare and purports to be meticulous in devising a salient question, the ambiguity is not satisfactorily addressed.

Beck and Gable extend their criticism of the EPDS by referring to Dalton's study (1980) in which she asked women to summarise their earliest symptoms of PND. The women described feeling anxious, having insomnia, being agitated, irritable and confused. Depression featured towards the bottom of the list. The PDSS is the only screening tool

to feature questions related to all five symptoms. As is clear from the preceding discussion, the focus of Beck and Gable's study (2001b) is to compare the PDSS with the EPDS and also the Beck Depression Inventory-II (BDI-II) (Beck *et al.* 1996). The BDI-II is a well-established screening instrument for general depression and comprises twenty-one symptoms that equate to the diagnostic criteria of the American Psychiatric Association (1994) Diagnostic and Statistical Manual of Mental Disorder (DSM-IV). A four-point scale is used with scores ranging from 0-3. A total of 150 women participated in the comparative study. Between two and twelve weeks postpartum they completed all three questionnaires followed by an interview with a nurse psychotherapist using the DSM-IV diagnostic interview as the 'gold standard'. The authors' findings authenticated their belief that the PDSS is the most reliable screening test for PND, identifying 17 of the 18 women diagnosed with PND by diagnostic interview. The EPDS detected 14 and the BDI-II found ten. Further details are contained within the paper (Beck & Gable 2001b) but of particular significance to this discussion is a broader question which will be discussed below. Prior to that one further screening tool will be discussed.

3.8 The Mother Generated Index

The Mother Generated Index (MGI) was compiled by Symon and colleagues (2003). The MGI is a three-step questionnaire administered during a face-to-face interview. Initially the mother is asked to identify eight areas of her life that have been changed by the baby. For the second step she is asked to score each area out of ten, with a high score indicating that it is as she would want it to be, and a low score indicating disappointment. The average of these gives the 'Primary Index Score', which in turn denotes 'global quality of

life'. The third step is the woman 'spending' 20 points across the areas most meaningful to her. She is directed to allocate most points to the areas most important to her quality of life, with twenty in total to 'spend'. The final stage comprises of **"Each Step 2 score is then multiplied by the points spent on that area in Step 3. The sum of these individual scores is then divided by the total (20), which gives the Secondary Index Score."** (Symons *et al.* 2003, p23).

One hundred and three women participated in the study. Sixty women were interviewed at 6-8 weeks postnatal and the rest at 8 months. In their discussion the authors defended the use of a screening tool to assess basically healthy women. They maintained that the MGI is unique in that it provided women with the opportunity to 'set the agenda' - in other words, construct a subjective postnatal assessment of their wellbeing. Symon and colleagues (2003) have made a valuable contribution to the issue of screening tools for postnatal psychological health in so much as they have endeavoured to discover and appraise the way in which motherhood effected key areas of the women's lives (as identified by the women themselves) rather than present the interviewee with a pre-determined set of questions/items. However, I have several misgivings about the MGI. I would suspect its primary use would be in research studies as it seems to be complicated and unwieldy. The health professional administering it might possibly be distracted with her/his calculations rather than attending to the woman s/he is with. A further problem is that of failed expectations. If, for example, a woman focused on social problems she had experienced since the baby's birth, anticipating that by completing the MGI her difficulties would be addressed and improvements made, she may feel deceived by the

research process if no improvements are made. The final criticism leads on to the wider question addressed below.

Whilst one could not dispute the rigorous assiduity of the originators of the EPDS, the MGI and the PDSS, it is vital to be clear about the primary objective of screening tools and to try and establish in what way they improve the lives of new mothers. It is often the case that secondary care for women who have been identified as struggling with the transition to motherhood (*possibly* having PND) is often piecemeal, with restricted availability and a long waiting list. PND is still considered to effect approximately 10% of all postnatal women and this figure is not improving. Meanwhile, more women are being screened and new questionnaires devised that arguably tell us what we already know – that most women experience the transition to motherhood as at best unsettling and at worst, traumatic and distressing. Adapting to their new identity can cause new mothers overwhelming distress, there is invariably a sense of 'loss' and a necessary, gradual restructuring of the woman's life, in all its existential dimensions.

Alexander (2002) expressed her concerns that screening tools **"...inappropriately extend a psychiatric model to assess what may essentially be psychological and social change inherent in parenting."** (Alexander 2002, p391). However, they are consistently employed in a wide variety of studies of women during the first year after birth and this is possibly because no study of the transition to motherhood is considered to be legitimate without such an assessment scale.

3.9 Treating postnatal depression: therapeutic intervention

There have been a variety of studies evaluating different approaches to treating PND with usually moderate success. However, I am going to concentrate on the group programme developed by Milgrom and colleagues (2003). This combined cognitive and behavioural techniques to provide a structured programme of therapeutic intervention. It runs for nine weekly sessions of 90 minutes duration, followed by a 'booster' session some weeks later. The programme is called "The Getting Ahead of Postnatal Depression Group Programme" (GAPDGP) and is administered from the Infant Clinic in Victoria, Australia. To date 4000 women have been screened for PND and over 300 treated. Throughout the development of the programme, the efficacy has been evaluated using the EPDS and the Beck Depression Score (BDS) (Beck *et al.* 1961) and this has consistently indicated a considerable reduction is depressive symptomatology. Alongside their statistical results are the unsolicited testimonials from women who have received treatment and wish to express their gratitude for what they have experienced as a dramatic improvement in their wellbeing. The preliminary pilot study testing the application of cognitive-behavioural therapy to women suffering from PND was very encouraging. The final phase of evaluation of the refined GAPDGP is ongoing but initial results indicate a 36% decrease in depression rating on the BDS and a 54% improvement in other variables such as anxiety, as assessed using the Beck Anxiety Inventory.

I found much that was encouraging about the GAPDGP, particularly the expression's of gratitude and descriptions of improved wellbeing submitted by the women. The authors offer a coherent, carefully researched and evaluated programme that offers practical

advice and accessible explanations of the experience of PND, and appears to be effective in alleviating the symptoms. However, my main concern is with their reliance on screening tools to decide who qualifies for the intervention, as research outlined above has indicated that all screening tools produce a preportion of false negative results, possibly resulting in women not being offered an intervention from which they might benefit. A further comment relates to whether the authors have sufficiently demonstrated that PND differs from general depression. Clearly this was not a primary aim as their interest originated in their concern for mothers who were depressed. However, their programme relies upon a technique shown to be efficacious with general depression and although specifications have obviously been included so that the focus is on depression after childbirth, one wonders whether it is possible to accurately differentiate one from the other (this is discussed further below). A final comment is a general lament that, due to funding constraints, programmes such as GAPDGP are only available to very limited numbers of women.

3.10 Normalising postnatal depression/distress

If instead of pathologising women's experiences, they are re-articulated as 'normal' then traditional approaches to studying them would require radical revision. This is not to say that there is not a small minority of women who display a psychotic reaction to motherhood and who need immediate medical intervention, or depression so severe that they require hospitalisation. Brockington (1999) described puerperal psychosis as generally afflicting 1-2 women in every thousand births.

In her critique of mainstream approaches to understanding women with depression, Stoppard (2000) explained that studies that focus on mothers who have been diagnosed (or self-selected) as having PND do appear to support the notion that their feelings of ambivalence, shock, disappointment and loss are indicative of a distinctive disorder. However, she goes on to argue that such an interpretation is difficult to sustain when the narratives of women who *have not* been identified as being distressed or depressed after childbirth are considered. For example, Lewis and Nicolson (1998) combined two studies for their paper examining the way in which medical discourse on depression circumscribed women's experiences of motherhood. Study one involved twenty-four pregnant women who described their own transition to motherhood (the women were aware of the researcher's interest in PND and self-selected with this in mind –with a history of depression and/or anticipating depression after the birth). Study two involved twelve women who already had children and were seeking support for depression/distress. They spoke about the experience of mothering. 'Penny' admitted that if she had known what motherhood **"was going to be like, I think I'd have thought twice about having any."** (Lewis & Nicolson 1998 p184) and 'Ros' used very similar words to those above, **"...and it's quite a shock, you know, a horrible shock...so much more difficult and exhausting."** (*ibid.*). Weaver and Ussher's (1997) study in which women who had *not* suffered from PND, were asked to describe the way in which motherhood had changed their lives, contains accounts that are remarkably similar to those narratives of women who have been depressed since giving birth. For example, in one of the interviews the woman described her shock at being a mother and how unprepared she felt, **"...it really is a complete and utter shock to the whole system.**

Definitely." (Weaver & Ussher 197, p58). This is strikingly similar to sentiments expressed by the women in my research. Chris described motherhood as a *"shock to the system"*, May echoed this, *"Read it, talk to people about it, but you don't take it in...what it's like to have a baby."* Wilma began her narrative with the same words as Chris, *"Shock to the system I think."*

Stoppard (2000) continued her argument by suggesting that new mothers commonly experienced negative feelings about their babies and the way their lives had changed and this should not be pathologised. Instead she proposed a social constructionist theory to explain women's responses to mothering, **"...view them** (women's negative experiences of mothering) **as reflecting the lived experience of women in the context of particular, and historically specific, ways of organising the work of mothering...women's experience of mothering** (is) **regulated by pervasive cultural discourse constructing what it means to be a woman and mother."** (p156). Stoppard's thoughtful analysis is interesting and merits further discussion but as her focus is on *general* depression in women, it will not be pursued here.

Shakespeare *et al.* (2003) revealed significant shortcomings with the use of the EPDS in clinical practice and it would be realistic to suppose that women would be similarly resistant to other screening questionnaires. Screening tools, regardless of their statistical merit, are conceived of as a way to identify potential *pathology*, albeit with honourable objectives. The clinician must also acknowledge the potential risk that, having a raised EPDS score and a recommendation for psychiatric evaluation, may *cause* the woman

greater distress and possible depression rather than any problems she is experiencing in her new role. The underlying assumption of studies using screening tools is that PND can be measured – that it is an extrinsic, observable and delineated manifestation and this, by definition, renders invisible the complexities of women's subjective experience of mothering (Nicolson 1998). One must pause and ask, "Is this helpful?" Drawing on the preceding arguments the answer would be no. The juxtaposition of the typical images of the prevailing myth of motherhood, and the lived experience of selfless giving, frustration, isolation, monotony and exhaustion results in a double burden for mothers – the practicalities of childcare are **"set against each woman's fear that she is somehow 'doing it wrong'. Her experience does not relate to her dream."** (Nicolson 1998, p37). Labelling this complex experience PND, does little if anything to alleviate the women's struggle. Oakley (1979) argued that PND is not a 'scientific term' but "ideological". **"It mystifies the real social and medical factors that lead to mother's unhappiness."** (p12). Screening tools may assist health professionals in identifying those women who require greater support over the postnatal period but only as a supplement to more comprehensive, responsive care, and ideally a paradigmatic change in the way in which the transition to motherhood is understood. However, if this 'greater support' is not forthcoming than the consequence of using a screening instrument may be disappointment for the woman and her family. Likewise, debating statistical sensitivity fails to contextualise, illuminate or explicate the lived experience of becoming a mother. Moreover, if health professionals fail to properly understand 'what it is like' then their efforts to improve the experience will inevitably fail.

3.11 Contextualising my research

Within the context of this diverse body of knowledge of the transition to motherhood, my research seeks to delve deeper and more broadly, whilst conversely remaining immersed in the particular and the subjective to illuminate the way in which the women who took part, 'lived with and through' the experience of becoming mothers. Furthermore, my findings and the ensuing discussion shed new light upon the prevailing medical discourse that delineates a 'normal' (successful) transition from an 'abnormal' (unsuccessful) transition, thereby challenging prevailing notions of PND.

4.0 Philosophical foundations of the method

4.1 Introduction

The aim of this chapter is a deepened understanding of the philosophy underpinning phenomenological investigation. Clearly, it is not possible to review the entire historical development of phenomenology, or examine in detail the canon of work produced by all the philosophers who have made major contributions to phenomenology. Hence, this chapter will concentrate on the work of Merleau-Ponty (1908-1961), a pivotal figure in twentieth century French philosophy, who was profoundly influenced by both Husserl (1859-1938) and Heidegger (1889-1976) and irrevocably associated with Sartre (1905-1980) through friendship, acrimonious political disagreement and their philosophical work.

4.2 What is phenomenology?

Merleau-Ponty answered the question, "What is phenomenology?" in the preface to 'The Phenomenology of Perception' (1995) thus, "(phenomenological reflection) **steps back to watch the forms of transcendence fly up like sparks from a fire: it slackens the intentional threads which attach us to the world and thus brings them to our notice; it alone is conscious of the world because it reveals that world as strange and paradoxical.**" (p*xiii*). He directs us to look behind science at that which science exists to explain, to seek to illuminate 'pre-objective' experience. All efforts should be concentrated on **"re-achieving a direct and primitive contact with the world."** (p*vii*) and potentially, **"return to things themselves...return to that world which precedes**

knowledge, of which knowledge always *speaks*." (p*ix*) Instead of relying upon sociologists, historians or scientists to provide causal explanations for the way we live, phenomenology seeks to provide **"an account of space, time and the world as we 'live' them."** *(ibid.)*. One must endeavour to describe the world as it is, rather than analyse or explain it, for the world as it is experienced by the individual proceeds directly from what Merleau-Ponty calls the **"absolute source"** - that is, the person doing the experiencing. However, it is important to make clear that Merleau-Ponty was not straying into the realm of idealism (the philosophical doctrine of reality being mind-related; the external world being dependent on cognisant minds and thus reflecting what the individual thinks). He held a fundamental belief that the world existed and individuals were inextricably bound to the world.

4.3 The lifeworld

Although there is not the space to examine all his arguments in great detail, Merleau-Ponty stated that, **"(t)he world is there before any possible analysis of mine"** (Merleau-Ponty 1995, p*x*). It is a **"closely woven fabric"** (*ibid.*) which provides the **"backdrop from which all acts stand out"** (*ibid.* p*xi*) and the individual is unable to separate him/herself from the world, for even an instant because **"only in the world does he know himself"** (*ibid.*). In other words, people are only constituted as such whilst they are in (of) the world, 'being-in-the-world' is as essential as breathing. Without the world there is nothing, the world and the individual are intrinsically intertwined – every person is a **"subject destined for the world"** (*ibid.*). It is not about being present in the world, but instead being present *to* the world, turned always towards it, with an 'intentional

posture'. 'Intentionality' is a key concept in phenomenology and both Husserl and Merleau-Ponty argued that one cannot be conscious without being conscious of *something* – in other words, one must 'intend towards' something at all times – although not necessarily an object that exists in the world – the individual can intend towards ideas, dreams, imaginings for example. Merleau-Ponty required us to recognise human consciousness as a **"project in the world, meant for a world which it neither embraces or possesses, but towards which it is perpetually directed."** (*ibid.* p*xvii*). He goes further when he says that it is meaningless to seek further clarification of our relationship to the world through scientific analysis as, prior to any intellectual investigation, **"the unity of the world is 'lived'...as ready-made and already there"**(*ibid.*). However, this does not mean that further understanding is impossible, but instead of examination and explication, philosophy places the world **"before our eyes and present(s) it for our ratification."**(*ibid.*) I take ratification to mean description, 'open-eyed looking' that illuminates every detail. Merleau-Ponty called this the **"phenomenology of origins"** (*ibid.* p*xviii*) and he made it clear that to truly 'understand' is to take in the whole "intention" – not only what the thing is, but also that which makes it unique. He described it thus, **"...the unique mode of existing expressed in the properties of the pebble, the glass...in all the events of a revolution..."** (*ibid.* p*xviii*). In practical terms, when a researcher is seeking a deeper understanding of phenomena, they must reject scientific claims that the way in which the individual experiences the phenomenon is no more than the consequence of social, or bodily influences, instead they must seek to illuminate the essential nature of the phenomenon and to consider the fact that nothing is 'by chance' everything is drenched in meaning. Merleau-Ponty says that,

"Because we are in the world, we are *condemned to meaning*" (*ibid.* p*xix*). In other words, it is not possible to function in the world and move out from 'behind' the meaning we have accumulated through being present (being 'alive').

Rather than looking to historical or social process to explain the 'situatedness' of the individual, Merleau-Ponty rejected any such notions, **"my existence does not stem from my antecedents, from my physical or social environment: instead it moves out towards them and sustains them"** (*ibid.* p*ix*). Instead he established the subject as absolutely distinct (and supreme) from all other objects in the world, **"...for I alone bring into being for myself ...the tradition which I elect to carry on, or the horizon whose distance would be abolished...if I were not there to scan it with my gaze."** (*ibid.*).

4.4 The 'reduction'

Merleau-Ponty argued that the objective world, the taken-for-granted everyday world that encompassed all the minutia of life, was actually preceded by an 'invisible' or unseen phenomenal field in which phenomena take on the appearance of people or things. By 'invisible' I am alluding to the way in which this field passes unacknowledged by the seeing subject in the natural attitude, for it is **"the nature of perceptual experience to forget the phenomenal field, for phenomena themselves always direct us beyond themselves to the things they represent."** (Baldwin 2004, p15). Husserl (2002) preceded Merleau-Ponty in his admission that it was the **"unnatural direction of intuition and thought which phenomenology requires"** (*ibid.* p170) that made it such a

taxing discipline. He was referring to the task of looking away from or, as he said, 'reflecting' upon all that is taken for granted

"...we must practice 'reflection', i.e. make these acts themselves, and their immanent meaning-content, our objects. When objects are intuited, thought of, theoretically pondered on, and thereby given to us as actualities in certain ontic modalities, we must direct our theoretical interest away from such objects, not posit them as realities as they appear or hold in the intentions of our acts." (*ibid.*)

In situating the subject as supremely placed to experience the world with the immediacy and peculiarity of a unique individual, Merleau-Ponty's approach encouraged phenomenological researchers to scrutinise the description of the phenomena, reading and re-reading the narratives until they are 'wrung out' and an authentic understanding has been reached. He argued that it is only through the revelation of the phenomenal field that we achieve a true understanding, a peeling back of the layers of human existence until we bring into view that which passed unnoticed and taken for granted. He directed us to **"suspend for a moment our recognition of them."** (Merleau-Ponty 1995, p*xiii*) and by this he means to look at the world afresh, as if for the first time and be filled with wonder and amazement rather than familiarity and complacency.

Husserl understood that this could not be sustained for any length of time – **"the well-nigh ineradicable tendency to slip out of a phenomenological thought-stance into one that is straightforwardly objective."** (Husserl, 2002, p170). Even if firm results

were achieved, there was the difficulty of communicating the findings to others, as it is **"impossible to describe referential acts without using expressions that recur to the things to which such acts refer."** (*ibid.* p171). It is important to remember that Husserl was discussing the business of *pure* phenomenology - a philosophical process that aimed to reveal an objective theory of knowledge or in other words, **"the pure phenomenology of the experience of thinking and knowing."** (*ibid.* p166). It was a method whereby Husserl hoped to 'lay bare' the fundamental laws of pure logic, his ultimate goal was to 'transcend' subjective experience and confront the ego; rise above the lifeworld and consider a particular phenomenon from a purely epistemological viewpoint. The metaphor provided by Dahlberg (2001) to illustrate this, of a thoughtful phenomenologist sitting on a free-floating platform above the lifeworld with an unhindered view of the phenomenon in question, captures perfectly this notion of transcendental subjectivity. However, it is obviously impossible to truly depart from the world in which we are so thoroughly embedded. Merleau-Ponty argued that the reason Husserl constantly returned to an examination of the reduction is because he realised that it was impossible.

"The most important lesson which the reduction teaches us is the impossibility of a complete reduction...If we were absolute mind the reduction would present no problem. But since, on the contrary, we are in the world and our reflections are carried out in the temporal flux on which we are trying to seize, there is no thought which embraces all our thought." (Merleau-Ponty 1995, p*xiv*).

Merleau-Ponty names Fink (1995), Husserl's assistant, as providing the best formulation of the reduction and Dahlberg (2001) draws on his commentary to propose a more 'creative' approach to this epistemological disagreement – namely, placing the emphasis on the continuum between pure consciousness and lifeworld immersion. This pathway prompts the philosopher/researcher to develop skills of self-awareness and reflection and although always imperfect **"what matters more is that we realise the importance of taking the first step on the path towards objectivity, that we develop an awareness of the conscious processes that contribute to our understanding of the phenomena."** (*ibid.* p63). Merleau-Ponty put it succinctly when he said that the philosopher was always a beginner and must take nothing for granted, not even philosophy itself and that **"radical reflection amounts to a consciousness of its own dependence on an unreflective life, which is its initial situation, unchanging, given once and for all."** (Merleau-Ponty 1995, p*xiv*).

There is considerable, ongoing debate within phenomenology regarding the status, feasibility and practicalities of achieving the reduction (also called the 'epoche') when carrying out phenomenological research. The arguments centre round whether it is possible to effectively banish all prior knowledge of the subject and approach it with a clear mind and unblemished contemplation – a confoundedly precarious position to try and occupy for any length of time. In accordance with phenomenological principles, the researcher must be as free as possible from assumptions and suppositions about the phenomenon being studied. Husserl called this process the epoche and it originated in his directive to put

"out of play all positions taken towards the already given Objective world...(this) does not leave us confronting nothing...what we acquire by it is my pure living with all the pure subjective processes making this up and everything meant in them *purely as* meant in them, the universe of 'phenomena' in the...phenomenological sense." (Husserl 1988, p20).

However, Husserl was a philosopher not a researcher and his interests lay in the study of pure consciousness. His was a quest for unassailable truths and as Ashworth (1996) pointed out, *pure* phenomenology is by definition incompatible with psychological enquiry. However, in his later work Husserl moved from an emphasis on transcendental idealism to the concept of the lifeworld, which became the foundation for phenomenological psychology and research. Heidegger and Merleau-Ponty dismissed the phenomenological transcendental 'epoche' as deceptive since it is impossible to put the world 'aside' and contemplate that which is left because the world precedes all reflection. According to Merleau-Ponty (1995)

"...what is at least certain for us is that there are things, that is to say, a world. To ask oneself whether the world is real is to fail to understand what one is asking since the world is...the inexhaustible reservoir from which things are drawn." (p344).

Ashworth (1996) explained how Merleau-Ponty argued that the existence of a transcendental realm is only compatible with an irreducible lifeworld. Therefore, instead

of the 'epoche' being a process of turning away from the world, it became an activity whereby the researcher put aside theories, prejudices, conjectures and presuppositions so as to be present in an open manner to the pre-reflective lived experience of the interviewee. Likewise, Heidegger considered that contemplation of the transcendental world was an activity performed within the lifeworld and not a revelatory activity that lead to the discovery of **"privileged, foundational truths"** (Ashworth 1996, p9).

'Bracketting' in phenomenological research allows the lifeworld of the participant to yield to the curiosity and perspicacity of the researcher and appear without obstruction and obfuscation so that a greater understanding of the particular phenomenon can be successfully achieved. The lifeworld is studied without reference to any external variables that may be utilised to confirm objective reality, instead **"alleged facts of objective reality have no power to confirm or refute the descriptions which investigation provides of phenomena of the lifeworld"** (Ashworth 1996, p12). There need be no search for **"inner or outer 'causal' factors in order to explain experience or behaviour"** (*ibid.*), in fact the aim is not to rationalise, explain or justify the experiences of the interviewee and issues of biography and history are not taken into account. 'All' that is required is an accurate, detailed description of the phenomenon as experienced by the research participants.

Phenomenology focuses upon concrete descriptions of experiences that the participants have lived – therefore it was not necessary for the women in my study to understand why they felt a certain way or reacted to circumstances in one way or another - I wanted to

know *what* had happened not why or how. Furthermore, phenomenology removes the researcher's obligation to know in advance what they are searching for. I did not have to restrict the study to a particular aspect of early mothering; instead the women who participated made these decisions in the process of sharing their story with me. They determined what was important and communicated this to me in the course of the narrative – if it wasn't important, it wasn't mentioned. Conversely, significant events were contextualised with considerable detail thus ensuring that I understood the meaningfulness of the experience for the women relating it. This process also allowed for divergent meanings to emerge for what might appear to be a broadly similar issue experienced by two or more of the women. By restricting themselves to relevant descriptions about the transition to motherhood, whilst locating these experiences within the context of their individual lifeworld, an enormous amount was revealed and a comprehensive picture constructed of this intangible and complex phenomenon.

When carrying out a phenomenological study the researcher must allow the lifeworld to **"enter anew into consciousness, and to look and see (it) again, as if for the first time...Whatever or whoever appears in our consciousness is approached with an openness, seeing just what is there and allowing what is there to linger."** (Moustakas 1994, p85). In other words, the epoche provided the researcher with the opportunity to truly look at and listen to what is before consciousness, prior to reflection and without making judgements or apportioning greater or lesser value to different aspects of the experience. However, it should be noted that the 'epoche' is never absolute; all people, including researchers, are constructed by their own lifeworlds from which they cannot

escape. The lifeworld provides a context for existence and as such is fundamental to 'being'.

4.5 The body and 'flesh'

Towards the end of his life Merleau-Ponty embarked on what would have been a substantial body of work had he completed it before his death. In "The Visible and the Invisible" (1968) his primary concern was ontological, in so much as he was trying to move beyond the subject/object language of consciousness and discard the notion of 'being' entirely, replacing it with his notion of 'flesh'. However, Merleau-Ponty's 'flesh' has nothing in common with the familiar understanding of the word – it is not matter, nor is it body. Defining absolutely what was meant by the term is outside the boundaries of this paper. Nevertheless although it remains a contentious and closely debated issue within scholastic circles, moderate interrogation within the context of this chapter will be useful. 'Flesh' is described by Merleau-Ponty as an **"ultimate notion…concrete emblem of a general manner of being."** (Merleau-Ponty 2004, p247). In developing his theory of 'flesh', Merleau-Ponty thought he could overcome the inherent solipsism of modern thought and discover the basis for a genuine intersubjectivity. To illustrate what he meant by 'flesh', Merleau-Ponty used the illustration of touching one hand with the other hand so that both are touched and touching simultaneously. This was first referred to in "The Phenomenology of Perception" (Merleau-Ponty 1995) and returned to in "The Visible and the Invisible",

"Between the exploration and what it will teach me, between my movements and what I touch there must exist some relationship...(an) initiation to and the opening upon a tactile land. This can only happen if my hand, which is felt from within, is also accessible from without, itself tangible for my other hand...Through this criss-crossing within it of the touching and the tangible, its own movements incorporate themselves into the universe they interrogate, are recorded on the same map as it. (Merleau-Ponty 2004, p251).

This experience revealed two dimensions of 'flesh', the touched and the tangible – the hand can experience touching and it can experience being touched and the relationship can be inverted, and is, repeatedly and it is this reversibility that Merleau-Ponty maintained is the essence of 'flesh' (Baldwin in Merleau-Ponty 2004, p248.). **"It is the coiling over of the visible upon the seeing body, of the tangible upon the touching body"** (Merleau-Ponty 2004, p261). The body is instituted as a chiasm or crossing-over and is an intertwining of subjective experience and objective existence. The concept of 'flesh' has no equivalent in the history of philosophy and it represented Merleau-Ponty's attempt to overcome the subject/object dichotomy. Rather than these two distinct forms of reality, subject and object were **"differentiations of one sole and massive adhesion to Being which is the flesh"**(*ibid*, p257). He was trying to break down the distance between seer and the seen and introduce the notion of **"intercorporeity"** (*ibid*)

"If we can show that the flesh is an ultimate notion, that it is not the union or compound of two substances, but thinkable by itself, if there is a relationship of the

visible with itself that traverses me and constitutes me as a seer, this circle which I do not form, which forms me, this coiling over of the visible upon the visible, can traverse, animate other bodies as well as my own." (*ibid.* p257).

This notion of a new general manner of 'being' is 'criss-crossed' with reciprocity and reversibility so that all that is invisible is actually present and in any union there is a confluence between that which is present as subject and that which the subject is directed towards – to such a degree that one becomes immersed in the other and vica versa. Merleau-Ponty (2004) urges us to let go of resistance and, **"...habituate ourselves to think that every visible is cut out in the tangible, every tactile being in some manner promises to visibility and that there is encroachment, infringement, not only between the touched and the touching but also between the tangible and the visible."** (*ibid.* p251).

In his complex discussion on the status of the body he aimed to replace the notion of the body as another object in the world with the body as that through which all our experiences of the world are mediated – the subjective body or 'phenomenal body'. Dahlberg (2001) asserted that it would be difficult to overstate the importance of the subjective body to Merleau-Ponty. The body is the lived body, embedded within the lived world and is **"our means of communication with it...the horizon latent in all our experience and itself ever-present and anterior to every determining thought."** (Merleau-Ponty 1995, p92). Merleau-Ponty talks about the body as being that which both constitutes the seer and makes the object visible – rather than being an obstacle it is their

mode of communication in so much as the thickness of the body is the only means whereby the subject can be in the world – remove the body from the subject and the subject immediately ceases to be. **"The thickness of the body, far from rivalling that of the world is on the contrary the sole means I have to go unto the heart of things, by making myself a world and by making them flesh."** (Merleau-Ponty 2004, p253). The body is the medium though which the subject is present to the experience (phenomenon), it is not possible to encounter anything without the body, **"It is the body and it alone...that can bring us to the things themselves."** (*ibid.*). In explaining the way that the subjective body replaces the traditional dichotomy between body and soul, Merleau-Ponty (1995) described it thus,

"Man taken as a concrete being is not a psyche joined to an organism, but a movement to and fro of existence which at one time allows itself to take corporeal form and at others moves towards personal acts. Psychological motives and bodily occasions may overlap because there is not a single impulse in a living body which is entirely fortuitous in relation to psychic intentions, not a single mental act which has not found at least its germ or its general outline in psychological tendencies." (p88).

What he means is that body and mind always function together, their relationship is distinguished by its immediacy – human beings do not have to pause whilst thought translates into action or vica versa. We have an unreflective awareness of ourselves or as Dahlberg (2001) says, **"One relates to one's body and oneself in the natural attitude."** (p51). The importance of this for research is that, when seeking a deeper understanding of

a particular phenomenon, one must pay close attention to the interviewee's subjective experience as their experience will be both unique, and contain familiar strands that reach out to those who have also experienced the phenomenon. Everything that is experienced is mediated by the embodied self, even concepts of space, time and memory. Merleau-Ponty (1995) reminds the reader that in considering space and time one should speak of bodies *inhabiting* space and time rather than the body *in* space or *in* time – the body's relationship to time is one of embodiment, as it is to memory.

"The part played by the body in memory is comprehensible only if memory is, not only the constituting consciousness of the past, but an effort to reopen time on the basis of the implications contained in the present, and if the body...is the medium of our communication with time as well as with space." (Merleau-Ponty 1995, p181)

In other words, memory is enfolded within the body, conveyed through the body and recounted with inevitable compromise from a place where the memory is complete; (this relates to Gendlin's 'pre-separated multiplicity' (1991) which is discussed in more detail below). Remembering entails being as faithful as possible to the situation, being engaged **"in a kind of process in which there is a creative tension between language and** (a) **more bodily felt-sense of** (the interviewee's) **situation."** (Todres 1999, p292).

5.0 Phenomenology as method

5.1 Introduction

This chapter will clarify the aim of a phenomenological study and the way in which the 'reduction' is considered fundamental to the research process, as well as the problems of maintaining such a clear, open-minded attitude to the data. The concept of the general structure will be examined as well as a discussion of the contemporary disagreements regarding its status within the research process. The importance of formulating a question with which to commence the interview that encourages the women to provide rich, evocative descriptions of the phenomenon is also considered in some detail.

5.2 Orientating to the phenomena and preparatory thoughts

It is more accurate to talk of phenomenology as an approach to greater understanding rather than a clearly defined method of study. The aim of a study that uses a phenomenological approach is to faithfully and sensitively describe the way in which a phenomena is experienced – the way the subject 'embodies' the experience, in this case 'the transition to motherhood'. There are many other phenomenological studies from which to draw guidance and clarification. These include 'playing chess' (Aanstoos 1985), 'being criminally victimised' (Wertz, 1985), 'living with PND' (Beck 1992), 'coping with pain' (Bradley-Springer 1995) and 'being ashamed' (Vallelonga 1998). The quality of the study depends primarily on the depth, richness and complexity of the description provided by the participants, which is dependent on the quality of the trigger question and the interviewer's implicit and explicit skills in encouraging and nurturing a detailed

description, without limiting or determining the subject matter. Rather than seeking data from a large number of participants, this was best served by studying the expansive testimonies of a small number of women, in considerable depth. To achieve a meaningful analysis of the stories told by the women there needed to be a manageable number of transcribed data. The emphasis must be on the *quality* of the narratives obtained and the skill in revealing the meanings contained therein rather than the *quantity* of words and pages. However, Giorgi (1985) made the point that, the more people were interviewed the greater the diversity of their experiences of the phenomenon might be, and hence an enhanced opportunity for the researcher to discover what was essential in their experience. However, it is possible to carry out a phenomenological study on one person (even on oneself) and still reveal essential aspects of the phenomenon as Giorgi demonstrated in his study on the psychology of learning (Giorgi 1985). Simms (2001) in her study on breastfeeding and co-existence and Bradley-Springer (1995) in her study on being in pain took the somewhat unorthodox step of researching their own experience.

Kvale (1996) described the over-burdened qualitative study as **"the 1,000 page question"** (p176). He goes on to warn the researcher that too many pages result in a superficial inquiry with a deficient overview and an inadequate conclusion, usually caused by time constraints curtailing the analysis prematurely. I would add the risk of researcher overload and frustration. With this in mind, I interviewed seven women and their narratives produced eight-six pages of text, which was converted into over five hundred meaning units.

In his defence of quality versus quantity in research Giorgi (1976) conceded that the natural sciences have benefited enormously from the quantitative approach adopted by some researchers. However, research on and about human beings benefits considerably from the additional material produced by a qualitative approach. Giorgi argued that to quantify people means to objectify them **"and objectified man is not a human person"** (*ibid.* p19). Human beings are immersed in experience and to understand those experiences the researcher must discover the quality, the uniqueness of the phenomenon (for instance - feeling anxious, or loved or victimised). Moreover, phenomenology provides the opportunity to articulate the nuances of the experience as well as the 'general structure' and 'constituents' of the phenomenon (these are key concepts within phenomenology and will be discussed in greater detail below). Phenomenology does not require a 'pure' example of the experience being studied, as is sometimes the case in traditional psychology (by a pure example I mean a definitive example against which psychologists can compare future presentations of, for example depression or anxiety). According to Giorgi (1966) **"it seems that the idea of an essential theme with multiple manifestations is a better model for research for the human sciences than identical repetition or duplication."** (p20).

Traditional research on birth and the postnatal experience might group women as those who had a vaginal birth and those who had a caesarean, or examine analgesia during labour or feeding choices. It would not be unusual for those factors to be implicated in the way in which women adapt to motherhood, possibly seen as predictive indicators of a successful or problematic transition. Traditional research often aims to account for all

variables, manipulating certain factors in a controlled manner to examine the outcomes and draw clear, unambiguous results.

"Uniqueness refers to an understanding that the individuality of participants takes priority over their position as representatives of a larger group. Lifeworld researchers are not interested in controlling, as potential bias, the unique perspective of individual participants". (Dahlberg 2001, p116).

In phenomenological research the participants are seen as unique individuals who are present in the world in such a way that no one else can truly share or replicate their experiences. They are not considered to be representatives of larger groups such as those defined by social class, age, gender, sexuality or ethnicity.

5.3 The 'general structure' and its constituents

Phenomenology does not aim to make comparative statements about different population groups, rather it is directed towards the identification of general structures and components of the phenomenon. In other words, the researcher is searching for particular aspects of the experience that are constant for the participants and *may* be familiar to others who have experienced the same event. If these particular aspects of the experience were absent then it would be a different experience. A crude but effective example of this is provided by considering the phenomenon 'chair'. Chairs can take a multiplicity of forms within consciousness and different descriptions will demonstrate endless possibilities. However, central to these variations is a principal 'model' that contains

within itself the limits to the definition of a chair and unifies all chairs, real or imagined. For instance, a chair has to have a seat otherwise it would not be a chair but it could be constructed from a wide variety of materials and be as big or as small as imagination will allow. Husserl explained

"...a unity runs through this multiplicity of successive figures, that in such free variations of an original image, e.g., of a thing, an invariant is necessarily retained as the necessary general form, without which an object such as this thing, as an example of this kind, would not be thinkable at all." (Husserl 1973, p341).

For instance, in Aanstoos' (1985) phenomenological exploration of 'Thinking in Chess' part of the essence of the experience was **"Thinking...is a process of discovery and making explicit certain implicit possibilities that are taken by the thinker to be present in the position"** (p94). If this were omitted then the description of the experience of thinking in chess would not accurately reflect the descriptions provided by the participants.

Fundamental to the uniqueness of human beings are common threads that connect us all. These **"cultural discourses which traverse the texts of our lives"** (Day Sclater 1998, p67) provide a familiar framework within which we all live and make sense of the countless interactions we share with each other. Humans are united in their sameness in so much as they have similar experiences in the world and by the fact that we are all human, whilst simultaneously remaining unique and irreducible in the way we chose to

live that life (Dahlberg 2001). Working within this dichotomy is a distinguishing feature of phenomenological research and will be enlarged upon below.

The general structure of the phenomenon is discovered by studying the vicissitudes and particulars of a person's lifeworld with reference to the experience under investigation. It involves 'unpacking' the meaning from the narratives, through a process of dividing the text into manageable meaning units and transforming them – turning them inside out – so that the essential information is emptied out onto the page and the researcher can begin to synthesise the meanings into a structure that weaves them together into a new whole. This new whole is called the general structure and is the essence of the experience for the study participants

5.4 The status of the 'essence' or general structure in phenomenological research.

Since starting this study, the status of the 'essence' in phenomenological research has changed – both for me personally as a researcher and also within phenomenology generally. Initially I was convinced that a phenomenological approach, if diligently and rigorously applied to a particular experience, would reveal the essential meaning or essence of the phenomena, that was true throughout all variations and for all individuals experiencing that particular 'thing' (Giorgi 1997, Dahlberg 2001). I became less convinced as I considered the possible reactions to my results, when published. If just *one* member of my 'audience' objected to my essential description of the phenomenon by declaring that she did not recognise her own experience within the general structure or

constituents, then this would fundamentally undermine the claim I was making. A less controversial, more cautious and 'idiographic' understanding of the findings generated from a phenomenological study are those of Ashworth (2003a, 2003b) and Van Manen (1990).

The version of phenomenological psychology that has been practised at Sheffield Hallam University for some years eschews the search for essences. Ashworth (2003a, 2003b) explained that the revelation of a particular lifeworld should be considered an 'idiographic' project in that it is related to an individual's unique experience and first-person account of a particular phenomenon. He distinguished between *the lifeworld* that is essentially unknowable and without which there would be no human existence and *lifeworlds*, distinct 'segments' of the lifeworld, actualised **"by the co-presence of particular individuals with their special set of projects."** (Ashworth 2003*b* p146). Ashworth emphasised that the researcher must not confuse the *particular* lifeworld with the *universal* lifeworld, nor must they seek to discover an essential structure within the particular. Instead, one must be open to the emergence of general themes but not presuppose their appearance as to do so would mean that the researcher had failed in the phenomenological 'epoche' and had not bracketted the fundamental assumption that a universal essential structure would be discovered. Ashworth (2003*a*, 2003*b*) lays claim to a considerable authenticity for any essences that *do* emerge in the course of analysis because,

"If essential – or even merely general – structures do emerge as a result of our studies, the fact that the existence of these has *not* been presupposed in the methodology of the research means that they gain enormous credibility." (Ashworth, 2003*a*, p146).

Van Manen (1990) was also cautious in his interpretation of essences. He argued that rather than being **"some ultimate core or residue of meaning"** (p39), phenomenological analysis should be 'demystified' and understood as revealing aspects of the experience that have been concealed. The general structure should be an accurate, evocative, receptive description of the experiences of the interviewees. Furthermore, it should provide an illuminating portrait of untold 'parts' of the experience that taken together might disclose some (but not all) of the essential structures of the phenomena, that in turn should resonate with other people who have shared the experience being studied.

"A good description that constitutes the essence of something is construed so that the structure of a lived experience is revealed to us in such a fashion that we are now able to grasp the nature and significance of this experience in a hitherto unseen way." (*ibid.* p39).

5.5 The research question

From the outset, this research had been seen as a voyage of discovery (Giorgi 1985) rather than the testing of a hypothesis or the gathering of statistics. The subject for investigation needed to be an 'everyday' experience in which I was deeply interested –

one that was **"descriptively well bounded so that the specifics, in terms of lived meanings expressed by the subjects could emerge."** (Giorgi 1993). For a phenomenological study to be successful, the researcher needs to cultivate an openness to the phenomena being studied, a clearness of mind and a willingness to be surprised and to embrace whatever presents itself to consciousness. Humility, sensitivity and flexibility are desirable features when conducting the interview and engaging with the text (Dahlberg *et al* 2001) and the researcher must treat the phenomenon with respect, as something about which it is not possible to discover everything there is to know. In other words, the phenomenon is always greater than the researcher. Being open to the phenomenon whilst remaining vigilant about all preconceived ideas and prior assumptions about the topic during the research process was a commendable principle to work towards but it was enormously challenging in practice as I will describe below in more detail.

My interest in mothering stemmed from both my personal and professional life. As a midwife I worked with new mothers and had been struck by how ill prepared the majority of women seemed to be for both the relentless demands of a new baby and the personal and social transformation, brought about by the birth of their first child. These issues became even more pertinent when I became a mother and experienced a profound sense of shock and disorientation after my son was born - more so because I had assumed that my professional knowledge would cushion the transition for me, whereas in reality it proved to be extraneous. When deciding upon a phenomenon to study, Van Manen (1990) directs the researcher to examine a phenomenon about which they have a deep

concern and interest, **"To truly question something is to interrogate something from the heart of our existence, the centre of our being"** (p43). Unless the researcher 'lives' and 'becomes' the question it will not be possible to achieve the depth of illumination and disclosure that is the aim of phenomenology. Having personally felt the force of the transforming effect of becoming a mother, I wanted to discover what this experience meant to other women. What does it mean to become a mother in our culture? How do women cope with the demands of a new baby?

In formulating the question, I had to be clear exactly what experience I wanted to learn more about. The peurperium has been the object of a considerable body of research – physiological changes after birth, the detection, treatment and prevention of postnatal depression, infant feeding and social support have all been the focus of both qualitative and quantitative studies and large amounts of valuable data had been generated. However, what was noticeably absent was any effective and practicable strategy to identify and support women at risk of depression after becoming mothers and improve their psychological adaptation to motherhood (Nicolson 1998). Furthermore, persuasive arguments revealed our professional ignorance as to what constituted a normal transition to motherhood and what defined it as problematical (Barclay &Lloyd 1996, Nicolson 1998). In her detailed evaluation of screening services for postnatal depression (PND), Shakespeare (2001) concludes that less than 50% of cases of PND are detected by primary healthcare professionals, that primary prevention of PND is piecemeal and ineffective, that there is no universally acceptable screening tool and even if this were available, access to secondary care varies significantly throughout the country.

Consequently, I concluded that alongside the burgeoning professional and academic interest in the postnatal period, women were still struggling with the same problems, with few successful professional initiatives to improve their experience.

Perhaps the most striking inadequacy of much of the published research is the failure to refer *directly* to women's experiences. **"One could be forgiven for thinking that** (postnatal depression) **renders mothers speechless, so rarely are their voices to be heard"** (Brown *et al* 1994, p173). There are admirable exceptions to this criticism, for instance Bergum (1989), Beck (1992), Brown and colleagues (1994), Aiken (2001) as well as first-person accounts such as Alibhai (1989), Shaw (1997), Chesler (1998) and Johnson (2000). I felt it was critically important that my research 'gave voice' to women's experience – but the question remained, of what exactly? Drawing on my own experience and informal discussions with other women, it seemed as though the birth of the baby was the catalyst for a journey from woman to mother, one of profound change and re-evaluation – and it was this lived experience of 'becoming' that I wanted to address.

In developing a question to ask the women who took part in the research, it needed to be clear, easily understood and non-directional. I did not want the women to theorise or provide explanations about their experiences; I wanted them to describe what it was like to become a mother. I avoided using 'scientific' words such as *transition, status* or *transformation* as it was important that the women felt at ease in the interview situation and not intimidated by my vocabulary. I also wanted to avoid any reference to particular

areas of the postnatal experience lest the women felt they were being directed by the question to address specifics. I required concrete descriptions of their 'pre-reflective' experiences that would serve as an entry point into their lifeworlds and I wanted the descriptions to contain whatever aspects of the experience were defining for them. With this in mind the following question was formulated:

"Please tell me, in as much detail as possible, of your experiences of becoming a mum".

6.0 The study

6.1 Introduction

This chapter explains the way in which the study was 'constructed' – recruiting the women who took part, arranging the time and place of the interview and then the process of listening to the women and the practical difficulties of orientating to their narratives whilst bracketting other knowledge, both professional and personal. The process of obtaining ethical approval is discussed in some detail, as is the consideration given to ensuring that the welfare of the participants was protected.

6.2 Inviting women to take part

The community midwives within one team based at Dorset County Hospital agreed to ask postnatal women if they would be interested in learning more about the research with a view to possibly taking part. At this point, women were given a brief explanation of the research by the community midwife and a short, general information sheet (see appendix one). This explained that the research was concerned with constructing a detailed picture of what it was like to become a mother for the first time and that they would be asked by the researcher to describe their experience of this during the course of one interview. If the women expressed an interest, the community midwife obtained permission for me to telephone them and introduce myself. The guidelines for recruitment were that the women were over the age of eighteen, spoke English as their first language (unfortunately financial restraints meant that interpreters were not available) and had given birth to their first baby within the previous two weeks.

6.3 When to interview

Deciding when to conduct the interviews presented some dilemmas. Although I was not planning to interview the women within the first two weeks of the birth, it was necessary for the midwives to mention my research during the that time as they only visited the women for this period, after the baby was born. In addition and drawing upon my own experience and that of my friends, the early weeks with a baby can feel particularly disorderly with frequent visitors both expected and unexpected, the midwife calling round and a debilitating lack of sleep. With this in mind, had the interviews been scheduled to take place within a few days of the birth, this would have presented an unnecessary intrusion into an already fairly chaotic period in the women's lives.

Enough time needed to have passed prior to the interviews for the women to have 'moved on' from the initial euphoria of birth. A 'situatedness' was needed, in so much as they were caught up within the transition to motherhood, living a life with their baby - but not so much time to have passed that they felt they could look back upon the transition as a completed process, without the experience of living the phenomenon during the interview process (the question of whether the transition to motherhood is ever completed is complicated and will be addressed later). Remaining true to the spirit of the phenomenological method required that no account was taken of any assumptions about the time it might take women to adapt to being mothers as this could have undermined and restricted the process of discovery.

The community midwives (with the women's permission) passed to me the contact details of those who expressed an interest in learning more about the research. I then rang them to introduce myself, arranged to send them the information sheet (see appendix one) and answered any preliminary questions. Approximately two weeks later, I telephoned again, at which point they indicated whether or not they would like to take part in the research. If they wanted to be included then we moved on to discuss the timing of the interview. A small minority of the women felt unable to make this decision only two to three weeks after giving birth, and as I did not want them to feel at all pressurised into making a commitment until they were ready, we would agree upon a date in the future for me to telephone and discuss the study further. The majority of the participants were keen to agree upon an interview date during this second telephone conversation.

It must be stressed that these conversations were always conducted in a relaxed, informal fashion, with the women often starting to disclose information about their experiences whilst on the telephone. With no exceptions, my impression was that they were eager to talk to me about the transition and had I detected any reluctance in their responses during our telephone conversations then I would have suggested that they might prefer to contact me when they were ready to be interviewed. As it was, all the women were keen to know when I was going to be in contact again either to conduct the interview or settle upon a convenient time to do so.

Based upon my own informal discussions with women, it seemed to be the case that becoming a mother was very much an organic, responsive process, and it was unlikely

that women passed through the same stages of adaptation and transformation at the same time. Therefore, to avoid imposing theoretical limitations on the richness and diversity of their narratives by assuming that by a particular point they would be more able to clearly describe and address specific areas of inquiry, the decision was taken to let the women's commitments shape the dates of the interviews. This process also went a small way towards redressing the power differential between researcher and interviewee. (The issue of power and control within the research process will be addressed in greater detail below). Consequently, the earliest interview was conducted eight weeks after the birth and the latest at six months.

6.4 The sample

Seven women were approached by the community midwives and all were eager to take part in the research. All seven women were interviewed and pseudonyms have been used.

NAME	AGE	MARITAL STATUS	PROFESSION	CAREER PLANS	TYPE OF BIRTH	FEEDING
May	28	married	social worker	returning, part-time	normal	breast
Wilma	29	married	receptionist	returning, part-time as a cleaner	normal	breast
Betty	23	married *	receptionist	returning, part-time	caesarean	bottle
Chris	28	married	shop assistant	returning, part-time	normal	changed from breast to bottle
Sue	36	married	not working	chose not to work	normal	breast
Jane	24	single	not working	chose not to work	forceps	breast
Yvette	30	married	estate agent	returning, part-time	normal	changed from breast to bottle

* Although Betty was married, her partner was in the forces and she had only seen him for two weeks since their baby was born.

All of the participants lived in villages within ten miles of a thriving West Country town, near to the coast. Although they were not affluent, several were homeowners; all worked who chose to and none appeared to be obviously socially or economically disadvantaged.

6.5 Ethical considerations

Ethical considerations for this research were concerned with the way in which the work would not only contribute to 'scientific' knowledge, but could also lead to improvements in the human situation being investigated. Further concerns were with the way in which informed consent was obtained, the impact of the interview process on the participants and the process of ensuring the women's confidentiality, both during the initial transcribing of the narratives and also later during reporting and publication.

- **Do no harm** – it is not enough that research does no harm to those who participate as well as to the wider community. The principle of non-maleficence is not as robust as that of beneficence whereby the research must be carried out with the expressed aim of 'doing good'. **"The sum of the potential benefits to a subject and the importance of the knowledge gained should outweigh the risk of harm to the subject and thus warrant a decision to carry out the study".** (Kvale 1996, p116). In the case of my research, there may have been a quasi-therapeutic benefit for the small group of women interviewed in having the opportunity to talk and reflect upon a life-changing event. However, whereas a therapeutic interview is designed to assist the person being interviewed in making changes in their life (or seeing with greater

clarity), a research interview is designed to gather knowledge. Had it become clear that therapeutic follow-up was required, this would have been discussed with the woman (see below). The general aim of this research was to improve midwives' and other health professionals' understanding of the way in which women experience becoming mothers so that we are better able to both prepare and support them during what is often a difficult transition.

- **Informed consent** – this entailed a sharing of information with the potential research participant regarding the aims of the research, the possible risks and benefits of taking part and the way in which the results would be utilised – all written or explained in accessible language. I hoped to gain the voluntary participation of the women, in the form of a signed consent form, whilst reassuring them that they were free to withdraw from the research at any time.
- **Confidentiality** – had the women felt that they would have been identifiable within the research it is possible that they would either have refused to take part or been considerably more guarded in their descriptions of their experience. Tape recordings and transcripts of the interviews were anonymised by allocating the participants a pseudonym. All research material is locked away in a drawer, to which I am the only person with access. Once the research is completed, and following best practice guidelines current at the time of submitting the proposal to the Local Research Ethics Committee, the tapes will be destroyed. Details of the pseudonyms are kept separately and securely and quotes used in the thesis will be utilised in such a way that anonymity will be ensured.

Kvale (1996) warned of the potential risk that interviewees could be seduced by the **"openness and intimacy"** (Kvale 1996, p116) of the interview situation and reveal information they may later regret. With this in mind a transcribed copy of the interview was posted to the women, by recorded delivery and they were invited to contact me by telephone if, on reflection, they preferred certain comments be removed. Although considered to be an essential stage in feminist research where the power differentials between researcher and researched must be reduced as far as possible (Oakley 2000), this process was potentially problematic as the women might have requested that large pieces of the narratives be removed, to the point where the descriptions were so truncated as to be virtually useless. Rapoport and Rapoport (1971) experienced just such a problem in their study on dual-career families. However, during my research no such requests were forthcoming.

6.6 Feminist ethical guidelines

I felt it was important that feminist ethical guidelines were also acknowledged and incorporated as far as possible, without compromising the aims of the research. Feminist scholars have expressed unease as to who is 'the knower' and what constituted knowledge within the research process (Stanley & Wise 1993). Lather (1991) stated that feminist research involved putting the social construction of gender at the centre of one's research, **"the overt ideological goal of feminist research in the human sciences is to correct both the *invisibility* and *distortion* of female experience in ways relevant to ending women's unequal social position"** (p71). A study such as this one, which invites women to speak freely about a subject that, up until recently has been marginalised as an

area not worthy of legitimate 'scientific' investigation, that seeks to understand rather than explain and ultimately to improve an often misunderstood life experience, can claim to be 'making visible' and correcting some of the distortions through which women's lives are contextualised and delimited.

Below are some broad principles for doing feminist research (adapted from Stanley & Wise 1993, p200):

- The feminist researcher is required to acknowledge her own reflexivity and constructive activity within the research process
- The 'objects' of the research are acknowledged to be people with complex and unique lives and perspectives and not simply the source of useful data
- The researcher rejects any notion of intellectual superiority and accepts that it is not her role to assess the narratives for their accuracy and truthfulness in describing the experience of the interviewee.
- It is crucial that feminist research is not just research carried out by women on women, but that it is carried out *for* women – with a view to bringing about change and improvement in the lives of women (Webb 1993, McPherson 1983).

Although the above are commendable aims that seek to subvert the established order within traditional research and introduce a more egalitarian framework, I agree with Oakley (2000) that too great an emphasis on research as an emancipatory activity coupled with the belief that democratic relations guarantee validity, resulted in feminist researchers **"getting into something of a tangle"** (*ibid.* p36). Eventually a compromise

had to be reached whereby an unassailable knowledge differential was presumed between the researcher and those upon whom the research is carried out. It is disingenuous to claim that researcher and researched are equal when, as Theman (1979) explained, overall control of the research resides with one person who will ultimately enjoy the intellectual achievement, gain greater recognition and the possibility of professional advancement when the results are published. He argued that there is greater value in admitting to the disparity and taking steps to change it rather than **"not being a genuine person, in a situation where that is demanded** (as this) **means missing the point."** (Theman in Dahlberg 2001, p158). In other words, claiming that researcher and participant are equal is disingenuous to the extreme and such a claim distorts the **"level of reality claimed for** (the study)" (*ibid.*). Likewise, Giorgi (1985) pointed out that he did not expect the research participants to be phenomenologists. Rather they should recount their experiences just as they happened – spontaneously and without reflection or artifice. Reflection and analysis are the 'jobs' of the researcher. Even the most sensitive researcher must concede that the power relations within the research situation cannot be entirely removed, however empathetic and enlightened the researcher (Day Sclater 1998).

6.7 Ethical approval

Ethical approval was granted by the Local Research Ethics Committee. The Head of Midwifery and two of the three obstetric consultants (the third being on sabbatical) gave their support to the research proposal. From the outset the women were assured that they could withdraw from the research process at any time and that this would not be reflected in the care they received from their health care providers. They were also given the

option of deciding where the interview took place – their home, the local health centre, or the hospital and they all chose their own home. The women were invited to sign the consent form prior to the interview taking place and every effort was made to provide adequate time for them to ask questions and express any concerns they might have, both by telephone before the meeting and face-to-face in their homes. Consent was sought and granted by the women to tape record the interviews.

Certain safeguards were included within the research process as it was clear from the outset that offering women the opportunity to discuss their experiences of becoming mothers could cause them to relive traumatic birth events or reveal that they were overwhelmed with the demands of a new baby and possibly required further social or psychiatric support. Had any of the women demonstrated any signs of psychological trauma or themselves expressed a need for counselling, practical support or medical evaluation I would have discussed with them potential sources of assistance. I would have suggested that the woman see her GP and, with her permission, would have discussed her needs with her health visitor and possibly provided the contact details of appropriate support groups. I would also have ensured that she had my telephone number and returned to see her at her convenience. Although the women's descriptions contained much that revealed the various problems with which they were often still struggling, it was not necessary to offer any substantial or professional support to the women following the interview. However, during my interview with Wilma I empathised with her description of feeling isolated, living in a village where she felt herself to be a stranger and after the interview had concluded I suggested that she might like to attend a Toddler

Group nearby which I had visited and found to be friendly and welcoming. I later heard from her (we met unexpectedly whilst shopping) that she had acted upon my suggestion and had found it to be very beneficial.

6.8 The interview

During our telephone conversations I requested that the interview be carried out with no-one else present (other than the baby). I felt it was possible that the women might wish to talk about how becoming mothers had affected their relationships with their partners (where this was relevant) and it was important that they were not inhibited in the subject matter that they chose to discuss. Likewise, with their partner (or significant other) present the women may have felt under pressure to describe motherhood in a way that conformed to certain ideals held by their partner or companion, rather than how they themselves were experiencing it.

My aim was to remain open to new and unexpected phenomena. Rather than having to rely upon systems of interpretation and categorisation to illuminate the data I wanted to immerse myself in the women's narratives, carefully observing their gestures and 'body language' and making no judgements or assumptions about their experiences. Instead of seeking definitive clarification when the women appeared to contradict themselves, such ambiguities were welcomed as indications of the complexities and incongruities of both the particular phenomenon and their life world in general. As Day Sclater (1998) remarked, during her analysis of one woman's narrative about her divorce, **"It is through an exploration of these oppositions that it is possible to discern the constructions**

and transformations of subjectivity that occur within the narrative" (p75). Likewise, in this research, the apparent inconsistencies in the narratives were not 'mistakes' but instead reproduced the women's changing consciousness as they reflected upon their experiences and built up a verbal picture, layer by layer.

As the aim of the interview was to elicit a description of the phenomenon that was as true as possible to the women's experience, I very much wanted to accompany the women on their individual narrative journeys without attempting to guide their recollections. My reasoning was that the women would describe the particularities of the experience that were significant for *them*, whereas if I was to question them about aspects of becoming a mother that I considered to be important (for example, "Did you ever feel depressed?" or "How did becoming parents effect your relationship with your partner?"), crucial details of their experiences of becoming mothers might have been overlooked as they sought to respond to my particular questions.

Anderson and Jack (1991), in their chapter entitled 'Learning to Listen', highlight the pitfalls of approaching interviews with an inflexible 'agenda'. The authors described a study in which they interviewed rural American women about their farm activities. In retrospect they realised that remaining within the study's original parameters determined their questions and responses and instead of creating an open, empathic space for the women to share their life stories, severely limited the interview's potential for discovery and reflection.

"Instead of encouraging further reflection on the importance of her relationship with her sister or on the difficulties of that period in her life, my next question followed my imperative for detailing her role on the farm." (Anderson & Jack, 1991, p14).

When an interviewee described her powerful need to 'escape' from her mothering role, the subsequent question about whether she was active in clubs ignored all the emotional content of her comments (*ibid*). These examples demonstrated the critical importance of providing narrative space for the women to tell their own stories, dwelling on what they feel encapsulated their unique experience of the phenomenon.

Having asked the trigger question in the interviews in my study, I then made only minimal contribution to the interview, except to murmur or smile encouragingly. However, I was aware that the descriptions that the women shared with me would be directly influenced by my presence even if I only spoke a few words. We were engaged in a dialogue on many levels. Although I only contributed a few words to the conversation, it is undeniable that my age, sex, the way I was dressed and my body language would all have subtly influenced the way in which the women responded to my question.

Prior to the interview commencing I explained to the women that my response to their words would be minimal. For the majority of the women interviewed, this was no obstacle to producing a long, evocative and detailed description. However, one of the

women requested that I direct her narrative as she "Didn't know what to say". This took the form of very general guidance such as, "Why don't you describe for me your experiences when you first came home from hospital". When such prompts were required it was crucial that they did not originate from theoretical or professional knowledge of the transition. During the interviews, I did have occasion to refocus the women's narrative – away from generalities or speculation and back to specific descriptions of the phenomenon. For example, during the interview with Jane there were occasions when her narrative would drift away from concrete descriptions of her experiences and she would start reflecting upon how a mother might successfully raise a son and whether individuals have the capacity to change for the better – provocative topics but outside the parameters of my research. This refocusing was achieved by requesting further detail and specific examples to illustrate earlier comments.

The aim of the interview was to gain a deeper understanding of the lifeworlds of the women and to meet with the phenomenon on as deep a level as possible, remaining open to unexpected revelations. As Gadamer (1995) explained **"Thus a genuine conversation is never the one we wanted to conduct...No one knows in advance what will come out of a conversation...it allows something to 'emerge' which henceforth exists"** (p383). To enable me to discover the constituents and general structure of the phenomenon as well as the diversity and variation intrinsic to the women's experiences, it was vital that the narratives contained detailed, rich descriptions of the women's daily lives with their new babies.

6.9 Remaining within the 'epoche'/'reduction'

As has been stated, consistently managing to remain within the 'epoche' when conducting research required constant vigilance. The process I underwent is detailed below. Initially I sought to address my professional knowledge about the transition to motherhood. The transition to motherhood is a vast and complex subject, theories of which abound in midwifery, obstetrics, social science, feminism, social anthropology, psychiatry, personal reflection, media commentary and the arts. It was not possible to consciously acknowledge and 'make notes' on all these influences but I was aware of their 'chattering voices' during the analysis of the data and to still these voices involved complete concentration on the stories the women had shared with me. All my energy had to be targeted on the narrative I was reading, I had to cultivate an openness to the women's words without allowing my formal knowledge to influence how I understood their experiences. For example, when May described how guilty she felt, not wanting the baby in the same room as her when she slept, I found myself thinking about the information midwives give to women to reduce the risk of sudden infant death syndrome, (part of which, is that babies sleep in the same room as the parents until they are six months old) without necessarily considering the impact of their well intentioned advice.

"All the other mums that I knew were having their babies in bed with them, sleeping with them, with the cot next to the bed and I just couldn't do it…and in fact it got to the point where we put (the baby) *in her own room at about four weeks which I felt terribly guilty about too."* (May).

When I found myself trying to 'fit' a woman's description into midwifery theory then I would pause, mentally 'set aside' those ideas and re-read the passage with as clear a mind as was possible. A more troublesome but conceivably enriching 'complication' was my own personal experience as a mother. Mothering is a fundamental part of my lifeworld, it is the horizon against which all other projects are accomplished as well as being intrinsic to my embodied sense of myself. In other words, it was impossible for me to engage with the research or the women as anything other than a *mothering woman*, moreover one for whom the transition was problematic and destabilising. However, I did attempt to follow Moustakas' (1994) directive **"...with intensive work, prejudices and unhealthy attachments that create false notions of truth and reality can be bracketed and put out of action."** (p90). I resolved to first recognise and acknowledge my own experiences but then consciously restrict them lest they become the filter through which I experienced the women's stories. I embodied my own journey from non-mother to mother and it was inevitable that through the research process I would encounter dissension and confirmation and might have felt disorientated as I tried to make sense of experiences that were both similar and different from my own (Dahlberg *et al.* 2001). In retrospect, I would take issue with Moustakas' (1994) exhortation as, although principled, it seemed almost an absurdity to expect a researcher to 'put aside' an aspect of her being that is so utterly fundamental – rather like advising a male researcher to temporarily forget his sex and gender during the research process.

To assist me in this process I have kept a personal diary for many years and my reflections on the research process are recorded on its pages. The entries are a personal

commentary on the narratives; a space to reflect upon my reaction and an example of the difficulties I encountered is described below:

'It is so difficult to listen to the women recounting their experiences and not compare them to my own, the disruption that a baby brings, the aching tiredness – and the constant, nagging anxiety, I have to bite my tongue during the interviews to prevent myself from leaning forward, reaching out my hand and saying, "Oh, I so agree with you, it can be horrendous can't it?"'

Writing down these reflections was an enlightening process that revealed to me my prejudices and assumptions about the phenomenon. Failure to consider this could have created a false notion of truth and reality and although it was impossible for me to *not be* the person that I am, by rigorously orientating myself towards the phenomenon as it is represented in the women's stories I remained open and able to be utterly absorbed in their lived experiences of the phenomenon.

7.0 Analysis of the data

7.1 Introduction

Beginning with a careful description of the guidelines used to analyse the narratives, this chapter continues with a discussion of the possible limitations identified in a strictly descriptive account of the general structure of the phenomenon. An argument is made in support of a textural, evocative account of the essential constituents of the experience (as described by the participants), rather than a purely 'scientific' exposition of the 'bare bones' in the hope that readers respond both emotionally and intellectually to what is being presented. Eugene Gendlin's (1997) interest in the situatedness of the body within language is drawn on to further illustrate the problematic nature of truly understanding the stories shared by those who take part in studies such as this.

7.2 'Mining' the narratives and achieving a coherent sense of the phenomenon.

The interviews were transcribed verbatim and then the narratives analysed following Giorgi's guidelines (1975, 1985).

1. The first stage in this process was to read the narratives to obtain a sense of the whole. As the individual narratives ran for ten to over twenty pages, this procedure had to be repeated several times to gain a coherent sense of the data. This could be described as a process of immersion - the researcher is not expected to make anything of the contents, simply to be open and receptive to it.

2. Following this, the text must be broken down into more manageable units of meaning, as it is not possible to coherently analyse such a large text (see appendix two). These units occur spontaneously and are delineated as and when the researcher senses a change of meaning in relation to the phenomenon under investigation. Giorgi describes this approach as one of **"circumscribed indeterminateness or empty determinateness"** (Giorgi 1985, p13). This meant that there was a balance established between an expectation of finding information pertaining to the phenomenon and an open-mindedness such that authentic discovery may spontaneously arise. (*ibid.*).

3. The next step was to transform the everyday language of the women, who described their experiences within the natural attitude, into a more formal language that reflected a psychological approach, with the emphasis on the transition to motherhood (see appendix three). These rewritten meaning units were called *transformed* meaning units. Here on in, the original voice of the women is no longer heard; instead we have the distilled meaning that has been drawn from their words by the researcher using a process of reflection and 'imaginative variation'. Imaginative variation provided a method of extracting from the meaning unit that which was essential to the phenomenon. For example, in the interview with Wilma she says:

   "Not being able to just do what you want to do, normally I'd, normally I'd if I wanted to go anywhere I'd get up, get dressed and go out whereas now it's get up, get (the baby)*fed, bathed, get the car-seat out, get his change bag out, check his nappy, then*

by the time you've done all that you think, I'll just change his nappy one more time before we go out. Then you've got to sort of get him down to the car, it's just a lot of hassle as opposed to literally getting up, getting yourself ready and going out." (Wilma).

This was transformed using imaginative variation to be:

"Prior to motherhood, going out could be a spontaneous activity involving minimal preparation. However, with a baby to organise, outings have to be planned in advance and the logistics are time-consuming and complicated."

Thus the essential components are retained and highlighted but the particulars are discarded. However, fundamental to all narrative analysis is the constant movement within a tripartite structure of whole-part-whole. Thus, the researcher moves from the text to the extracted meanings (whole to parts) and back repeatedly, until absolute harmony has been achieved and all that is in the narratives (and pertinent to the phenomenon) is contained within the general structure and vica versa. Gadamer (1995) described this as the hermeneutic rule but it can be equally applied to phenomenology,

"Thus the movement of understanding is constantly from the whole to the part and back to the whole...the harmony of all the details with the whole is the criterion of correct understanding. The failure to achieve this harmony means the understanding has failed". (Gadamer 1995, p291).

4. Having completed stage three, Giorgi advised writing both a specific description of the phenomenon which retained recognisable aspects of the original subject and situation, followed by a general structure which established a distance from specifics to communicate the more general meaning of the phenomenon (Giorgi 1985). However, in this research, I was confronted with over five hundred transformed meaning units – too many to proceed straight to a general structure (at this point the meaning units were regarded as one group and were no longer identified with the interviewee from whom they originated). Further readings and reflection upon the data suggested obvious similarities between transformed meaning units leading to the formation of groups which yielded greater clarity in understanding the general structure of the phenomenon. Seven groups emerged which are referred to as the constituents of the general structure of the phenomenon and discussed in detail in a later chapter.

5. The next stage was to express the general structure, or 'essence' of the phenomenon as it was experienced by the women I interviewed. Contrary to Giorgi's guidance, I did not write separate specific and essential structures – rather I combined the two **"Structures can be understood as essences and their relationships. What is important about structures is not so much the parts as such, but the interrelationships among the parts."** (Giorgi 1997, p248). This process required a synthesis of all of the transformed meaning units to form a coherent description that

illuminated the essential core of the phenomenon for the women who took part in my research (Dahlberg *et al* 2001).

7.3 'Texture' and the text

In writing the general structure, the researcher must endeavour to move from specificity to generality and it is at this point that strict adherence to a commitment to produce a disciplined, generalised description *may* result in a piece of writing that whilst 'scientifically' correct, fails to move the reader or provoke any sense of recognition, empathy or insight (Todres 1998). Willis (2004) in his commentary on a recently published phenomenological study says of the results,

"There is an irony when the very text that has set out to uncover the livedness of lived experience can become deadening not intentionally but because of the scientific/propositional genre of the writing." (p5).

The cautious language of scientific investigation is probably unlikely to touch the 'soul' of the reader. It does not contain any *catalytic validity*, (Lather 1991) in so much as the reader comes away from the piece unchanged. Reading the general structure may have been experienced by the reader as superficial, in so much as there is no vitality within the text and the 'heart' of the reader remains cold with no understanding of the original phenomena having been engendered. In my view, this quote from Coles (1961) in Halling (2002) perfectly describes this dilemma for researchers:

"As the words grow longer and the concepts more intricate and tedious, human sorrows and temptations disappear, loves move away, envies, jealousies, revenge and terror dissolve. Gone are strong, sensible words with good meaning and the flavour of the real." (Coles in Halling 2002, p29).

Willis (2002) argues for the use of poetic forms of expressive writing in phenomenology as distinct from the more traditional **"explanatory"** or **"analytical"** (p1) manner of presenting a research text. He goes on to explain that expressive knowledge is generated by the researcher making a receptive response to the data, contemplating the phenomenon as it presents itself and then **"constructing a text which accounts for that experience in its wholeness"** (*ibid.* p2). In other words, allowing the phenomenon to favour certain words and to flavour the tone rather than the traditional requirements of an academic audience. Phenomenology is *not* about proving a hypothesis or collating and presenting statistics, it is about illuminating a human experience in such a way that the audience *sees* it differently. Although in the following quote Willis (2002) is referring to the researcher's response to the phenomenon, I would suggest that this could equally apply to the desired reaction from the audience.

"Phenomenology wants to slow the researcher down and hold his or her gaze on the phenomenon itself...it seeks to give space for the subjective in knowing how something immediately affected the knower while also attending to the so-called 'whatness' of the experience itself" (*ibid.* p3).

In presenting research findings, Halling (2002) warned against assuming that one rendering suited all audiences. With regard to my research, I am hoping the findings will be accessible to a broad readership from various disciplines – midwives and other primary care providers, phenomenologists, feminist scholars and of equal importance, pregnant women and new mothers. I would argue that in the past many researchers have been seduced by the option of writing for a relatively small group of like minded academics and as Halling (2002) pointed out, there is nothing intrinsically wrong with this. However, if the results of my research are to prove accessible to varying groups of readers, they must be presented in different styles. A sensitive consideration of this is provided by Wertz's (1985) phenomenological study of the experience of being criminally victimised in which five different forms of presentation are explored. These vary from **"individual case synopses"** which are written primarily in the interviewee's own words and so are accessible to a wide readership, to the **"general condensation"**. This version succinctly presents the essential constituents of all the subjects' experiences and would require the reader to have a more sophisticated understanding of phenomenological psychology (Halling 2002).

Merleau-Ponty (1995) explained the way in which understanding comes from physical engagement; in other words the researcher and the reader must be able to place themselves within the phenomenon, to *feel* the texture as well as the structure of the experience, **"To experience a structure is not to receive it into oneself passively: it is to live it, to take it up, assume it and discover its imminent significance"** (*ibid.* p258). Moustakas (1994) provides three examples of what he had identified as evocative

'lyrical' general structures that succeeded in retaining **"textual-structural synthesis"** (*ibid.* p144) and could not fail to 'move' the reader. Rhode's (1987) portrayal of women's movement from dependency to autonomy, Yoder's (1990) study of guilt and Palaian's (1993) synthesis of the experience of longing. Add to these Bradley-Springer's (1999) personal experience of being in pain and Simms' (2001) reflection on infancy and co-existence in which the author examines the effects of severe neglect on child development and a convincing case can be made that phenomenology is a potent source of *living* description that engages the reader in both intellectual and aesthetic participation.

As a final thought I would suggest that academics may feel 'safer' when presenting their data in an erudite, 'highbrow' fashion as it may be experienced as confirming their membership in a particular group of learned individuals. Furthermore, the researcher who adopts a more 'poetic' 'textured' style may find themselves labelled as both courageous and something of an iconoclast. They may be criticised by some of their colleagues for failing to uphold standards of academic rigour and exclusiveness. This dilemma will be discussed in greater detail below but for now I make no apologies for identifying myself with the latter group.

7.4 Gendlin

Before proceeding to the findings of my study, the work of Gendlin (1991, 1997), will be discussed. Gendlin is a philosopher and psychotherapist who was influenced by Husserl, Merleau-Ponty and Heidegger, as well as formulating a psycho-therapeutic technique

called 'Focussing'. However I am restricted to a relatively short discussion of the tension he identified between language and the lived body and the way in which this contributed to my understanding of the women's narrative recollections of their lived experience. I would suggest that the **"bodily-contextual-intimacy"** that Gendlin is evoking (Todres 1997, p290) could, in skilful 'hands' provide an intimate, authentic dimension to attaining a deeper revelatory understanding of a phenomenon.

"When we humans speak, think or read, we *experience* meaning...(a)nother way to phrase it is that we *feel* the meaning...we notice that meaning is not only a matter of things and symbols and their relationships: it is also something felt or experienced." (Gendlin 1997, p45).

Gendlin's concept of 'sense-making' (Todres 1999) invited researchers to approach their subjects and the data with renewed respect. By 'sense-making' Gendlin is less concerned with the way in which the researcher responded to the data (whether the narrative 'makes-sense' to her/him) but instead he wished to make explicit the way in which language is 'alive' and embodied. Todres (1999) described this way of knowing as not just " **"logical" but "responsive."** " (p285) to the **"bodily evocative dimensions"** (*ibid.*) that enabled language to transmit unique experience in a comprehensible fashion. Levin (1997) explained the way in which all interpretations and conceptualisations proceed from the body which is inevitably more intricate in its experiencing then any words can contain. This intimacy of knowing can only be accessed by attending to the implied meanings – a process that will ultimately be frustrated by the impossibility of accessing

the completeness of individual embodied experience. In other words, there is always 'more than' we can know.

"Experience is neither the interpretations that we can make of it nor an already formed given. In response to any interpretation, the body of experience talks back with more intricacy than was contained in the interpretation. To notice this intimacy one needs to attend to the implicit meaning and its response to what one intends to say." (Levin 1997, p55).

Gendlin had developed a particular interest in the situatedness of the body in philosophy and language and the way in which the relationship between body, meaning and language established ' fertile tension' (Todres 1999). This has the potential to provide a valuable aesthetic dimension to researchers' analysis of bodily experience in which knowledge is intimately engaged with interpretation and is constantly evolving. In other words, the researcher may be privileged to gain access to that which the interviewee struggled to find the words to express, that moment which is bigger than words or as Todres (1999) described it, **"more than words can say."** (p290) Neither the body nor language achieve primacy in the process of understanding, rather Gendlin (1997) proposed a continuity of process whereby embodiment and language are crucial to understanding. **"These components of knowing cannot be reduced to one another and are both required in the rhythm of closeness and distance that is required for meaningful knowing to occur."** (Todres 1999, p290). Building upon the work of Heidegger, Merleau-Ponty and Husserl, Gendlin's basic premise is that there is a visceral participation of the body in the world, from which all knowing emanates and without which, there would be no

beginning: **"We do not first interpret things; we live and act in them; we inhale and cry and feed. We are always already within interactions (situations, practice, action, performance...)"** (Gendlin 1997, p405). Therefore, one could understand the lived body as a swirling accumulation of experience and knowledge, a prerequisite to language and of major interest to those conducting research into the lived experience of others. Todres (1999) describes this form of knowledge as pre-reflective. It is a whole and has yet to be isolated into discreet meaning units – it is prior to logical understanding as **"logic works only with what has been separated."** (Gendlin 1991 cited in Todres 1999, p288). This wholeness offers the possibility of new understandings and **"new possibilities that were not separately there before."** (*ibid.*).

When one considers the process of pregnancy, birth and mothering it is clear that the body is fundamentally implicated throughout this experience, with the memories of this time scripted on the woman's body, 'criss-crossed' with meaning and counter-meaning and that her embodied knowledge of such a profoundly challenging, life-changing experience will often be, "more than words can say." In reclaiming the significance of bodily knowledge and accessing this dimension of experience which is beyond words, Gendlin proposed the concept of a responsive order whereby the way in which the body has responded to an experience will be revealed, albeit imperfectly because knowledge is never complete, it is always evolving and building on that which went before. **"Within the responsive order, both the separation of languaging and the non-separated 'more' of bodily-contextual-intimacy are utilised as sources of ongoing authentic understanding."** (Todres 1999, p290). This 'incompleteness' is the 'more' of the

phenomenon, the 'place' from which the experience originates and the speaker speaks. It is not a separate object that can be considered and described from all angles, it is always dispersed and we are contained within it (Todres 1999). Todres (2004) explained that Gendlin formulated this concept through observing his therapeutic encounters with clients and realising that they developed a **"bodily felt sense of their situation"** (*ibid.* p44). Gendlin's (1979) concept of 'more' requires the researcher to espouse an ontological approach that no longer required any point of closure to a piece of research, but instead supplants a desire to understand fully with the concept of an **"ongoing conversation...shar(ing) 'good words' and phrases that are evocative and carry understanding further."** (Todres 2004, p49). Arguably this is all that research could ever hope to achieve and Gendlin is only making explicit what has been unacknowledged amongst the claims sometimes made for research findings in the past.

7.5 Scrutinising the narrative

However, I do feel some unease as to the way in which this bodily knowledge is accessed and the status of the data discovered. Todres (2004) highlights important features of Gendlin's psycho-therapeutic approach, known as 'focusing' that would be relevant to an embodied approach to research. Attaining the level of skill to successfully articulate that which is fuzzy, hazy and not yet grasped except as a shadow of itself would seem to be a significant challenge with considerable potential for a 'slipping away from' the phenomenon in question. As Todres explained, referring back to the 'more' of the experience requires a certain quietude, a willingness to be open to **"conceptually vague experiencing"** (*ibid.* p45). The practitioner must engage in **"a subtle kind of dipping**

back and forth between the 'felt sense' and a way of 'languaging' (the phenomenon) **in the broad sense."** (*ibid.*). These somewhat enigmatic directions *could* lead to sloppiness rather than rigour and indulgent musing rather than keen attentiveness to the phenomenon. Restrictions on time and space prevent any further expansion of these concerns at this point and I would not advocate a rejection of this embodied approach as greater access to the body and embodied knowledge has the potential to produce evocative, empathic phenomenological description.

However, although Gendlin's (1962) approach was not consciously adopted for my research, certain aspects of it resonate with my memories of listening to the women recounting their experiences of the transition to motherhood. Many times they battled with a certain inarticulateness, searching for the right words to convey the complexity and disparity of their experience. It is not that my interviewees were vague about the experiences they struggled to articulate, they were in fact fastidious in their search for authenticity. Todres (1999) made a similar point in his reflections on interviewing a homeless woman,

"She is in a situation that is a 'pre-separated multiplicity'. There are meanings of this situation...that are 'more than words can say'...Her struggle to find words is an authentic expression of how any words that she can find are not a mere representation or simple reflection of her situation...she wants the words to be faithful in some way to what she is in touch with." (Todres 1999, p292).

Day-Sclater (1998a, 1998b) interviewed women to learn more of their experience of divorce and conducted a detailed analysis of one woman's experience (Nina) to further scrutinise the way in which subjectivities are constructed and transformed in narrative accounting. Although she utilised discourse theory and psychoanalysis, she concluded that narrative accounts of experience signified a transformation of subjectivity in which self-identity is **"formed, reformed and transformed."** (Day-Sclater 1998b, p85). Reflecting on the way in which her interview progressed, I was struck by Day-Sclater's sensitive exposition of Nina's journey through her narrative and the way in which naming her experiences signified that a process of personal transformation has commenced. **"These new meanings are both cause and effect of Nina's 'naming' of her experience as one of being "hoodwinked"** (by her ex-husband). **In naming her experience in this way Nina signifies that a process of personal transformation is underway."** (Day-Sclater 1998a, p72). She also demonstrates that close attention to both the structure and content of personal narratives reflected the shifting back and forth of Nina's transformative process and that what might at first appear as inconsistencies and contradictions revealed **"not the narrator's 'errors' but her changing consciousness."** (p75).

I would tentatively suggest that the process of naming and transforming as experienced by Nina within her narrative is consistent with the process experienced by Mandy, (the homeless woman interviewed by Todres, referred to above) as she 'tries on' words or phrases to find cogent expression for the **"preseparated multiplicity"** (Todres 1999, p292) of her complex situation. Although Day-Sclater does not make reference to the

'body' in her analysis of Nina's story, it would seem that the transformative moment within the narrative is akin to Gendlin's 'responsiveness' in which language resonates with an aliveness **"in awakening the sense of presence of what it is referring to."** (*ibid.* p293).

Likewise, the women I interviewed sometimes visibly struggled to capture the essence of their experience – trying out words in an attempt to grasp the 'more' of the particular situation and moving forward and backward through the narrative in a quest for the truth of their experience of their transition. As Day-Sclater cautioned, careless reading of the text might lead to the erroneous conclusion that the women are muddled or simply 'making it up' whereas they are actually engaged in the search for authentic truth – and for women who's vocabulary is less expansive, they may demonstrate an emotional response to a memory that is "more than words can say" (Todres 1999). For instance, in my study, when Chris was describing her struggle with feeding her baby,

Well, feeding nearly every half-hour during the day, she was so, so, tiny (pause as Chris is searching for a tissue)*...Now she's that much older, I love her more now... but it's when she was very young* (starts to cry) *sorry, it brings back all the memories."*

It would seem to be the case that such an emotional response represents a raw and truthful manifestation of the **"bodily felt-sense that opens or touches the holistic presence of the phenomenon as it is experienced."** (Todres, 2004, p293)

8.0 Results

8.1 Introduction

This chapter will begin with a presentation of the general structure of the experience of becoming a mother for the first time, accompanied by an explanation of its status within the research process. This will be followed by an analysis of the seven constituents of the general structure. Quotations from the interviews testify to both the commonalities and the variations that are clearly heard within the stories narrated by the women. The women's descriptions also provide life-world evidence for the conclusions reached during the research process.

8.2 The general structure of the transition to motherhood

Analysis of the seven transcripts yielded an enormous amount of rich, evocative and often contradictory data that provided remarkable insight into the way in which the women experienced the transition to motherhood. The general structure for the women I interviewed, of the experience of becoming a mother is as follows:

"Becoming a mother for the first time introduced some fundamental changes into the woman's manner of being in the world. Essentially this concerned the development of a new becoming-a-mother-change-of-body subjectivity in which the woman was required to re-order her way of 'being' in all its existential dimensions. The new mother sought to integrate and authenticate

this challenging life event within her biography – she manifested both an openness to the beloved child and a resistance to the truncation of her existential possibilities. This re-attunement was negotiated on an individual basis and the success with which the new mother came to embody mothering was dependent on many factors, beginning with the experience of 'encounter', when mother and baby met face-to-face. Although the baby is in the world, a symbiotic relationship persisted with mother and child ontologically entwined. The new mother's lived experience of spatiality and temporality are disrupted and distorted. Her existential possibilities are abruptly curtailed as the baby filled her vision, temporarily eclipsing all that had gone before. 'Time' became 'babytime' and there was no 'space' between the woman and her infant. The child was under her skin and even when physically separate, the woman was still 'bodying-forth' mothering – her 'being' inextricably entangled with that of the child. The new mother's physicality was breached both physically and existentially. She 'dwelt' in the world in a 're-awakened' body that was transformed by birth; softer and heavier and leaking both milk and blood in a process she was unable to control. In the first weeks after the birth the woman entered into a period of discontinuity – much of the familiarity of life before motherhood obscured by a sense of chaotic disorganisation, both literal and ontological,

manifesting in various ways for individual women. As time passed the woman acceded to her own particular sense of herself as an embodied mother. For some, this assimilation is accomplished with relative ease - these women demonstrating a generous openness to major existential change. However, most new mothers experience major existential disruption in all its variations and then gradually and hesitantly re-establish a sense of 'being in control', wresting orderliness from disorder and coherence from perplexity."

As has been discussed previously, there is considerable debate regarding the status of the general structure. At this point, I would commend it as having realised a profound level of insight into the experience of a particular phenomenon for a particular group of women and this understanding is offered to other scholars, healthcare professionals and most importantly mothers to broaden their understanding of the way in which the transition is negotiated and assimilated, providing solidarity and possibly assisting new mothers in negotiating a difficult transition.

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The general structure is the invariant core of the phenomenon for the women who shared their experiences with me. In other words, although the women interviewed provided notably contrasting descriptions, underlying and uniting their individual experiences is the general structure. This is not to say that they all experienced the phenomenon in the same way, instead there were particular essential constituents through which each woman

negotiated her transforming journey into motherhood. Some women assimilated these changes to their embodied self with ease, others struggled and resisted, feeling assailed and overwhelmed. These differences are called variations and will be discussed in detail below.

8.3 The constituents of the general structure

Further elucidation of the phenomenon can be obtained by examining the seven constituents of the general structure:

- Welcoming the intimate stranger
- Anxious loving
- The baby fills her vision
- Acceptance: from crisis to comprehension
- Exhaustion, recovery and the physical body
- Relationships: re-evaluation and conflict
- Isolation, ambivalence and tears

The reader must be aware that the constituents are not in any way sequential and it is entirely inaccurate to view them as such. The transition is not a sequential process whereby the women progressed from overwhelming love to isolation and misery. Rather, each constituent is present and inextricably linked to all the others. The transition is defined by its fluidity, by the composite relationship of contradictory experiences that interweave and transpose themselves one upon the other. Reflexivity, immersion and

emergence, and a feeling of looking back whilst walking forward are aspects of a more representative framework within which this transition takes place.

8.3.1 Welcoming the intimate stranger

This constituent encapsulated a time of profound recognition and discovery as the women came face-to-face with the imagined child of their pregnancy. A feeling of love was ignited that for some burnt brilliantly from the first moment with an intensity that was startling – for others it simmered softly and increased gently as the woman and child grew to know each other. The women were utterly enthralled by this intimate stranger who seemed so vulnerable at the moment of birth as to be barely embodied and every detail of the child was examined and revered. This extraordinary love came to surpass anything the women had ever felt before and proved to be both nourishing and consuming as time passed. The birth often united family and friends in shared celebration and joy; a short period of time 'outside of' normal daily life.

Although the birth was described with varying degrees of detail, the women in my study did not just experience love for the baby. They also described feelings of shock, amazement, satisfaction and pleasure when their babies were born. Wilma described the drive home from the hospital as

"it was like I'd had a love drug, I was all, ahhh, he's so lovely... overwhelming love was probably what I'd say but I didn't think I would feel that, not at all, not at all".

Likewise for May, *"the minute I saw her, I just fell in love with her straight away, absolutely immediate, the most incredible experience... I held her and looked at her and it was just so overwhelming the feeling of love for some little person I'd just met."*

And for Betty, *"I was absolutely amazed by the instant love I had for* (the baby), *it was frightening in a way... one minute you didn't have him and the next minute you didn't want to let go of him, didn't want him out of your sight."*

Yvette was awe struck by her son, *"and you just sort of look at them and think, it is amazing, you look at them in awe, wondering how it could happen* (laughs)."

Jane reveals the potent mixture of love and worry that defines the mother/child relationship, *"I loved him as soon as, as soon as he came out because I wanted him so much. In fact, because of the kind of person I am, I had to keep dampening down the hope and the expectation and the joy even, because if it was taken away from me I don't know what I'd do. I couldn't bear to be without him, not at all."*

Whereas for Chris, her response was more ambivalent, *"when she was first born and I held her I did love her and then, I dunno, although I never stopped loving her, when I sat down in the hospital, I looked at her and thought, I resent you because I didn't get much sleep"*.

And Yvette experienced a love slowly growing in intensity, *"I probably loved him more later on actually rather than that instant, I don't think I had that instant overwhelming love ... but I think as they grow up, you tend to feel more love for them"*

Chris also described the initial period of 'getting to know' the baby, *"I just needed time with her to get to know her, just me and her. I think you can bond better... it takes time."*

However, on first seeing the baby, everything that the women had imagined was swept away by the real baby's presence. Betty's moving description of meeting her son for the first time demonstrates this. Her immediate reaction was how much her son resembled his father,

"and then my second thought was, that's a baby and it's mine and you can't comprehend; when you're pregnant and you're going for your scans and you're going for your antenatals and you hear the heartbeat, it's all wonderful but you never really acknowledge that it's human until you see it and you think, "Oh my goodness, that's a real baby and it's mine.""

For Sue this is touchingly described as a 'letting go' of her illusory baby daughter to make space for her real baby son: *"I could see this little boy walking towards me and he did walk right into my heart...and I did love him right from the start...you do just feel this... huge connection, he was a part of me, he is a part of me I will protect him with my life and that is how much I love him".*

Whereas for Yvette, there was the frank amazement that he was really here: *"Yeah, amazing really, you just can't believe it. You're wondering what they're going to look like for nine months and all of a sudden they're out and you can actually see what they look like which is quite a weird thing".*

Jane spoke about her baby son's ethereal presence, *"He was like a little being from another planet then, he wasn't like he is now... he was just that perfect, perfect being".*

The women described how becoming a mother was a cause for celebration, and families were united in their joy at the birth. *"And it was wonderful having my Mum and my sister see the baby and hold him – it's just becoming part of the family isn't it, the extended family and I really enjoyed that."* (Sue)

"Babies bring so much excellent love with them ... it draws ties together and when you're in the world you might let ties slip for a long, long time and it knits them back together again" (Jane).

On the whole this was a time of happiness and rejoicing. The women felt 'special' and the focus of considerable love and admiration from their families and friends,

"... and we had loads of visitors which was lovely. Everything was lovely those first few days, the room was full of cards and little presents for him." (Wilma).

May spoke of her first few days in hospital as idyllic, *"I was so calm and I just felt completely peaceful about everything"*.

Sue provided an evocative account of the symbiotic relationship she enjoyed with her son whilst breastfeeding him, *"it's the only thing that's ever come from within you but it was like he was still he was very much part of me and I found that very much with feeding him ... was like we were still very connected ... everything he was, every single cell of his body came through me and still through breastmilk, nothing else was coming from anywhere else, it was through me."*

However, this period ended fairly abruptly for most of the women and they no longer felt special and for the majority of the women this brought with it considerable difficulties. This is vividly depicted by Wilma,

"I think it was after those first few days and it was all a bit of an anti-climax. From suddenly everyone, everybody disappears and you're on your own."

8.3.2 Anxious loving

All of the women experienced a constant fear that the child would die or disappear – constant vigilance and anticipation of danger was required which meant that the women were encumbered by anxiety and needed to have the child close by at all times. As time passed there was a movement from complete interdependence (mother and child) to an

opening up of the space between them and a sense of both mourning and relief at this slow dissolution of the exclusivity of the mother/child unit. There was a sense of acute anxiety about being judged to be an inadequate mother whilst often being utterly bewildered as to why the child seemed to be unhappy or unsettled. The women's confidence increased as they came to know and understand their babies.

It is not an overstatement to say that the women were haunted by a fear that their child would die, or inexplicably disappear, as Jane described,

"At the beginning I was so frightened that he was, that I'd wake up one morning and he'd be gone again...and that was a real feeling that perhaps he was only here for a little while."

This fear intruded upon every aspect of life and in the beginning it seemed like a necessity; the women forfeited their peace of mind for the continued safety of their child. May's experience was not unusual,

" The biggest anxiety was her dying in the night. I've still got that now. When she was asleep I just wanted to watch her, make sure she was still breathing."

And Sue suffered from the same concerns, *"I was always worried that I was going to go to the cot and find him dead and I still have that now. I still put my hand on his –*

sometimes in the middle of the night and think, are you breathing, is your chest going up and down?"

Initially this seemed to be because the babies were perceived as being *"so fragile to start with"* (Chris) and *"really delicate"* (Jane). As they became more robust the women expressed relief, possibly because the babies seemed to be more embodied, more 'in the world' but the women were still unable to relax their vigilance 'just in case'. The women felt a profound level of attachment to their babies, as Sue tells us

"and it's like you've got this whole thing in your arms, it's been a part of you because nothing could be more a part of you than a baby could it".

And this sense of 'connectedness' underlay a physical need to keep their babies close and by definition safe because, as several women explained,

"I wanted to, to make a cocoon for him, to keep him safe and I was, you know, I was worried all the time that something would happen to him" (Jane) and *"... they are so, so fragile to start with ... she was so, so tiny"* (Chris).

May reiterated the need to keep her baby with her on returning home, *"I must have* (the baby) *by my side the whole time and I didn't know how I was ever going to let her be apart from me ... that protection instinct is still so huge".*

As time passed some of the women described an opening up of the space between themselves and the baby and this was both welcomed and resisted. May spoke vividly of feeling trapped within an impenetrable *"shell"* with her baby and it was only with the passing of time that other people could break into it,

"it's like you're in a little shell the two of you and that you speak to people but they're not actually coming into the shell with you". However, at the same time, she says, *"I didn't want her to grow... she needed me one hundred percent and I didn't want that ever to change...I still feel that now* (at the time of the interview) *I don't want her to get older, I don't want her to become independent"*. But she concluded by declaring that she had begun *"letting people in"* and she felt more comfortable with relatives caring for the baby sometimes, thus considerably easing the pressure.

Yvette was also anxious about other people misinterpreting her baby's needs, *"and though you trust them* (her parents), *you worry about him and what he's going to do because he's so new to you"*, whereas a little later on she says, *"when they're older you know what they're* (the baby) *going to be like and you don't worry so much about leaving them"*.

Any threat to the baby's physical wellbeing always caused significant anxiety and distress and several of the women interviewed described feeling utterly unprepared for the strength of their reaction to what, in anyone else, would be a minor health problem. Seeking reassurance from health professionals was not always a straightforward task for

some of the women interviewed as there was often a complicated interplay between needing reliable advice whilst wanting to be thought of as confident, calm, knowledgeable mothers. Betty explained her misgivings about consulting the doctor when her child has a minor ailment,

"I don't want to go to the doctor because I don't want him to think that I'm an inadequate mother and I'm worrying needlessly... I want to know what it is (but) *I almost feel like everyone's judging me."*

Likewise, seeking advice from her midwife did nothing to assuage May's concerns about her baby's health and only succeeded in undermining her confidence,

"... and she whipped (the baby's) *hat off her head and told me how ridiculous if she had a temperature that she had a hat and coat on and I thought that was outrageous and I felt very, very put down, I felt totally useless."*

8.3.3 The baby fills her vision

The baby 'filled their vision' and the women were unable to concentrate on anything else for long without their thoughts repeatedly returning to the child. Even when absent from the child the women retained a feeling of overall responsibility which they could not suspend and which often hampered their opportunities to enjoy time away. As time passed there was an easing of the acute anxiety often associated with this level of responsibility but nevertheless the women never felt free to let their thoughts roam and

drift aimlessly. For some women there was considerable fulfilment to be gained in wholly embracing the responsibility of motherhood whilst others felt resentment at the curtailing of their freedom.

All of the women interviewed felt they were woefully unprepared for the almost constant demands made on their time, attention and fortitude by a new baby. Wilma laughed at her naiveté when she said,

"I thought after two weeks I'd be back to normal, I thought I'd be running round doing everything that I used to do and not think twice." She goes on to describe how she had thought motherhood would be, *"I really thought it would be feed him, change his nappy and the bits in between he'd be asleep."*

Motherhood seemed to entail a new, unanticipated way of looking – instead of focusing on themselves and their own future, the women found themselves entirely preoccupied with their babies. Jane says,

"...you'll be talking to someone and then you'll stop because he's crying... because nothing that you might say is as important as looking after (the baby)*."*

Prior to giving birth, the majority of the women believed that they would be able to 'switch off' from the baby when s/he was not demanding attention, but motherhood seemed to be entirely different to anything they had anticipated. The baby was always present in the women's minds,

touching upon every aspect of their lives and even when the women had time away, it was always circumscribed by the baby's needs. As Wilma described trying to organise leaving her baby with her husband just for a few hours a week,

"Like on a Saturday afternoon, I've just fed him, he's got a clean nappy and I literally get three hours and then I try and zap off somewhere on my own but I know I have to be back in three hours to feed him" and Yvette reflected upon her struggle not to respond to her baby's cries when she was supposed to be resting,

"If he was in the house while I was trying to sleep I'd just be listening out to hear if he's crying or not and I'd run down and say, "Did I tell you he needs such and such?" ".

Sue provided a vivid picture of the never-ending nature of the responsibility of being a mother,

"...people say it's a job for life and you're always a mother but I don't think I really realised it ...you know he might not be in the room with me now, he's a couple of miles away but I'm responsible for the bottle of milk that's waiting for him when he comes home and is it safe for him and is the house warm enough for him to come into." Momentarily she allows herself a moment of retrospection and yearning for times passed, *"... it's just never ever ending and I just didn't realise that at all, not at all and sometimes that's quite difficult to come to terms with because you wonder when you're ever going to get time off again, to just, to not only have to do nothing but to not even have to think about anything".*

The baby filled their vision and the women were often unable to concentrate on anything else. May felt a sense of loss when she reflected upon how her life had changed,

"As far as me being different with like the forgetfulness and not being able to do things in sequence, I don't know if I'm ever going to get back to being the same person... it infuriates me so it does matter but I think the intense feelings of caring so much about the baby and my priorities are way different now and that won't change."

It was as though there was an implicit understanding that becoming a mother entails unconditional selflessness. Sue acknowledged the self-sacrifice that motherhood seemed to assume,

"because it does still seem to be an absolute self-sacrificing thing and that's a huge measure of how good a mummy - that you sacrifice yourself – they are first."

Yvette described this fundamental change in lifestyle, *"I probably didn't know what to expect fully, not knowing that it's like a twenty-four hour thing and you've got to put everything else on hold or on the side until, you've just got to look after the child really..."*

Wilma said of her previous life, *"Yeah, I said to* (her partner), *what did we do before? You know, I can't you know - I know what we did do before – that was another thing I think... we used to be able to go down the pub and now we don't do that."*

Jane described the way in which, from the moment of waking, *"it's just the first thing you think of every day and the first thing, the first thing you have to do every time."* She is unconcerned that her old friends will find her boringly baby–orientated and, overall feels eminently comfortable with the way her life has changed, *"... my friends without babies would probably be thinking well, it's not very interesting being with someone talking about babies all the time but I'm not really bothered."*

For some women it was difficult to recall their lives before becoming parents, it seemed so long ago, *"... since I was in hospital, since before he was here seems an age, you can't imagine life before, life before baby – that was a distant memory"* (Yvette).

Chris talked about the shock of having to care for a new baby, *"... it's a complete shock to the system – you try and think how it's going to be, how you'd like it to be but it never actually is how you expect it to be, you could never ever be planned enough or expect enough of what it's going to be like".*

Some of the women found the inescapability of motherhood absolutely intolerable, evoking in them a keen sense of loss and despair. Chris lamented the restricting of her freedom,

"You've got to think of the baby first... and it's demanding, very, very demanding... I used to rush around and try to do everything... I think initially I did resent her because I didn't have any time. Even simple things like washing your hair, it's like a luxury".

Whereas before motherhood the women's lives were fairly organised and predictable, it is as though there has been an irrevocable disintegration, and order has been replaced by chaos, as May describes,

"I can't do things logically and that's so different for me. I mean, I had a career before that involved being very organised and astute and I just feel like all that's gone out the window at the moment."

Every moment of the day is spent caring for the baby who is not easily distracted, whilst the mundane but necessary duties of running the home mount up all around. Sue felt that the disorganised, chaotic state of her home seemed to reflect her state of mind after the birth and she found this situation almost intolerable in the early weeks,

"feeling that you expected life in some ways to carry on just the way – you could just go to the supermarket, you could cook a meal but all of that, it just kind of goes out the window, when have I got time to eat, when have I got time to sleep, when have I got time to hoover ... your mind's in a chaos and I couldn't stand the house being in a chaos as well. It was horrendous..."

Wilma had expressed her apprehension at the thought of giving up work to care for her son, but although there were aspects of her working life that she missed, she spoke warmly about her new role,

"I think just being a mum makes you generally softer and I think when he smiles and it makes your heart jump, it's like – if he's happy, you're happy." She goes on to explain how she *"didn't know any different other than to go to work"* but now, *"I get so much pleasure from making sure that he's happy."*

Some of the women found great pleasure in the traditional role of housewife and mother. To their surprise, instead of feeling apprehensive about being responsible for a baby, they become quickly more confident of their capabilities as the weeks pass and with this responsibility came a feeling of having 'become an adult' - a feeling that was not necessarily confined to young mothers. Jane (24 years old) explains that, for her, being young meant only having to think about herself whereas now,

"I suppose that is one important way of growing up which is that you're not thinking about yourself one hundred percent of the time"

and Betty agrees, *"I don't feel twenty-three... and I don't miss going out and I thought I would... he's my life now and the thought of not running my own life is strange because it was always me, me, me, I was so selfish – I'll do this, I'll do that and now it's, I'll do everything for* (the baby)*"*.

Prior to the birth, the women who were planning to return to paid employment rarely foresaw any difficulties with this decision. However, as the time to return to work approaches, Betty voices the concerns of several of the women,

"But then suddenly, the thought of having a little person and it's your soul responsibility is terrifying. I go back to work on Monday and I'm dreading that, I'm seriously dreading it...but even though I know my Mum's having him...I am dreading dropping him off and going to work."

8.3.4 Acceptance: from crisis to comprehension

The women described their gradual hesitant progress towards a clearer understanding and assimilation of the transformation wrought by motherhood. It was a time of reconciliation and acceptance, as the women moved from initial frustration and despair to acknowledging and enjoying some aspects of motherhood. There was a gratifying sense of being rewarded for the enormous effort they have made to care for the child and the personal sacrifices this has engendered. This process was influenced by their recovery of a sense of control over life and a lessening of tension as they realised that life with a baby passed in stages and even the most difficult were only temporary.

Most of the women interviewed came to accept and eventually advocate the institution of motherhood albeit with more or less reservations and caveats. Jane's pleasure in motherhood was immediately obvious and fairly consistent throughout the interview. She spoke of a feeling of being welcomed into a

"massive, big club of people who have children and then you relate to them in a different way than you do to everyone else on the planet because you know you've also shared this massive human experience."

For Sue, the title 'mother' was still associated with her own mother rather than herself, *"it's a job for me to say what a mother is... if you had it written down in a textbook we could say, yes, I can care for him, I anticipate his needs, I feed him, I cloth him but to me being a mother is probably much more of an emotional thing, it's that little extra bit, so I don't know that I quite feel like a mother yet."*

And Chris explained that, *"But it's only sort of since Christmas that I have really started to enjoy it whereas I used to rush round and try and do everything but now I just sit down and enjoy her."*

This acceptance was rarely an immediate or uniform process for the women interviewed, and depended to a considerable degree on their babies becoming less querulous and more engaging and agreeable. This was particularly true for Wilma, whose baby had severe colic for the first few weeks,

"I thought I must be doing something drastically wrong because he's crying all the time... but he's a pleasure now..."

For the women there was a sense of being rewarded for the immense effort of caring for their babies. As Chris says, "... *you do get used to her as you get into a routine more,*

then it becomes easier and they get older and they're not so fragile... she is getting easier, once they get their own independence and start learning things."

Yvette illustrated how a baby's responses can enhance mother/child interaction, *"I think that was a turning point when they can take more interest. Before, you're just there to feed them and change them and do everything and you don't, sort of have any gratitude (laugher), there's no response, no feedback at all whereas now at least he smiles ... so you know that you're doing something right (laughter)".*

Initially it is as though the women lived only in the present moment, with no viewpoint outside of their relationships with their babies. However, gradually most of the women found themselves able to reflect upon the past and find reassurance in the knowledge that life with a baby happens in phases and even the most difficult and perplexing will pass. Yvette described an 'easing up' of the demands made on her by her baby as the weeks passed, and how this enabled her to enjoy him more,

"By eight weeks or so he started to get better in terms of his stomach ... everything started to ease off... he was doing all the bits and bobs and taking more interest in everything and I think that was kind of a turning point."

For Chris, returning to work was a considerable relief and an escape from the monotony of being *"... tied to the four walls and not being able to go out when I wanted"*, although the baby kept her occupied, *"... I still wanted to go back to work. I couldn't have been a*

Mum twenty-four hours a day, seven days a week, although I am, I couldn't have not gone back to work, I couldn't be a housewife completely, I'd go spare."

Gradually the women acquired a sense of their own needs and an acceptance of the way in which these must be combined with those of the baby. Sue described how important it became to make time for herself,

"I find now I have areas of the day that are for me that you have to find, like (the baby) *gets up in the morning and watches* (her partner) *shave, he's out of my hair for half an hour ... then I can sit down ... and read a bit of the newspaper and eat my breakfast and then I've done something for me and I'm fed which I now consider is absolutely basic."*

Whereas for Chris, being at work came to symbolise a return to her 'real' self, *"... it really was a great relief, having some intelligent conversation, some adult company, it was such a relief being able to go out, be yourself for a few hours ... when I'm with* (the baby) *I'm her Mum, but when I'm at work I'm myself, I'm my own person, when I come home I'm a Mum again"*.

Any sense of 'order' was felt to be irredeemably lost in the early weeks of motherhood, so the significance of establishing a daily routine with the baby, through which the women were able to reinstate a feeling of control over their lives cannot be overemphasised. Chris highlighted the importance of this process and, like some of the

other women, suggested that routines are often disrupted by partners who are unaware of this,

"whereas if it was just me and her we could get into a routine, get to know one another properly and sort of work things out, just the two of us and get into a routine with sleep times and feed times and getting her to bed at a reasonable time at night."

Betty was also concerned as to whether her partner would respect the way in which her life with the baby was organised, once he returned home,

"I can see when he's home for these ten days it's going to be big problems because I'm going to have him (the baby) *in a routine,* (her partner) *is almost going to want to do his own thing with him and it's going to mess* (the baby) *up completely."*

Should this routine be broken – if for instance the child will not settle at bedtime – the women felt absolutely wretched. May describes her feelings after a difficult night when her baby would not settle and woke early, *"I feel desperate, I just feel, I don't know how I'm going to get through the day."*

And Sue reflects upon the value of sticking to her routine, *"if you have a nice routine thoughout the day he goes to bed at half past seven at night you then have time with yourself and time to do the million chores, if not and he's not going to bed until nine it absolutely nearly blows my brain."*

This daily routine also restored a feeling of normality particularly when it included certain rituals from before the birth. For many of the women interviewed these daily rituals, however trivial, symbolised a connection to the person they were prior to becoming a mother – as May explains,

"It's been really important, right from when she was first born, I've put my makeup on and got dressed...I had to keep part of me the same."

All of the women described the ways in which simple activities had to be re-evaluated, often illustrating this by describing going on a car journey with their babies. This involved lengthy forward planning and the success or otherwise depended upon the capricious nature of a small baby, as well as how organised the women had been in anticipating all eventualities and assembling every piece of equipment that might possibly be required. Wilma considered the forward planning this required,

"...whereas now it's get up, get (the baby) *fed, bathed, get the car-seat out, get his change bag out, check his nappy, then by the time you've done all that you think, I'll just change his nappy one more time before we go out. Then you've got to sort of get him down to the car."*

On the whole, motherhood involved a scaling down of the women's lives in several ways. Their lived experience of the space that they inhabited became smaller, moving as it did

so from the public, social world to the private world of the home. For some of the women interviewed there is a sense that nothing in their life compares to being a mother – whatever they have accomplished in the past is insignificant, eclipsed by the relationship that they have with their baby. As Jane explains when discussing how she has given up the itinerant lifestyle she used to enjoy,

"... and now all my fulfilment is coming from looking after (the baby) *which I'm happy to do – that's what I've exchanged it for"* and a little later she says, *"I'll always be his Mum and that's the most important thing to me"*.

However, not all the women interviewed embraced motherhood with such serenity and ease. The practicalities of caring for a baby were mastered quickly but accepting their identities as 'mothers' was a gradual affair, as Sue describes,

"I do begin to feel that I'm coming out the other side of it now but I still don't quite know where I am in the middle of it all... but I'm not quite there yet, I know I'm a mother but it's not the soul defining thing that I am, I am other things as well but funnily enough, I almost couldn't tell you what they are."

Motherhood propelled all of the women into some fairly major lifestyle changes, usually involving new, self-imposed limitations for social activity and behaviour. In the main their social lives came to revolve either around the home or baby-friendly events such as toddler groups and nurseries. Any resentment or fear that the women felt at the changes

they had undergone usually dissipated with time, and motherhood for many of the women comes to represent one of the simplest, most essential pleasures it was possible to experience. For instance, when Betty's baby son was Jesus in the nativity play, she said,

"I've never felt so proud in my life...I nearly cried and I thought, "you stupid cow, why are you crying when your son's up on stage and he got his own round of applause at the end" and I remember turning to Mum and saying, "I never felt like that in my life"."

The women spoke with pride at their acceptance of a lifestyle that called for considerable sacrifice and which would have seemed alien and dreary a few months earlier. Betty described both the practical changes she has made in her lifestyle since the birth of her son and the way in which her values have changed

"Umm, one - I smoked, two – I'd spend money 'til it came out of my ears, three – I'd be out 'til all hours and I did respect my parents but not in the way that I do now... I'd eat my dinner, if it wasn't on the table I'd want to know why...and I'd be out the door again because I wanted to be out with my friends...and now the time I have with Mum, I'll quite often go round and see Mum...and say, "Mum, can you cut his nails, can you do this?" And I never realised how much I needed my Mum before".

Sue is surprised to discover the pleasure in attending community events with her son, *"We went to a Christmas party, the church do it with all sorts of people I've never met*

and I've lived here eight years and it makes you think, there are still people out there who do nice things and nice children who enjoy playing musical bumps."

However, the reader must not assume that this equilibrium is achieved without significant emotional and physical costs to most of the women, who described feeling isolated, miserable and anxious in the early weeks of motherhood. It is clear from the women's descriptions that most of them felt unprepared for the relentless demands of a new baby and this is perfectly summed up by Wilma who, whilst admitting she knew nothing about babies, says,

"I honestly thought I would walk it. I'm an organised person, I can do this. I just thought, this'll be a doddle and it wasn't, not at all."

Chris echoed this sentiment, *"...you try and imagine what it's going to be like but it's nowhere near that, nowhere near, you're never prepared enough for it."*

8.3.5 Exhaustion, recovery and the physical body

Their familiar bodies were no longer dependable; instead they were softer, heavier, transformed by birth, aching and leaking and fraught with a surplus of emotion. This was compounded by the grinding exhaustion from which there seemed to be no respite. It became almost intolerable, sapping the women's energy and leaving them feeling utterly wretched and despairing. The broken nights profoundly effected their ability to cope during the day with never enough time to recover from the birth, physically or

emotionally. No longer did there seem to be anything 'natural' about breastfeeding and instead it became a struggle to feed and pacify the querulous child.

The baby waking during the night resulted in the women interviewed feeling exhausted and in some cases quite debilitated. May described the way her sleeping pattern had had to change following the birth of her daughter,

"I mean, before I used to have nine hours sleep, needed nine hours sleep and if I get five hours sleep now it's brilliant... if someone had told me that I'd have four months of disruptive sleep every night I wouldn't have thought I'd cope".

Some of the women resented their babies and were irritable, short-tempered and tearful - sometimes feeling that they cried even more often than their babies did in the early weeks of motherhood. As May said,

"I'd be feeding her and crying because I was so tired and I couldn't believe she just still, she wanted to feed and that, I just felt like I was a zombie really".

Although Yvette described herself as coping fairly well with the broken nights, she did say that, *"... there have been a few times when I could see someone could hurt a baby, when you're really, really tired in the middle of the night, that's the worst time when it's just cried and cried and you've fed it and you've changed it and you're thinking what are you crying for now and you rock them a little harder, so I can see..."*

Betty felt extra pressure to keep her baby quiet at night because initially they were living with her parents, *"When we first came home it was every two hours that he'd wake up, guaranteed and I was surprised how lack of sleep really effects you, even when he was sleeping you'd wake up to see if he was alright... we'd* (her and her partner) *take turns sleeping in the day."*

The women often felt crushed by the unmerciful tiredness and this feeling was intensified by the baby's constant demands during the day. As May described,

"... and by the evening I'm shattered and I just need to go to bed... I go to bed and she wakes up five minutes later, it's so tough".

Chris had a very similar experience, *"Feeding and trying to stay awake, I thought it was going to be easy (laughs) I didn't expect to be like this at all... I didn't expect her to be feeding every half hour, expected every two to three hours, not every half hour... I didn't plan for her to be so demanding as a tiny baby ... it was very, very tiring."*

Chris's exhaustion was compounded by her partner's disinclination to help with household chores, *"I had to do up bottles –* (her partner) *wouldn't do it... I had to sort out with her clothes... sort out the house, do the washing up."*

Sue felt that she and her partner looked much older due to being so tired in the early months, *"... we're coming through the worst of that because the tiredness has gone, I*

mean both of us looked like about ten years older three months ago because we were just (so tired)*."*

Wilma voices the frustrations of many mothers when confronted by a baby who cries constantly, *"... and I had the baby – and he would not stop crying... he screamed constantly from six in the morning 'til one o'clock in the afternoon and I was on my own and it was hell."*

This is a theme that Wilma returned to as it dominated the first six weeks of motherhood for her, *"I don't think I realised how long I'd feel tired for... I thought, literally after the birth, a couple of days and I'd be running around and you're not... and I think when you've got this baby and you don't know what to do with it and it's crying – it's like, insult to injury. The worst time is just after they've been born and yet that's the worst time for your body."*

The women's narratives demonstrated insufficient time to recover from the physical and emotional exertions of the labour and birth. Even when the babies slept during the day the women rarely rested; instead they tried to complete all the outstanding household chores until the babies woke up again,

"I don't think I realised – it is the lack of sleep but it's the fact that it goes on for so long, you never catch up and there's still everything to do, all the household things to do... he

has two good sleeps a day but when I am coming to the end of my chores he wakes up, you have no time for yourself and that is very difficult." (Sue).

The exhaustion described by most of the women is inextricably linked to their lived experience of their bodies. The majority of women are unprepared for the physical changes that occur during pregnancy and the birth. Sue vividly describes how her body changed,

"I didn't expect the physical shock that it all was, I never thought that I'd have trouble like with weeing myself and things like that (laughs), I never dreamt how huge my legs were going to get with all the water, you know, just that sort of thing, all the physical parts of it", and later, *"So the first few weeks were not as easy as I thought they were going to be because I was so physically wretched... my back was absolutely agony with feeding him because I had such huge breasts... and the backache was incredible ...I felt like a cripple."*

Yvette expressed her dismay at *"The size of my stomach, oh dear – that is, that is something that did shock me straight after the birth going to the loo and sitting down and thinking that my stomach was going to fall away and holding onto it and thinking, my God, what's happened?"* And later, *"I didn't expect all the blood as well, not that it really worried me either but you don't really think about the gory bits that are going to happen."*

Jane was the only woman who referred to the effect that becoming a mother had on her sex life – possibly because she was unconcerned by the falling off of her libido following her son's birth, a situation that she feels was due to the pleasure she experienced from breastfeeding,

"(breastfeeding is) *probably the best part of it I think, the best part, so much so... I wouldn't mind if I wasn't having sex – at all. I've got to really, really try to find any kind of sexual feelings but it's buried very, very deep – I don't really need it at all in fact."*

Yvette expressed dismay at her physical appearance after having given birth, *"That was a bit of a thing, when you feel that you're a bit drab, the weight not particularly coming off, you think your clothes are going to fit straight away afterwards – nobody tells you it's actually going to be a couple of months before they fit again."*

The experience of breastfeeding provoked mix responses amongst the women interviewed. For Jane it was a deeply rewarding experience but she struggled initially

"he was slow to start and we had to have the milk expressing machine and that worked quite well and after about three days he picked it up and he was sucking alright... I'd been worried before, I'd been going through a lot of worry and that even makes it slower I imagine... you don't sort of get into it I suppose".

The other women who breastfed encountered varying problems that for some proved insurmountable – for these women there is a sense in their narratives of their bodies 'letting them down'. Yvette struggled for days with breastfeeding, eventually reluctantly changing to bottlefeeding – she describes this experience thus,

"(I) *came home, and that's when all the hassle started because I obviously wasn't feeding him properly and he started to get hungry and my boobs started to get hard…he wouldn't sort of go onto the nipple shield even and he was getting very frustrated and I was getting frustrated…I kept trying him with the boob and he didn't want to know and he didn't want to know…and I felt a bit useless really because I thought, he could go with anyone".*

She explained her disappointment at 'failing' at something she had taken for granted as being a 'natural' activity, *"I didn't think it would be important but it was as soon as I couldn't…I just thought it was the natural thing to do and it would just happen, I didn't put a lot of thought into it…when it didn't happen I think it's a bit of a shock to your system really".*

Wilma struggled initially with breastfeeding and also spoke of her surprise that a seemingly natural activity could be problematic, *"But I remember like, trying to feed him and …oh, I'd be leaking everywhere and he'd be throwing up, he'd be crying and it was, it was just a nightmare."* And later, *"I thought it would come natural and it doesn't. It was hard work because he wouldn't latch on…and I just honestly thought he would just suckle…when he won't latch on and your boobs are leaking as well – like at first there'd*

be this little flood in the kitchen and I wouldn't have anything there, literally dripping out of me."

Betty found the idea of breastfeeding distasteful and embarrassing. Although she had decided to 'do what was right', the timely, if rather unorthodox intervention of the midwife in hospital was experienced by Betty as reassuring and legitimised her preferred method of feeding – and so she bottlefed from birth.

"And I've always had a real thing about breastfeeding – watching (sister) *makes me feel sick and seeing somebody do it makes me feel very embarrassed ...I was dreading it and I thought, but I've got to because everybody says it's the best way ...I'm never going to go out the house because I'm never going to do it in public and I remember the midwife asking me and I said to her, I know I've got to breastfeed and she looked at me and said, "You don't want to do you... Why do it if you don't want to...Do you want to bottle feed?" and I said yes, I do and that was the best decision of my life* (laughs)*"*

8.3.6 Relationships: re-evaluation and conflict

Such an outpouring of love for the baby left the women depleted and unable to respond to their partners as they had in the past - and often this give rise to a time of dissolution for the women and their partners with the women's lives transformed and their partner's barely changed. Levered apart by the baby they seemed to be living different lives, with channels of communication disrupted and angry words exchanged. But at the same time, the birth of the child brought about the birth of a family, strengthening the bond between

the woman and man and focusing their commitment. Contradiction abounds – partners remaining at home were sometimes a hindrance as their presence disrupted the routines the women were eager to establish and delayed a return to normality. However, their partner's support and practical help mitigated the women's exhaustion to some degree and the father's love for the child was deeply reassuring.

Several of the women interviewed expressed surprise that far from enhancing their relationship with their partner, the birth of the baby put considerable strain on even the most committed and compatible couple. Sue and her partner had been together for over twenty years and she had not anticipated any problems when they became parents,

"At times I've had to remember that we have been together for about twenty two years and no wonder it is difficult to adjust, ten months of a baby, twenty two years without, very different and I do at times have to remember that we do love each other. Every now and then it comes through and you think, everything is alright actually and it will be OK."

As Betty said, *"I didn't realise – I mean a baby does put pressure on a relationship...I've heard it said but I didn't think that it would, you think, oh no, that won't happen to me."*

May described the impact on her relationship of her daughter's birth, *"I wasn't prepared for the fact that we wouldn't be able to sit down and have a meal and talk at dinner and when we went to bed we wouldn't be able to cuddle up and chat because we're too tired and so that has had a huge impact on our relationship."*

All of the women interviewed described the way in which the baby came between them and their partners, propelling them apart and absorbing all their energy, attention and patience. May alludes to this when she is marvelling at her baby's sense of timing,

"... but those first few weeks we didn't sit down and eat together because you can guarantee every time we got a meal prepared (the baby) *wanted to be fed or she cried, every time – absolutely incredible."*

Chris also found that attending to her baby left almost no time for her and her partner, *"... but it was difficult when she was young because she never used to sleep a lot until late on in the evening, not go to bed till late, now she goes to bed about half past seven so we can sit down and relax and talk about things – whereas when she was younger we never used to get the chance, she'd go to bed, we'd go to bed."*

Sue identified a marked deterioration in her relationship and describes her son as being in the 'middle' of his parents, *"I think one of the worst bits has been how* (her partner) *and I have got on since* (the baby) *was born... had I been physically able to get up and leave I think I probably would have, because you do just sometimes feel like saying actually I'm going... I never think about* (the baby), *oh if only he wasn't here we'd get along perfectly, and I never think, oh I wish he wasn't here because then we'd go back to how we were but he's a thing in the middle..."* and she is adamant that, *"babies can never bring people together because they absolutely cannot."*

Several of the women recalled the way in which the baby's needs took precedence over everyone else's in the household and the women considered their own needs to be of so little importance that they were all but forgotten. As Chris ruefully explained,

"She's the number one person and you've got to build your life around her", and a little later, *"You've got to think of the baby first and your partner second, or third and it is demanding, very, very demanding."*

Sue used the following experience to illustrate this dilemma, *"Tonight* (her partner) *has taken* (the baby) *out and* (the baby) *was fed and I made sure* (her partner's) *tea was there but I haven't had any yet – it doesn't matter because I can have it later...It's hilarious isn't it, as per usual I make sure everyone else is alright and I'm bottom of the woodpile. But I think that's one of those mythical things that mummies do – you expect to do that, you do come last."*

And Yvette agreed, completing her comment with some prudent advice, *"I suppose you put them* (the baby) *first before you all the time, like my Mum used to do* (laughs) *– that's a sort of Mum thing... if you're in the middle of dinner and they're creating then you don't worry about your dinner and you look after them and not worry about it, try not to get stressed about it."*

It became apparent that most of the women interviewed had assumed that they were in broad agreement with their partners about how to care for a baby, and were at times

bewildered to find themselves disagreeing over various aspects of childcare, as Sue recounts,

"*...and* (her partner) *horrifies me sometimes with the things he lets* (the baby) *do, that's my tough bone of contention, he thinks I'm too protective and I don't think he's protective enough, that sort of thing is very – I always thought that we'd be of one accord because we basically have been throughout life and I can't quite believe that we're not.*"

A frequent complaint was that their partners failed to recognise how monotonous and tiring it is to care for a baby all day and that they (the partner) continued to live their lives as if there was no baby to consider. Chris described her frustration at her partner's apparent failure to modify his lifestyle now that they have a baby,

"(He) *still doesn't seem to understand that you've got to make sure you go out at certain times and you're back by a certain time – he doesn't care in that way, he just goes out as and when, he doesn't realise that over the weekend when he's home everything's got to revolve around her,*" and later, "*...cos at the moment he just sort of leaves things where they fall, not tidying up and she's going to be putting things in her mouth...I've tried to explain to him... tried to get him into the routine of picking things up but he hasn't got there yet (laughs).*"

On the whole May spoke positively about her partner's support but she was not alone when she described the way in which he failed to understand what it was like to be with a baby all day,

"(her partner) *can't understand because he comes back from work and he cuddles her and she's lovely and she smiles at him and he does, he dips in really. He'll give her a bottle of milk or he'll bath her, whatever, but he's never, he hasn't got her all the time, he hasn't got the responsibility. He doesn't wake up in the night, doesn't hear her crying and I'm so tuned into her."*

It was during the Christmas period that Wilma pointed out to her partner how distracting an unsettled baby can be, *"I said to* (her partner) *over Christmas, now if* (the baby) *was sort of being demanding, I said, now do you understand what I do all day, and do you understand why the days are so long?"*

May talked about her need to escape from the baby's persistent crying. She left the child with its father and rather than the baby sleeping, May hoped she remained crabby and tearful so that her partner would better understand the relentlessness of a baby's cries.

"...I couldn't cope anymore, I just needed him to see what it is like to have a baby you couldn't pacify...I wanted (her partner) *to realise what it's like not to be able to settle her and I knew he couldn't settle her because she wasn't taking milk from a bottle..."*

However, on her return May is *"furious"* to discover that her partner has defrosted some of her very *"precious"* expressed milk. As she explains, "... *the biggest thing was that he's been able to settle her, stopped her crying and that wasn't the point, the point was I*

wanted him to realise what it was like to have a baby...you try everything to stop it crying and he did (stop it crying) *so it didn't work."*

The majority of the women interviewed described the way in which the baby seemed to absorb all their love and attention, to the point where it was as though everything they felt for their partners was inadvertently transferred to the baby. Betty recognised that her feelings eclipsed all other relationships, even those thought to be the most precious and indispensable,

"... the love is weird, you love your parents, I love (her partner) *and you love your sisters and your brother but it's a love that just, bang – as soon as you see them – you know he's only four months old but it's never gone and it, it is so strong."* May agreed, *"I just wanted to be with* (the baby) *and hold her and wrap her up and protect her and love her and it was **intense** that love and I couldn't love* (her partner) *as well those first few days."*

Their commitment to their babies was unconditional and to their surprise it was possible to imagine circumstances in which they no longer loved their partners and their lives together unravelled, whereas their own lives will always be inextricably connected to their children's. Jane describes this feeling in the process of telling me about her partner's reaction to fatherhood,

"Just 'cos (her partner) *is the dad... it doesn't have anything to do with me and motherhood because whatever happens I'll always be his* (the baby's) *Mum and that's*

the most important thing to me, more important than the relationship which as I can see can be turned on and off but this is not going to be turned on and off."

Imagining her son as a grown man, Betty wonders if he could ever behave in a way that would stop loving him, *"But my first reaction is no, even though everyone in the world would be hating him, you'd still love him and that to me is strange because if your partner did it, you'd hate them instantly...you'd never want to know them...you never could do that with your child."*

There is a general assumption in Western society that the father should be encouraged to remain at home after the birth of a baby for as long as work commitments allow. Therefore it came as something of a surprise to me that some of the women in my research expressed irritation and exasperation at their partner presence in the home during their paternity leave. In Sue's description we can clearly hear her frustration at having her partner at home for a month after the baby was born

"... frankly I think we just all got in each other's hair too much...I couldn't wait for him to go back to work because I know what I do when I do it with (the baby) *and I do like being in a routine with him"* and she described how he failed to fulfil the role that would have been most useful,

"... in theory, yes, it's wonderful having your husband home but it's almost, you need another mother... you don't need a father – nice for (the baby), *nice for* (her partner) *but*

not for me, I needed a mummy, I needed somebody else who could cook, you know, because he was around more there was sort of more pressure as such to provide meals for him and that sort of thing...and it almost makes a longer suspension of getting back to normal."

Although Chris *"wouldn't have been without"* her partner for the first few weeks, *"...whilst* (her partner) *was here we couldn't get into a routine 'cos he always wanted to do something at awkward times whereas if it was just me and her we could get into a routine...It was when* (her partner) *started back at work, it was very helpful... he sort of got on my nerves being home."*

For most of the women I spoke to, re-regaining a sense of normality seems to be especially important and because their partners would usually be at work, their presence prevented the women from establishing a reassuring daily routine.

However, as was invariably the case in the stories that the women shared with me, the discouraging account outlined above is only half of a complicated, often contradictory picture. Most of the women spoke with immense enthusiasm and warmth about the support they receive from their partners and the way in which they adapted to being fathers. Sue speaks fondly of her partner's involvement with their son,

"Having a husband that helps a lot does help an enormous amount, yes he might drive me mad at times with, the fact that he'll virtually let (the baby) *play with barbed wire*

(laughs) but it does... I wouldn't even care if I didn't get that much help so long as he was interested but (partner) *is very interested and does help an enormous amount with him and that helps to be a family, and also it does take the load off me."*

Chris also recognised that their daughter's birth had brought them closer, *"... instead of arguing we do sit down and talk things through, now I sit down and I say, stop shutting things in and talk things through, for* (the baby's) *sake... and he is starting to talk things through more."*

Wilma spoke proudly of the way in which her partner interacts with their son, *"At the moment things are better... I mean* (her partner) *absolutely dotes on* (the baby). *If* (her partner) *is in the room I can't get any sense out of him, he's (*the baby) *constantly like that* (cranes her head around the room) *because Dad is the person who walks in at night and gives him attention... I mean, not what I expected of* (her partner)... *in a lot of ways it's made me and* (my partner) *better."*

May readily acknowledges the positive impact that becoming parents has had on their relationship, *"It's very positive because she's a joint enterprise really and we're both working so hard to make her happy and do everything for her and work together. We don't argue so much as we did..."*

and in contrast to the other narratives, she recalls her partner's paternity leave as a wonderfully happy period, *"... the first two weeks when* (her partner) *was at home and wasn't working and it was lovely because I couldn't wait for her to wake up because I*

just wanted to be with her and see her and talk to her and cuddle her." Yvette described how birth of her son symbolised the birth of a family and enriched and strengthened the bond between her and her partner,

"... it was a feeling of, oh yeah, we're going to be a family, coming home, there was a sort of feeling, to start with a very close bond between the pair of us that we hadn't felt before from having brought (the baby) *into the world."*

Yvette emphasised the crucial importance of the physical act of handing her baby over into the hands of another. She explained that this is a vital component in alleviating the exhaustion of caring for a baby all day,

"It's handy to have lie-ins over the weekend, when (her partner is) *not at work and he just takes over the baby because it does sort of accumulate over the week and you need to have some sort of catch up time... You do need time to just hand the baby to somebody else, it's just that literally, and someone to talk to, to share it all."*

7.3.7 Isolation, Ambivalence and Tears

The euphoria of the birth faded away fairly quickly. For some women this was a gentle return to 'normal life' but for others it was experienced as inescapable as the women were engulfed by the relentless responsibility of their new lives. Being with a baby all day could be unbearably lonely. At times, the women felt detached from the world and a prisoner at home. The cries of a colicky baby filled the house and provoked feelings of

regret and hostility in the women who found themselves paralysed by the level of noise. Most of the women struggled to establish an identity that was not wholly tied to the baby, even though they were quintessentially defined as mothers now, holding fast to memories of their life before motherhood and seeing this as representing their 'real selves'.

Most of the women I spoke to referred to feelings of isolation and sometimes abandonment. For Chris, this feeling was intensified by her desire to return to work,

"... it was very, very difficult 'cos where I was so used to going out as and when I wanted to and then being tied to the four walls initially and not being able to go out when I wanted... it was a nightmare, it really was a nightmare."

Wilma described the way in which her days stretched out before her with only a baby for company, "(her partner) *goes out* (to work)... *and says, "I'll be back at twenty past six" and I said that's eleven hours and twenty two minutes... I do watch the clock for* (her partner) *to come home. It's alright if I've got things to do in the day... but the day in, day out of seeing nobody is a long day."*

Even women who lived close to their family would sometimes feel deserted and alone. May raised this issue several times,

"I think having a baby is very isolating and lonely at times... I've been desperate at times and find I have to go out everyday. I have to have something planned and if I haven't I go

round the bend and she does too." She goes on to explain, *"... even though I've got friends who 've got babies and my antenatal group was fantastic and we 've all kept in touch... it's still very lonely."*

For Wilma, the physical separation from her family caused her significant distress in the early weeks,

"I think a lot of girls have got a mum around the corner. My Mum lives in the Midlands, and (her partner's mum) *is at work all day anyway and I wouldn 't – I don 't want to trouble anybody. It's not like, a lot of girls can just say, oh Mum, have him for an hour you know and whatever friends I've got are in (*the town in which she used to work), *I just felt so much on my own."*

The moment of birth invariably signalled a dramatic change of focus for the women's families – their attention slid from the women to the baby, as Yvette confirmed,

"... when you're pregnant and everyone says, "How are you? What's this, what's that, what's the other?" And as soon as the baby's here, you're forgotten... and everyone pounces on the baby and coo-coo's and ga-ga's around the baby... everybody suddenly wants to have a piece of the baby They don't necessarily want to know anything about you."

Sue agreed with this, *"I had the age old thing whereby everyone's interested in the baby and not interested in the mother at all – I mean my Mum's very good she makes a point of it but you know it's a point of it (laughs)"*, although she also acknowledged that she experienced great pleasure from *"becoming part of the family... the extended family"*.

The women in this study found their babies' crying utterly bewildering and it often seemed purposeless and unfounded, invariably causing them considerable distress. Chris described her daughter's crying as,

"that horrible high pitched cry – the only time she wasn't crying was when she was asleep but she always seemed to be crying".

Wilma described her distress at her ignorance, *"... it was hell, it really was and I didn't know what to do with him and all I remember thinking was, this can't be right."* Wilma's description of her baby's crying paints a vivid picture of what it is to live with an inconsolable baby, *"And the cries would go from one meal to the next and I was literally constantly feeding him because I was thinking, he must be hungry,"* and she continues, *"I thought I must be doing something drastically wrong because he's crying all the time and that just can't be right."* Over time and through the use of a colic remedy, her baby became more settled and it was only then that he became, *"... a pleasure. Whereas before I'd be picking him up to constantly try and soothe him and calm him down; because he was crying I'd be picking him up as a solution, now like... it's nice because he sort of watches me... as opposed to me picking him up because I've got to."*

Yvette was initially perplexed as to how to respond to her son, *"After having been so brilliant in hospital it was a bit of a shock because he then just started to cry and cry and I'd think, "Oh my God." ...He wouldn't sort of be put down, you had to hold him nearly all the time... and you worry about when they start to cry whether you should pick them up or leave them or what you should do."*

However, as the weeks passed, all of the women felt that they were more able to respond confidently to their baby's needs,

"... and although sometimes it's a complete mystery why they're behaving like that, normally I can work why he's behaving in the way he's behaving" (Jane).

As the initial celebrations gradually concluded, some of the women experienced this as 'coming back to earth'

"I was on a real high for days and days and the feeling kind of ebbed away slowly, I didn't have like a massive postnatal blues or whatever, it just declined slowly and put me back down to earth"(Jane).

But others described feeling despondent and lonely. May sometimes felt as though, *"... there's no hope, it feels like, if I'm feeling down, I'm feeling tearful normally, I'm feeling that I just want something to change – basically it's not going to at the moment."*

Sue was able to recognise that her state of mind following her son's birth was temporary, *"So it's like you vegetate for a while really...for the first two months after having him... I didn't get depressed about it as in weepy – not a clinical sort of thing but it was sort of, you get so stuck in the mire of breastfeeding and not sleeping very much and not going out at all."*

Wilma described the juggling act of an inconsolable baby and a meal to prepare, *"... to do tea and keep the house tidy but it's harder work because you haven't just got to clean the house, you've got to have one eye on* (the baby) *at the same time and if he's not co-operating I've got no chance."*

Yvette's description of being home with her son caused her to laugh ruefully, "(for the) *first three or four days I hardly got out of my night dress and I'd been wandering around thinking, "what the hell's happened?" After having been so brilliant in hospital it was a bit of a shock because he then just started to cry and cry."*

May felt as though she had lost her freedom, *"... and I think the other thing I hadn't planned for was how I'd lose all my freedom,"* and she goes on to clarify the way in which she was utterly unprepared for the reality of being a mother, *"Read it, talk to people about it, but you don't take it in, you can't, you can't imagine what it's like to have a baby."*

May described feeling as though part of her real self had been lost in the process of becoming a mother, *"... maybe because I feel as though I've lost part of me. Because I'm giving so much to another person who can't give anything back to you."*

Sue described her struggle to establish a 'new' identity since becoming a mother, particularly in contrast to her partner's identity as both a father and a working man, *"... he's got a job and he's a daddy and a husband and he's alright in all of that lot but I'm not quite there yet, I know I'm a mother but it's not the soul defining thing that I am, I am other things as well but funnily enough, I almost couldn't tell you what they are".*

Chris' comments echoed this sentiment, *"...you're not your own boss anymore, you're a mother, you're a mother,"* and she goes on to discuss her experience of returning to work and the way in which this serves to exemplify how being a mother can seem like a different way of being from being oneself, *"When I'm with her I'm her Mum, but when I'm at work I'm myself, I'm my own person. When I come home I'm a Mum again..."*

The majority of the women in this study described the mother/child relationship as decidedly one sided due to the baby's rudimentary communication skills. Some of the women found that caring for a baby was not always a stimulating occupation – the endless repetition was boring and on the whole, motherhood felt like a prosaic task, as May explained,

"The biggest thing is when you spend all day devoted to the baby, you don't get time to sit down for a cup of coffee or to watch TV or talk on the phone or whatever and by the evening you're exhausted."

Yvette agreed, *"But just going through every day with him, what have I done actually; nothing other than feed, change and look after the baby."* Sue's pithy comment summarised this dilemma, *"I do enjoy being a mother but it's, so far it's not very scintillating."*

Moreover, a baby who cries relentlessly quickly became unbearable for all the women. Tiredness and exasperation severely tested the women's fortitude and many of them were appalled by the hostility they felt, on occasion, towards their babies. Chris was not alone when she admitted,

" I did resent her the first sort of month or so – I don't know why. I really, really hated her but although deep down I knew that I still loved her. It's hard to come to terms with, the conflict of feelings."

On a deeper level there was an enduring love but it was not unusual for the women whose babies cried a lot to feel that there was no longer anything positive about motherhood – handling the baby became a perfunctory activity with the sole purpose of trying to stop it crying as Wilma tells us,

"Whereas before I'd be picking him up to constantly try and soothe him and calm him down – because he was crying I'd be picking him up as a solution..."

These experiences sometimes lead to quite negative feelings being voiced. Sue was able to recognise her resentment as nothing more dangerous than a heartfelt response to an upsetting situation and was entirely confident of her protective instinct,

"...and yes I might think, why don't you get lost, why don't you just go away... how the hell do I know what you want, it could be one of ten things and you can't tell me so I know you're frustrated but I'm frustrated because I can't help you and he keeps on and on and on at you and I have felt like smacking him but I've never remotely – it's all in here (points to head)*, no action comes out... it's like there's two parts of you, the part that at all costs will protect him from absolutely* any*thing that would harm him and that includes yourself so it...* (pauses)*... doesn't kind of bother me."*

8.4 Concluding thoughts

These narratives demonstrate that only rarely is the experience of becoming a mother wholly joyful or the transition smooth and unconditionally embraced. Inherent within the descriptions provided by all the women are the frustrations and contradictions that seem to be fundamental to this process (It is interesting to note that Jane was the least resistant and most accommodating to the transition. Although she was aware of the potential difficulties, she did not experience them as problematic). The women provided articulate, evocative descriptions of the transformative journey and although every woman and every pathway to motherhood is clearly unique, there does seem to be a sense both of

emergence *into* and acceptance *of* the state of 'Being a Mother' which will be discussed in greater depth in the following section.

9.0 Discussion

9.1 Introduction

This chapter seeks to develop the many themes revealed during the process of data analysis. Motherhood and the experience of becoming a mother are discussed within several contexts, the overall aim being to provide a loose coherence to the complex transformation that is wrought by the birth of one's first child and to develop an understanding of the way new mothers come to embody the existential challenges of their new role. Beginning this chapter, the findings of my study will be compared with themes and concepts from other studies that have focused particularly on women's experiences of PND. This in turn informs the debate about whether PND exists as a distinct condition or whether a level of distress should be considered normative as women gradually adapt to early motherhood. There is also discussion of the disjunction between the concept of the 'perfect' or 'good' mother and the way in which the women came to embody mothering and gradually feel 'at ease' in the mothering role.

The chapter will then move on to a comprehensive analysis of the ontological nature of the transition to mothering. Aspects of embodiment, fragmentation and discontinuity of self inform this section, as well as Merleau-Ponty's concept of 'flesh' and Boss' re-interpretation of Heidegger's theory of Dasein and 'being-in-the-world'. Socio-cultural pressures that juxtapose women's desire to be 'perfect mothers' and their feelings of ambivalence and ambiguity towards their new role are discussed, as well as the way in which the women in my study re-ordered their sense of self in all its existential dimensions, gradually assimilating the responsibility and 'weightiness' of mothering into

a coherent identity. The final section examines the contribution of cross-cultural commentaries on adaptation to motherhood and the shortcomings of trying to compare disparate traditions across vastly different cultures.

9.2 Contextualising motherhood

The experience of being a woman is intrinsically tied to mothering. Women are contextualised and defined within its framework and crucially, whether they do or do not have children, their identity is still constructed within its parameters (Ussher1989). At the same time, research conducted into mothering originates in and is still largely focused on maternal role achievement, psychological adaptation, identification of deviation from 'the normal' and ultimately answering the question, "Is she a good/happy/fulfilled mother or not?" and if she isn't, how can we as health care professionals, sustain her in this transition (Bergum 1997). Such an approach has obvious value in aiming to improve women's experience of mothering. However it also requires that researchers make an implicit value judgement and consequently further reinforce the parameters within which women are considered to have failed or succeeded in their mothering. Qualitative studies into the transition to motherhood aim to provide texture, richness and depth to the important statistical data generated by quantitative studies. If successful, qualitative studies **"reveal knowledge to show us how to live rather than to pin knowledge down in order to control life."** (Bergum 1997, p135). Qualitative data should demonstrate that what is of greatest value is to understand and construct a composite picture of the way in which women embody the becomingness of motherhood, the way in which being 'with child', physically and ontologically redefines their way of 'being'. From the moment of

meeting the child, face-to-face, through a period of discontinuity, fragmentation and loss of self, to a gradual re-integration and embodied acceptance of mothering.

9.3 Comparing and discussing themes, constituents and experience

This section will further advance the argument that the transition to motherhood is challenging for all women and furthermore, that those diagnosed with PND have comparable experiences to women who are free of any such diagnosis. The discussion is centred initially on the constituents revealed by my study but also encompasses other aspects of the transition revealed in other studies and the variations of experience revealed therein.

9.3.1 Postnatal depression or a 'normal' transition

'Symptoms' considered to be indicative of postnatal depression (PND) may well be experienced by the majority of women who have recently become mothers, albeit with varying intensity or longevity. Dysphoric mood and self-reproach, taciturnity and reclusion, loss of vitality, feeling of role-failure as well as somatic features such as inability to concentrate and sleeplessness are often included by women when they describe their postnatal experience. Sleeplessness can be experienced as either a broken sleep pattern due to waking to feed the baby, or an inability to fall asleep even when the baby sleeps as new mothers worry about whether the baby is too warm or cold, or if it is about to wake.

Pitt (1968) described PND as atypical because, he claimed, it was usually mild, manifested a greater level of anxiety but did not included the familiar symptoms of suicidal ideation, early morning waking and increasing dysphoria in the morning. Otherwise, one could argue that the symptoms of PND and general depression are not dissimilar. Indeed, the general consensus is that depression after childbirth is clinically similar to other types of depression and there is little agreement as to whether it should be assigned the status of a distinct disorder (Whiffen 1992, Gallant & Derry 1995, Stanton & Danoff-Burg 1995). In addition there is no clear-cut evidence that depression after birth is any more common than that amongst pregnant and non-pregnant women (Stoppard, 2000). Whiffen (1992) in her review of the literature on PND concluded that it did not deserve the distinction of its own diagnosis. Incidents tended to be relatively mild and 'quick' to resolve (starting to resolve by six months, fully resolved by a year following the birth) – although she did acknowledge that both major and minor depression is more prevalent in the postpartum period. She proposes that PND be reconstructed as an 'adjustment disorder' to a major life event. Furthermore, aetiologically it relies upon the same variables as non-postpartum depression (previous psychiatric history, marital tension, low levels of social support and 'life-stress') Her review is based upon 24 studies published between 1964 and 1991, which met her inclusion criteria. She was of the opinion that women who have depression during their pregnancies and were still depressed after the birth should not be 'diagnosed' as suffering from PND as their depression could be a continuation of antenatal depression or have developed within **"the context of a pre-existing vulnerability"** (p496). Overall, she concluded that PND may

represent a manifestation of women's struggles to come to terms with the major life event of having children. Furthermore, this explanation raised the possibility that **"elevated levels of depression in the postpartum period are artifactual"** (p505). In other words, one might *expect* rates of mild depression to be elevated during a major life event, particularly if the individual has responded in a similar way in the past.

Whether PND exists as a distinct condition or not, this debate should not obscure the fact that many women have to struggle to adapt to their new role, reconciling the imperfections of their experience with the idealised image they have nurtured. The fantasy baby (and mother) are inevitably forfeited after the birth and as Raphael-Leff (2001) explains,

"Distress may result not only from external imposition but also from an internal mismatch. A woman's self esteem may be jeopardised as she feels herself torn between the orientation she has anticipated prenatally and the materialisation of her capacities as a mother." (p191)

It would seem to be the case that the experiences of the women in my research sound, at times, remarkably similar to the narratives provided by women who identified themselves as suffering from PND. Milgrom and colleagues (2003) drew on a wide selection of research when they described the symptoms of PND, as well as first person accounts from women who had sought treatment with them. The similarities to the narrative accounts in my study are immediately obvious, as a few examples will indicate.

According to Milgrom and colleagues (2003) women suffering from PND had symptoms of low mood, sadness, tearfulness, feeling worthless, anxiety, worrying about their baby's wellbeing, exhaustion (**"I'm tired, so tired." "Everything is an effort."** (p4)), irritability, reduced concentration (**"I have trouble deciding." "I'm confused and my thinking seems foggy."** (*ibid.*)), oscillating moods, inability to sleep (even when the baby sleeps) and feelings of hopelessness. An example of a typical presenting case is given:

"She had difficulty managing her baby's constant crying...a strong preference for order and predictability but this had been disrupted by her newborn and she struggled to cope with the 'chaos'...she felt a despairing sense of loss of her past lifestyle as the exclusive couple relationship was changed and the demands of early parenting were constant." (Milgrom *et al.* 2003, p15).

Sue described her intense dislike of the chaotic feeling 'in her head' which was mirrored by the mess in the house and although the other women did not use the word 'chaos', it was implicit in their narratives as they struggled to impose order and routine on their disorganised, unfamiliar lives.

Milgrom and colleagues (2003) present a meticulously researched, convincing case for active intervention to alleviate depressive symptomatology in the postnatal period and I am not suggesting that their basic premise in incorrect – clearly many women experience the transition to motherhood as difficult, unfamiliar and exhausting. However, I am

unconvinced that their experience is exceptional or characteristic of a distinctive 'illness'. Rather, it seems to be part of a 'normal' transition particularly if one considers that the women in my study, none of whom described themselves as depressed, used such similar vocabulary that extracts of their narratives could be transposed into Milgrom and colleagues' (2003) book and vica versa. My results indicate that possibly all women have to confront similar difficulties as they adapt to being mothers, but the way in which they re-order their lives to include the tiredness, or the reduced concentration is dependant on a huge number of variables – in so much that some women negotiate the transition with relative ease whilst others feel 'marooned' or 'out of balance' and unable to re-establish a coherent identity. Accordingly, it is possible that all women would benefit from the therapeutic intervention proposed by Milgrom and colleagues (2003) (see above) as a preventative measure during the postnatal period rather than a treatment once a diagnosis has been made. However, there are obvious cost implications to this labour intensive support programme being more widely available.

There is however one symptom, that of thoughts about death and suicidal ideation (**"sometimes I think everyone would be better off without me"** (*ibid.* p5)) that was identified by Milgrom and colleagues (2003) but was absent from my narratives. This issue is discussed in detail below.

9.3.2 Losing control of one's life

Beck (1992) used a phenomenological approach to study the lived experience of PND by interviewing seven women already identified as suffering from the condition. She asked

them to describe in detail what it was like to experience PND and identified eleven essential themes. In seeking to develop a substantive theory of PND, Beck (1993) conducted further in-depth interviews with twelve women who attended a PND support group and used a grounded theory approach to analyse their experiences and then compared the findings to those from her earlier research (Beck 1992). 'Loss of control' was revealed as the basic social psychological problem and women immersed in this were described by Beck as **"teetering on the edge"** (Beck 1993, p42) of sanity and insanity.

Echoing the theme of 'loss of control', Morgan *et al.* (1997) established and evaluated a group programme for postnatally distressed women (they had not been *diagnosed* as suffering from PND) and their partners. Thirty-four couples took part. There were eight weekly sessions for women and at the onset the women completed three screening questionnaires, one of which was the EPDS. These were repeated at completion of the course and 6-12 months afterwards. The women who took part in the study reported feelings of resentment that their lives had changed so drastically and they had so little control over their time – this made them feel as though they had failed to embody their ideas of what it is to mother successfully.

Ruchala and Halstead (1994) analysed the postpartum experience of fifty puerperal women in The United States, with a particular emphasis on the postnatal support available. None of these women identified themselves as having PND or sought any professional help but during their interviews many of the women described this period as

a 'time of adjustment' with debilitating exhaustion figuring noticeably in their responses. They described feeling tearful and irritable; they complained about feeling isolated, being troubled with mood swings and transient depression. Such descriptions are not unusually when women recount their experiences of early mothering, both for those who have been 'diagnosed' as suffering from PND and those who have not.

Part of the general structure of the transition to motherhood for the women in my study was, "Typically the women now enter into a period of discontinuity – much of the familiarity of life before motherhood obscured by a sense of chaotic disorganisation and intense emotional responses" and what is vital is "a need to re-establish a sense of 'being in control', wresting orderliness from disorder and coherence from chaos." New mothers seem to loose control of their day-to-day activities, they are unable to plan ahead or conversely, act spontaneously. For instance, going out with the baby becomes a *"time consuming job"* (Yvette) and the women's financial independence was often severely limited due to most of them being on maternity leave from full-time employment. Their relationships with their partner deteriorated and they were rarely able to organise any quality time together. The babies' needs would not submit to negotiation and instead demanded an immediate response. The women had no control over their sleep patterns and this tiredness exacerbated the feeling of chaos surrounding them. Chris remarked that she used to *"just bomb off in the car"* but was unable to since the birth of her daughter. Later on she became more positive - as time passed, she was able to *"get into a routine... work things out."* Sue describes the early days with her son thus:

"...your mind's in a chaos and I couldn't stand the house being in a chaos as well. It was horrendous, that was some of the worst bit for me, I loathed that."

Yvette was fairly sanguine about the disruption caused by the baby, but several times she spoke of the way in which *"you've just got to put everything on hold, or on the side"*. For May, loss of structure and control of her life is a persistent problem for the first few months, *"...since the baby's born basically I'm forgetful, I'm late for everything, I can't do things in sequence."* Towards the end of her interview she acknowledges that the 'homesick' feeling she encountered on returning home from hospital was *"because it was almost like I knew that I'd lost some of my freedom...and I knew that I'd never get that back again."*

Yvette also was astonished by the way her life changed, *"I thought I'd be running around doing everything that I used to whereas...* (trails off into thoughtfulness)".

9.3.3 Looking for similarities

At this point I want to examine further the way in which women who are 'diagnosed' with PND and the women who participated in my study, often described similar experiences, using similar words. It is important to make clear that my aim is not to overturn the findings of the studies referred to below. Arguing that PND was a 'phantom' diagnosis would further marginalise women's experiences and effectively silence those for whom the label PND legitimised their desperation and possible help-seeking activity. Rather, I am proposing that the way in which women embody this exceptionally

demanding period of their lives, when much that is familiar seems to fall away leaving them inchoate and grieving, as well as blissfully happy and fulfilled – is difficult to predict, to provide effective support for and to discuss in a consistent, authentic manner. Factors that have been implicated in past research as sometimes contributing to women experiencing this transition as exceptionally distressing, are not necessarily indicative of PND – in other words, a woman might present with several risk factors but experience the transition to motherhood as relatively unproblematic. Even the experiences themselves (for example, feelings of anxiety, isolation, confusion and disorder, loss of freedom, awesome love or physical dissonance) may appear to be superficially very similar between new mothers, whether they are identified as depressed or not. Crucially though, the way in which individual women have traversed these experiences varies considerably. Nicolson (1998) in her comprehensive analysis of PND and the transition to motherhood, suggested that instead of particular stressors such as social background or birth experience being the notable factors that propel a woman into PND, **"...the woman's life and the meaning she placed upon that particular period of time may be more important in determining her emotional state."** (p87).

Aiken's (2000) collection of personal accounts of PND are evocative and revelatory of the despair and anguish experienced by the ten women in her book as they struggle to adapt to motherhood. It is a particularly important book in that it provides a unique insight into the daily lives of women who had been diagnosed, or considered themselves to be suffering from PND and Aiken provides a sympathetic forum for their frank descriptions as she herself suffered from depression after the birth of her daughter. The

narratives will be considered in greater detail below as I discuss the similarities between the experiences recounted by the women who took part in my research and women such as those in Aiken's book (2000). Aiken's summarises what she understands to be the 'symptoms' of PND and many of them *are* reflected within the narratives recounted to me during this research. Hatred of the baby's cries, fear of being left alone with the baby, difficulty sleeping, feeling isolated and lonely, loss of libido and resentment of partner, feeling anxious, feeling they are failing and problems with breastfeeding are all mentioned many times by the women in my study as well as the women suffering from PND (Aiken 2000). Likewise, if Beck's (1992, 1993) essential themes of PND are compared to the essential constituents of the experience of becoming a mother as revealed in my research, there are areas of striking resemblance.

9.3.4 Anxious Loving

In my research the constituent entitled "Anxious Loving" encompassed the women's fear that their infants would die or disappear.

Jane spoke of her nagging anxiety that her baby would not be in his cot in the morning, *"I was so frightened... that I'd wake up one morning and he'd be gone again, because he can come like that* (giving birth to him) *and he'd be gone again the next day or whatever and there was that real feeling that perhaps he's only here for a little while."*

These sentiments are repeated by another woman called 'Jane' interviewed in Aiken's book (2000),

"She also had terrible fears of her baby dying and found it hard to take her eyes off her...Jane couldn't enjoy Daisy for many months because of the thoughts of Daisy dying which dominated her mind..." (*ibid*, p42).

Jane, whose comments display what *might* be judged an excessive anxiety, actually experienced motherhood as overwhelmingly positive and her concerns dissipated over the early weeks as she became confident that her son was a permanent presence. Whereas 'Jane' who contributed to Aiken's (2000) book experienced crippling anxiety and depression which required psychiatric support and medication and which did not resolve until some months after the birth of her second child.

9.3.5 The baby 'filled their vision'

The women who took part in my research described the way in which the baby absorbed all their thoughts, and efforts to concentrate on anything else for longer than a few minutes were futile as their thoughts repeatedly returned to the child. This constituent was called "The baby fills her vision" and encapsulated the way in which the women retained a feeling of overall responsibility for the baby which they could not suspend and which often hampered their opportunities to enjoy time away. They never felt free to let their thoughts roam and drift aimlessly. Beck (1993) identified **"Shrouded in fogginess the mother's ability to concentrate is diminished"** and **"Haunted by the fear that any normalcy in her life is irretrievable, the mother grieves her loss of self."** (p46) as two of the major components of PND. A quote from one of her narratives starkly illustrates

this fear, **"My biggest fear was that I wasn't going to ever be the person I had been before postnatal depression."** (I would suggest that for 'postnatal depression', one could substitute 'having a baby'). These constituents are mirrored in my findings as the women speak of their past lives as something to which they cannot return. I describe it thus, "The past remembered with the precariousness of a dream, as though it was a different woman who lived that life". Yvette laughed when she tried to recall her life before her son was born, *"since before he was here seems an age, you can't imagine life before, life before baby – that was a distant memory"*. Sue was fairly pragmatic in her acknowledgement of how different her life is now, *"I mean I know you'd never return to whatever, you're never going to return to not having that baby."* She spoke candidly of the practical steps she took to recover a sense of herself and time/space physically separate from her baby and although this proved to be a restorative course of action, she admitted towards the end of the interview that she is still uncertain as to the person she is now,

"I do begin to feel that I'm coming out the other side of it now but I still don't quite know where I am in the middle of it all... I know I'm a mother but it's not the soul defining thing that I am, I am other things as well but funnily enough, I almost couldn't tell you what they are... it's just not the only thing I am."

On her return from hospital Yvette found for the first few days, *"I hardly got out of my night-dress and I'd be wandering around thinking, "What the hell's happened?"... But just going through each day with him, what have I done actually? Nothing other than*

feed, change and look after the baby." Later she spoke about the way her new life differed from her life before children, *"It's a definite – it's a definite change of everything."*

One of the women interviewed by Beck (1993) described her inability to focus on an activity as simple as reading a book, **"I had been a very avid reader and could comprehend well. I lost all that in my postpartum depression. I would have to read lines over two and three times."** (p45). This is remarkable similar to May's account of trying to write Christmas cards,

"I can't work out how to write them logically...I'm writing half a card...I wrote the envelope to a card and put a card that I hadn't written in, sealed it in the envelope, posted it off... if I'm writing to a family I've forgotten one of the children's names ... so I've left a space and having to remember that I've got to fill that space and daft things like that."

Although Beck (1992) does not comment on the way in which the woman recounted this incident, we can assume it was not in a humorous manner whereas May and I shared laughter and recognition at her (temporary) distraction. That is not to say that one incident was more or less serious or revealing than the other, but the differing approaches of the women possibly provide an insight into the way in which such incidents are perceived and contributed to women's experience of the transition to motherhood. What seemed to be the case is that when women talked about their own unique transition into

motherhood they often described strikingly similar events, but their *experience* of them, the way they 'lived' them was remarkably different. This difference does not invalidate any research findings as the aim of a phenomenological study is to identify some of the fundamental experiences that comprise the phenomenon, in this case: the transition to early motherhood – it follows that the way in which an individual woman embodies these experiences within her own lifeworld is infinitely variable. What can be experienced by one woman as cataclysmic might present only a minor irritation to another.

9.3.6 Isolation and ambivalence

Although the women I interviewed made many positive comments about being mothers, their struggle to come to terms with the dramatic changes brought about by their new identity was constantly referred to. In the constituent entitled "Isolation, Ambivalence and Tears", I described the way in which motherhood was experienced as something from which the women in my study could not 'escape' – even when they were absent from the baby they always carried the responsibility of their child's welfare with them. However the women demonstrated wide variation in the way they reacted to this intrusion. Price (1988) drew on women's accounts of becoming mothers to better understand the intense emotions of this transition without resorting to the medical diagnosis of PND. She explained that women are deeply troubled by their interpersonal sense of desolation and annihilation and although not a phenomenologist, she recognises that women embody this distress in various ways.

"Having a baby changes everything, both within and around a woman. Nothing is the same again and that overwhelming unfamiliarity is frightening to even the most capable and supported of people." (Price 1988, p126).

Sue talked openly about the animosity her son's cries evoked, but she was able to rationalise her response as both predictable and posing no threat to her son, as she was confident that she would never act upon her feelings. This provided her with a reliable coping strategy and protected her from the (irrational) feelings of guilt that such feelings often arouse in other mothers.

"and yes I might think, why don't you get lost, why don't you just go away or, I have felt like smacking him, when they scream at you it sort of like you think, how the hell do I know what you want, it could be one of ten things and you can't tell me so I know you're frustrated but I'm frustrated because I can't help you and he keeps on and on and on at you and I have felt like smacking him but I've never remotely – it's all in here (points to head). " (Sue)

Likewise Yvette recognised the lethal combination of tiredness, frustration and misapprehension when her attempts to settled her baby fail,

"... there have been a few times where I could see someone could hurt a baby – in the middle of the night when you've had no sleep whereas before that I wouldn't have ever believed that anybody could actually hurt a baby".

These comments and many more like them were made by women experiencing a *normal* transition. However, their stories would not have been out of place in Aiken's book. For example, 'Julie' (Aiken 2000) spoke with considerable sadness about her struggle to come to terms with motherhood,

"I knew that there would be hard times, but also knew that there would be lots of love and sharing as well. In reality, there *was* a lot of love but I definitely was not prepared for the hard work a baby brings, the insecurity you feel as you're no longer centre-stage, the frustration, anger, resentment, fear and responsibility." (*ibid.* p46-7).

She described how entangled with the baby's needs her life became, unable to find any time for herself (apart from a snatched half hour bath), she struggled to maintain high standards of housework whilst feeling exhausted and constantly guilty that she was not being a 'good enough' mother. **"When Sarah cried it split my skull."** (*ibid.* p49) and 'Jane' responded by screaming at her baby which then compounded her guilt. Excursions with the baby required so much planning that eventually she lost interest in leaving the house and her relationship with her husband deteriorated – a mixture of resentment and disinclination. A combination of anti-depressants, and crucially, practical help from her mother-in-law who cared for the baby during the day so that 'Julie' **"caught up on some sleep and did whatever she needed to do to make herself better."** (*ibid* p49) helped her to regain control of her life and gradually learn to enjoy being a mother. Without

exception the women in my research protested about their inability to go anywhere 'on a whim' now that they were mothers. Even the simplest shopping trip with a baby became a major expedition as Yvette explained,

"... it's difficult to just pop down the shops... it's a question of putting them into the seat, bringing him to the car, settling into the car, getting to the shops, unstrapping him...just literally to get a bottle of milk... a time consuming job." (Yvette).

"...you can't really go out on a spur of the moment...you've got to carry loads of baggage and I've got to carry millions of nappies... it just sort of takes the spontaneity out of life." (Jane).

Although in essence the women in my research and the woman in Aiken's book (2000) are discussing the same experience, namely the additional 'paraphernalia' and forward planning required to negotiate 'going out' with a baby, they have 'lived' the experience in profoundly different ways. For the women I interviewed, it was undoubtedly a nuisance but ultimately, one to laugh about - exasperating but manageable. For 'Jane' and 'Julie' (Aiken 2000) it was infuriating and served to intensify their frustration, sense of isolation and misery. Whereas the women in my research were able to gradually assimilate these practical demands into their new lives as mothers, 'Jane' and 'Julie' (Aiken 2000) alternated between battling against this imposition and resigning themselves to the unmanageability of it.

I would speculate that a majority of new mothers experienced feelings of desolation, resentment and anger when their baby cries inconsolably, or is fretful and that this compounds the exhaustion. 'Isobel', one of the women who took part in Nicolson's research (1998) struggled with her son's relentless crying and generally found motherhood a **"great shock"** (p114). She did not describe herself as depressed, instead saying that she was, **"Just keeping her head above water. Just managing to cope with every day...but I feel I've got to put effort into getting that far."** (*ibid.*). This comment illustrates the way in which women often locate their experiences within there own biography rather than a medical discourse of dis-ease. 'Isobel's' obvious struggle to 'keep going' would not be 'out of place' in a study on PND.

9.3.7 Impact on relationships

Becoming a parent has a huge impact on a couple's relationship that is intrinsic to the experience of becoming a mother. As Sue explained, *"you know you've got to find a new relationship and we haven't quite found it yet"*. This constituent was called "Relationships: re-evaluation and conflict". In many ways it is defined by contradictions – the women felt 'emptied out' of love for the baby, which could provoke feelings of dejection and irritation in their partners when they (the partners) expected attention. Likewise, many of the women spoke of their resentment that their partner's life had barely changed whereas theirs had deteriorated in every practical aspect. May resented her partner being able to go away on business trips, Wilma envied her partner going out to work everyday and Chris bemoaned the fact that her husband failed to modify his lifestyle to take account of the baby's requirements. Both Sue and Chris expressed relief

when their partners went back to work as only then were they able to establish a routine and recover some control of their lives. However, Sue and Chris, as well as the other women in my research also talked with considerable warmth about their partner's support and practical help and how this relieved their exhaustion to some extent. They also spoke enthusiastically about how much the men loved their children and that this was a source of great joy.

In 'Julie's' narrative describing her experiences of early motherhood (in Aiken 2000) she spoke of the way her relationship with her partner deteriorated severely after the birth of their first child. The majority of people still defend the misplaced belief that parenthood brings couples closer, whereas all the research and anecdotal evidence suggests otherwise. Repeatedly, research on the transition to motherhood, as well as that which focuses specifically on PND, contains revealing descriptions of the detrimental effect of babies and motherhood on women's relationships with their partner. Sue acknowledged that although she had been married for over twenty years she had to 'remind' herself that she and her husband were very compatible prior to their son being born and she is contemptuous in her dismissal of the unfounded belief that a baby enhances a couple's relationship *"I can understand why people get divorced and yes, babies can never bring people together because they absolutely cannot."*

Although Betty had seen little of her partner since their son was born (due to his working away), she drew on the wisdom of experience that belied her years when commenting on a friend who is anticipating motherhood as a way of redeeming a failing relationship,

"I didn't realise – I mean a baby does put pressure on a relationship...you think, oh no, that won't happen to me."

May describes the way in which she felt unable to love her partner immediately after the birth because all her feelings were subsumed by the baby with an intensity that overwhelmed her. As time passed a more even balance was established but negotiating time together was difficult,

"I wasn't prepared for the fact that we wouldn't be able to sit down and have a meal and talk at dinner and when we went to bed we wouldn't be able to cuddle up and chat because we're too tired and so that has had a huge impact on our relationship."

In Cowan and Cowan's (1992) longitudinal study where the lives of one hundred couples were followed for the first five years following parenthood, the researchers concluded that the transition to parenthood is deleterious for a majority of marriages. By the time the baby was eighteen months old approximately a quarter of the interviewees reported that their marriage was in distress and over ten percent had already divorced. Overall, 97% of the couples who took part described a deterioration in their relationship with more marital conflict since the baby's birth. Moreover, by the time the children were five years of age, a fifth of the couples had divorced, however the divorce rate for comparable couples *without* children was nearly 50%. Commenting on this research, Maushart (1999) in her book that aims to deconstruct the fallacy of stress-free motherhood says,

"When partners become parents they might like each other less and less, but they stay together more and more...there will be a marked divergence of interests and activities...a dramatic widening of the gap between 'his' world and 'hers'." (p218)

In Beck (1992) one of the women describes her aversion to her husband, **"I just wanted him to leave me alone and not touch me."** (p169). Likewise, In Lawler and Sinclair's (2003) phenomenological hermeneutic study of women's lived experience of PND, they discovered that relations between women and their partners suffered significantly, **"Descriptive words like 'despised' and 'disliked', 'distrusted'..."** (p39) epitomised the women's perceptions of their partners and their relationship after the baby was born. Some of the women moved out of the bedroom, two moved back to their parent's home. In Aiken (2000), 'Jane' admits that she experienced, **"a complete lack of interest in sex...**(our) **sexual relationship hasn't yet returned to how it was prior to having children."** (p44).

Disharmony between new mothers and their partners, is not an exclusive indicator of PND. Indeed, it seems to be commonplace in the transition to motherhood. In my research the only woman who did *not* refer to similar experiences was Jane who lived apart from her son's father (she lives with her parents and had done prior to the pregnancy) although they did see each other fairly regularly. She expressed relief that she was not obliged to incorporate her partner's emotional and sexual needs into her developing relationship with her baby.

"I've got to really, really try to find any kind of sexual feeling but it's buried very, very deep – I don't really need it at all in fact and that's another thing why I'm quite happy to live here, the pressure's off me as far as that's concerned."

Paradoxically, some of the women also spoke very warmly and with real affection about their partners. In my research they described the warmth and emotional support provided, their delight in observing their partners playing with the baby and the practical assistance some of the men provided. Likewise some of the women in Aiken's (2000) book speak of their partner's as a **"reassuring presence"** (p45) and **"What I would have done without a partner like Michael to step in..."** (p49). **"...if it hadn't been for his support and encouragement all the way, (I) wouldn't be where I am today."** (p56). **"Our relationship has shown tremendous strength throughout this whole ordeal."**(p102). Although the women do discuss their partner's failings as well, what is clear is that the fragmentation of women's most intimate relationships are the norm rather than the exception as they negotiate the transition to motherhood.

9.3.8 'Unpreparedness'

Motherhood is distinguished by certain factors that all women with new babies are compelled to confront. Before discussing these aspects of the transition, it is important to emphasise that not all women will experience these factors as disrupting. The majority of the women in my study did struggle to assimilate the changes required, but for Jane this process of assimilation appeared to be executed with minimal resistance.

Aiken (2000) included her own story in her collection of ten women's experiences of PND, as well as a discussion of the implications of their narratives and their partner's responses to the women's depression. She highlighted particular aspects of their life - experiences that she felt to be relevant to the onset of PND, one of which was an absence of preparation and ignorance of the mothering role. Even if the women had cared for siblings or other relatives in the past, their own child presented a unique level of responsibility. Topham (2002) used a grounded theory approach to better understand PND and one of the common themes she identified was "idealisation of motherhood" which I would argue is linked to this sense of 'unpreparedness'. Wilma and Chris felt wholly unprepared for motherhood and although May had experience with babies and children she said, "*...you can read in all the books and talk to other mums but nothing prepares you for that does it.*"

"*...and you're on your own and he had his milk spots and I was like, what are these spots and just because I didn't know what to expect. I didn't know anything about babies at all. None of my families have got babies, there's nobody here I know with a baby.*" (Wilma).

"*...it's a complete shock to the system – you try and think how it's going to be but it never actually is how you expect it to be, you could never ever be planned enough or expect enough of what it's going to be like...you're never prepared enough, never prepared enough.*" (Chris).

The general structure of the transition to motherhood, thrust the women in this study into a period of discontinuity where much that was familiar prior to giving birth was obscured by a sense of chaotic disorganisation and intense emotional responses to new, unforeseen experiences. It was these elements that overwhelmed most of the women and felt inescapable, sometimes for a relatively short period, sometimes for months. During pregnancy, motherhood was imagined as an idyllic scene of maternal gratification but this proved on the whole, to be unrealistic. This theme is explored in Miller's (2000) study on the narrative construction of motherhood. She interviewed twenty women, during their pregnancies and at approximately 2 months and then eight months postnatally, using a semi-structured interview technique. Women were asked to speak about their expectations of motherhood and what their lives were like after the baby was born. Her results and subsequent discussion disclosed the discontinuity and inconsistency between what was imagined (antenatally) and what was experienced (postnatally) by the women who took part in her research. She speculated that,

"...postnatal depression may be a symptom of the discontinuity of an account. When the discrepancy between antenatal expectations and postnatal experiences becomes too great or too difficult to contain, depression may be more liable to occur." (p319).

Although the women in my research did not describe themselves as suffering from depression (unlike some of Miller's (2000) participants), the 'unpreparedness' they

experienced resonated with Miller's findings and with the disjunction of motherhood as imagined and motherhood as lived.

As Wilma said, *"I thought, I honestly thought I would walk it. I'm an organised person, I can do this. I just thought, this'll be a doddle and it wasn't, not at all."*

In my study, all of the women described the way in which their lives had changed dramatically since the birth – although it was experienced in contrasting ways by the different women. Every aspect of their lives was altered, as the constituents of the general structure indicate. Chris pined for her old life and felt unable to enjoy even the simplest freedoms that she had taken for granted in the past, *"... initially it was very, very difficult 'cos where I was so used to going out as and when I wanted to and then being tied to the four walls... it was a nightmare, it really was a nightmare."*

Descriptions of similar frustrations are found in Aiken's (2000) book. 'Pippa' voiced her regret about the way her life had been taken over by her baby, **"He ruled my life completely, always knowing what he wanted...he was never content to sit...My self-image was very low...I wasn't even sure of who I was anymore."** (p54). This is reminiscent of Sue's description of having to be always 'on call' for her son, *"... he's a very boisterous little boy... he's into absolutely everything and you feel like you've got to chase him round the room and stop him doing things"*

'Rosemary' (Aiken 2000) also felt inexorably changed by becoming a mother as well as disappointed in herself for failing to live up to her own expectations. She had had an **"excellent"** job in the United Kingdom but was living abroad with her husband, unable to speak the language. **"I felt like a prisoner...I felt frustrated, low, entrapped...I especially felt a loss of my identity...why was I not happy and radiating as mothers are supposed to be?"** (p38).

The study conducted by Brown and colleagues (1994) into the mothering experiences of ninety women in Australia, also echoed many of the circumstances of the women in my research and the studies mentioned above. In relation to the baby absorbing all their time and attention, the women in Brown and colleague's (1994) study described how they felt confined – physically, emotionally and socially. They felt "tied down", unable to enjoy a bit of adult time. Having children was invariably at odds with having any undisturbed time, space or privacy to enjoy activities previously taken for granted. This frequently extended to an intrusion upon their emotional life, as 'Katrina' explained, **"There's no way I can back out of emotionally still giving to them – they still need me; if you just want space to be quiet for a while, it's just not there."** (Brown *et al.* 1990, 167).

Bergum's (1997) book is based on the results of research carried out since 1983 into various aspects of pregnancy and motherhood including labour pain, and mothering both through giving birth and by adoption. She interviewed **"many"** (p4) women (but does not state the number) and analysed their narratives using a phenomenological hermeneutic approach. One of her respondents describes the way in which her daughter is always on

her mind, **"I've got Brett on my mind all the time, whatever I am planning to do. It's ongoing. It's fragmented my thinking...mothers live a very fragmented existence."** (p138).

9.3.9 Suicide and suicidal ideation

When considering the sensitive issue of suicide and new motherhood, one is presented with an apparent contradiction. Although suicide has been identified as the largest cause of death amongst pregnant and parturient women (up to a year postpartum) (CEMACH 2004), pregnancy and new motherhood also seem to confer 'protection' onto the woman and make it *less* likely that she will take her own life (Appleby 1991). Women diagnosed as suffering from PND do sometimes contemplate suicide so the risk must be taken seriously. However very few women do actually kill themselves. Beck (1992) discovered that her interviewees contemplated death as a release from the nightmare of their experiences. One mother despaired, **"...I was very suicidal. I loved my baby but I thought if this is the quality of life I am going to have, there's no way. No way anybody could endure the kind of pain I was going through."** (*ibid.* p168). It *may* be that suicidal thoughts following the birth of a child are specific to women struggling with PND as they do not seem part of a normal transition. Based on population data for England and Wales between 1973 and 1984, Appleby (1991) conducted a retrospective review of mortality rates amongst women aged 15-44 who committed suicide whilst pregnant or in the first postnatal year. He found that pregnancy and the postnatal period are a time of very low risk of suicide (the standardised mortality ratio was calculated to be 0.17 – one sixth of that expected). Holden (1991) is reassured by Appleby's (1991)

findings. However, she pointed out that in an earlier study carried out by Holden and colleagues (1989), in which counselling interventions were assessed as a means of treating PND, out of the 53 women with PND, four attempted suicide and others described feeling suicidal but could not bear the thought of leaving their babies motherless.

The Confidential Enquiry into Maternal and Child Health (CEMACH, 2004) published their most recent report into maternal deaths for the period 2000-2002. There were 391 deaths during that period, which are classified as direct, indirect, accidental and coincidental. Of these, sixty were due to psychiatric illness and of those **"around 50"** (CEMACH 2004, www.cemach.org.uk) women took their own lives, thus making suicide the commonest cause of indirect maternal death during pregnancy and up to a year postpartum. Of the sixty psychiatric deaths, 34 women had a history of mental illness and out of the 26 suicides, 17 had a psychiatric history. This finding reflected that of the report covering 1997-1999 (CEMD 2001) which also confirmed suicide as the leading cause of maternal death overall. The authors of the latest report upheld the seemingly contradictory conclusions on suicide from CEMD (2001) – **"...despite the clearly elevated rate of mental illness ... the risks of completed suicide...are markedly reduced."** (chpt. 12, p3). There is speculation that the presence of an infant may be protective.

"The lower risk of suicide during pregnancy or in the year after its termination confirms previous findings ...The lower risks of suicide ... in the year after birth

remain largely unexplained. Although postpartum depression is common, it does not seem to result in an increased incidence of suicide compared with the general population." (CEMACH 2004).

In Aiken's (2000) collection of ten women's experiences of PND, seven of them expressed a desire to die or felt suicidal. 'Gail' recalled, **"I was living through hell. One day, I was lying in the bath and thinking, "If I just slipped under the water, it would be over and I would be free". It was my way out – an escape route."** (p63).

It is undoubtedly the case that women with a history of mental illness are at increased risk of suicide and parasuicide in the postnatal period, although both CEMD (2001) and CEMACH (2004) emphasise that this is specific to severe psychotic illness and not 'just' a history of PND. However, there were case studies of women for whom the onset of depression and suicidal tendencies was ominously sudden with no prior history to alert healthcare providers to the risk. Relative to the percentage of mothers expected to suffer with PND, generally agreed to be approximately 10%, the number who end their lives are small. Whilst acknowledging that this is an enormously sensitive issue, I would contend that *expressing* past feelings of hopelessness, exhaustion and anguish in the form of suicidal ideation is more often than not an acute 'outlet' for the often considerable frustrations of early mothering. In other words, it is one of many possible diverse responses to what can be an intensely difficult transition as well as a way of 'giving voice to' that experience. However, it would of course be irresponsible for a health professional to dismiss suicidal comments as merely 'giving voice' to the difficulties of caring for a

new baby. A new mother expressing such despair during a postnatal visit with her midwife or health visitor should always be taken seriously.

9.3.10 Loss of freedom, self-sacrifice and the perfect mother

In her book, Aiken (2000) identified the enforced surrendering of personal freedom and disintegration of the women's past identities as key themes in the women's stories. The women who contributed to my research implied that the past was another place, remembered with the uncertainty of a dream. As Yvette said, *"since before he was here seems an age, you can't imagine life before, life before baby – that was a distant memory."*

Often it was difficult to remember details of life prior to motherhood as this memory felt as though it belonged to someone else. May equated her 'past life' with lost freedom,

"I hadn't planned for...how I'd lose all of my freedom. I think that will gradually come back but I hadn't planned for that at all."

Betty felt no resentment when she reflected upon the woman she was prior to becoming a mother,

"I would almost say he's my life now and the thought of not running my own life is strange because it was always me, me, me, always, I was so selfish – I'd do this, I'd do that and now it's, I'd do everything for (the baby)*."*

Wilma felt that becoming parents was the next step for her and her husband so although she is surprised by how her life has changed, she is not resentful,

"I said to (her partner), *what did we do before? I can't you know, I know what we did do before...you know we used to have a drink of a night as well and that went out the window...I think, God, we used to be able to go down the pub and now we don't do that."*

The celebration, sense of achievement and delight experienced immediately after the birth, gradually faded and although for some women this was experienced as a gentle return to normal life, others felt despondent and lonely. The wonder and excitement of becoming a mother seemed like a distant memory when confronted with an inconsolable baby and a meal to prepare. The exhaustion and drastic curtailing of freedom was unexpected, as was the feeling that their lives were no longer their own and however much they tried to assert some control, it slipped away again and again. Often during the day some of the women realised that they had failed to provide for their own basic needs so focused were they on the baby. It was as though they had instinctively adopted an attitude of sacrifice and selflessness and this stance was seen as being inextricably linked to motherhood. As Sue reflects

"I'd love to know where we all get our ideas of motherhood from because it does still seem to be an absolute self-sacrificing thing and that's a huge measure of being a good mummy, that you sacrifice yourself."

It is interesting to note that there was very little mention made by the women of any efforts to maintain activities and associations that pre-dated motherhood. Jane had willingly 'given-up' her gregarious, bohemian lifestyle to be a 'stay-at-home' mum. Efforts to preserve any recognisable connection with her previous life had been willingly abandoned so that nothing intruded upon her mothering role. May spoke about her reluctance to continue horse riding as it presented a physical risk to her and, by association, to her baby as she would be unable to care for her daughter if she was injured. *"I don't feel the same when I'm riding, in the back of my mind I'm thinking if I fall off and hurt myself, you know, what is that going to do to* (the baby)*."* She did not express any regret about this sacrifice and one might speculate that such actions were considered to be a requirement by mothers that in turn indicated good mothering behaviour. When Wilma spoke about having three free hours on a Saturday afternoon to go out without the baby, it was described less as an opportunity to indulge herself and more as a hurried excursion, with the baby on her mind and her eyes on the clock lest she not be home in time for his feed.

The concept of the 'good mother' is explored by Small and Brown (1997) in their study of ninety Australian women who had recently given birth, (this extensive project is described in more detail above). This aspect of the project sought to identify what the women understood to be a 'good mother' and the authors commented that,

"It was as if 'good mothers' did not have partners or friends with whom they liked to spend time alone, go for a walk without their children, or play sport, read a book, have lunch with friends, or go to work and enjoy it." (p194).

The self-sacrificing attitude of new mothers seemed fairly immutable and as Brown and Small (1997) pointed out, signified something more fundamental than the increased physical workload and associated time constraints of caring for a baby. It seemed to be a tacit assumption that all their time would be transformed into 'baby-time' – time with and for the baby. This 'devotion to duty' demonstrated the uniqueness of the women's non-transferable bond with their babies and positioned them as being the only people qualified to care for them. This imperative to devote themselves entirely to the mothering project is culturally derived but so pervasive that it is rarely acknowledged, particularly by those who 'mother'.

In Thurer's (1995) history of motherhood, she explains how mother love is contextual and has reached the status of a moral imperative in Anglo-American society, circumscribed by the belief that **"the wellbeing of our children depends almost entirely on the quality of their upbringing...(a)n intense, prolonged loving bond between mother and child is essential."** (p*xvi*) Numerous childcare experts in countless books counsel new mothers to nurture the 'loving bond' between them and their offspring. Brown and Small (1997) discussed the way in which Leach (1989), one of the most popular and respected childcare 'gurus' outlined an ideal of reciprocal symbiosis where the woman consistently and successfully meets her baby's needs which increases

her sense of self worth and in turn fuels her enthusiasm to continue providing such exemplary care. In a recent issue of Junior Magazine (May 2005), self-styled as "the world's finest parenting magazine", parents (mothers) are cautioned that,

"The interactions we have with our child when she is crying, shouting...may determine her future (career)**...whether she has many friends, how kind she is...we need to tune into our child's feelings, take notice and respond immediately."** (p24).

Marshall (1991), in her review of pregnancy and childcare guides, concluded that women are expected to selflessly lay aside any aspect of their life that may impede the child's progress (if her child's development is abnormal, the mother will be blamed). Women need to be present and available for their children at all times, providing stimulating, devoted mothering. Implicit within these manuals is the warning that if she fails in this task then the moral welfare of the next generation is at stake (Marshall 1991). The cumulative effects of this 'professional' discourse is that new mothers unwittingly absorbed this advice and re-interpret it as being the only acceptable way to embody mothering. When the reality contradicts the message, the women struggle to re-order their mothering to fit the ideal.

Yvette described her frustration when struggling to persuade her son to breastfeed and how eventually she gave him formula milk. Like all the women who planned to breastfeed, Yvette had assumed it was a 'natural' process that would be uncomplicated and as such was intrinsic to successful mothering. The exclusivity of the image of the

breastfeeding woman and her baby was shattered for Yvette when she 'failed' and her distress was exacerbated by well meaning relatives who fed her baby for her,

"I kept trying with the boob and he didn't want to know... and I felt a bit useless really because I thought, he could go with anybody... I hadn't been well and (her partner) *took the baby down to his parents and I went down later and there was his thirteen year old niece feeding the baby and I thought, anybody can do this, he doesn't need me. Which was really pretty awful. That must have been one of the worst things... He could just be fed by the cat, he wouldn't care, you know, he doesn't* ***need*** *his mother."*

At this point in her story, her new mothering identity felt threatened and unstable and she had to re-order her existential 'being' to encompass the fact that she would not be able to fulfil a crucial aspect of her role. A selection of midwives advised and helped her in hospital and at home and although they had confirmed what she should be doing, they were ultimately unsuccessful. This disjunction in her perception of what it was to be a mother was overcome by Yvette as she gradually disengaged from professional perceptions of successful mothering. Within her narrative her growing expertise is revealed. Initially she said, *"I obviously wasn't feeding him properly"* and although her disappointment was still present within her experience of the transition to motherhood, it dissipated as time passed and she constructed a mothering experience that was unique to her. As she says, *"It's down to you at the end of the day; you haven't got the midwife just down the hall."* Jane also described the process of learning how to respond appropriately to her baby, *"It's a learning process all the time"* – for her it is about 'tuning' into her

baby, a tacit communication that is intrinsic to her 'being' and exemplified the connection between mother and child. Jane demonstrated her equanimity and growing confidence in her mothering expertise – there is no sense of frustration at her own ignorance, or fear that she is failing to meet any expectations. Although her mother has been available and has advised her on occasion, Jane realises that too much advice is confusing rather than helpful,

"I think it's just aware of being on your own with a baby really... at the end of the day it's a one on one thing and if you allow too many people to give advice really I think that makes you confused again. If you're spending all the day with your baby... you know why he's restless or if he's bored or if he's sort of suffering a bit with his stomach and although sometimes it's like a complete mystery why they're behaving like that normally I can sort of work out why he's behaving in the way he's behaving and I'll take him for a walk just to do something."

This exclusive mother-child relationship is discussed by May when she described her relief at gradually being able to trust other people to care for her baby, now that some time had passed since the birth,

"I felt as though I was the only one who could cope, who could look after her, I was the only one I trusted, I was the only one who could comfort her ... It's being able to acknowledge that I'm not superwoman ... just being able to let go a bit, to let people in..."

Chris was possibly the most successful at recovering time for herself and being able to enjoy it. Her sister and mother were very supportive with childcare and crucially Chris did not experience time away from her baby as being indicative of 'sloppy', unfocused mothering. Rather she regarded it as an essential safeguard

"My Mum and my sister have been brilliant ... I could just say can you have her for a couple of hours so I could just go off shopping, just spend some time with myself and it's brilliant in that respect ... It's wonderful, really is wonderful, I can just please myself. "

Chris's struggle to adapt to being a mother was in places one of the most pain-filled narratives. However, one of her responses to her new role was the implementation of effective practical steps to mitigate her distress – namely, returning to work, organising childcare and arranging time for herself. An understanding of the way in which women redirect all their time and attention to attend to their babies is not straightforward; time spent with the baby encompassed pleasure as well as self-sacrifice. Although much of Chris' narrative revealed her resistance to a traditional mothering role, she did describe how rewarding motherhood could be, as the weeks past,

"I've never really thought about it before. It is rewarding, knowing that you've brought this little bundle into the world and everything you do influences her ... It's interesting sitting down and watching her as she plays and moves things, she sort of looks at it, and

stares at it and takes it all in and moves it around...her first smile, her first giggle... I love her more now, she's a little star, she really is, I wouldn't be without her."

This seems to exemplify the constant negotiation of experience and expectation, of frustrated self-sacrifice and the sweetest of conviction and one would have to speculate that mothers are set up to fail in their mothering project as dissonant voices provide a trenchant commentary on their mothering skills. New mothers are inevitably influenced by what society considers to be 'in the best interests of the child' and their inevitable failures and successes are also implicated in the negotiation process. The way in which the women in my study endeavoured to locate themselves within this barrage of advice, to reconcile this with their own imagined mothering experience is pivotal to the way in which they came to integrate their new role and embody mothering. This process is mirrored within the latter part of the general structure of the transition to motherhood,

"With differing degrees of resistance and acquiescence the women accede to their own particular sense of themselves as embodied mothers and fundamental to this is a need to re-establish a sense of 'being in control', wresting orderliness from disorder and coherence from perplexity."

9.3.11 Ambiguity

Defining what it is to be a mother is a complicated process. For some of the women it is their own mother who comes to mind when they consider the nomenclature 'Mummy'. Sue's feelings are very clear,

"To me still 'mother' is my mother; I don't feel like a mother at all. I have a suspicion, I think when he starts to say Mummy, I think it'll sink in a bit but at the moment still it's not, because it's a job for me to say what a mother is." And then towards the end of the interview she says, *"But I'm not quite there yet, I know I'm a mother but it's not the soul defining thing that I am, I am other things as well but funnily enough, I almost couldn't tell you what they are…"* (Sue).

For some of the other participants, the ambiguity of their position was exemplified by who they turned to for advice in caring for their babies. More often than not it was their own mothers who were relied upon when practical guidance was sought. Betty was grateful that her mother was available to advise and answer her questions, particularly as consulting 'experts' made her feel anxious and incompetent, *"I quite often go round and see Mum, just to turn round and say "Mum can you cut his nails, can you do this?" And I never realised how much I actually needed my Mum before."*

Jane lives with her parents and spoke with warmth about their support, *"... like my Mother, obviously she's a mother herself so she knows a lot of things and she's helped me out a lot ... she'll tell me not to worry, or of he's been crying a lot with wind she'll say, "You go away and I'll rock him..." "*

Wilma longed for her mother's presence and envied women whose mothers lived close by and Sue spoke to her mother daily on the telephone. For all of the women in this

study, giving birth re-defined their relationships with their mothers as although still daughters, they were themselves mothers as well. It is clear that the majority of women still relied upon their mothers, particularly in the early weeks when the ambiguous nature of their new role was most acutely felt. An interesting variation was revealed in Sue's narrative when she discussed her own mother. Although obviously very close, it was the midwives and health visitors who Sue originally relied upon for practical advice as she felt that it was some years since her mother had cared for young children. However, she recognised the regression that she has undergone in her need to have her decisions sanctioned by an expert,

"It's kind of like having mothers to give you advice because I'm sure you do regress to be childlike yourself, you want to be told what to do, particularly at the very first ... and sometimes it was permission to just do what you wanted to."

As time passed she gained confidence and laughs at her initial desire to 'do the right thing'

"You soon get the confidence of being a mother that you'll do what the hell to please yourself but it's taken me quite a long while to do that and if I want to still give him his milk first before his food I'm going to do that and I don't care whether it says by now maybe you ought to be having... as long as he's drinking I really couldn't give a monkey's (laughs)."

Integral to this gradual emergence and clarification of themselves as mothers was the way in which the women in my study (and new mothers generally I would suggest) felt that society and particularly those in authority, viewed and judged them. As has been demonstrated above, Sue quickly developed an immunity to the possibility of professional criticism but not so May and Betty. May is an articulate professional woman used to dealing with fellow primary care providers but when her baby daughter was unwell, she felt ridiculed and undermined by her doctor and midwife

"I just wanted reassurance ... he 'd told me to stop being so silly and it's just a temperature and if she gets too hot then to make sure I cool her down because she could have a fit which had left me in a complete state... I'm a professional person myself and I've got intelligence and I wouldn't do anything to harm my baby ... so because she wasn't very well I put her coat on, put her hat on... and a midwife came out and asked me what I was doing there and I said that (the baby) *wasn't very well and she* ***whipped*** (the baby's) *hat off her head and told me how ridiculous if she had a temperature that she had her hat and coat on and I thought that was outrageous and I felt very, very put down, I felt totally useless."*

May's experience demonstrates her lack of agency in this situation and how insubstantial and inchoate her maternal authority is when challenged in this insensitive way. For Betty, the threat to her maternal authority was anticipated rather than experienced. She felt she needed to be 'on her guard' lest anyone assume she could not cope with caring for her son.

"I think to myself, do I go to the doctor, don't I go to the doctor ...I don't want him to think I'm an inadequate mother and I'm worrying and ... I have to fight two sides. On one side I want to know what it is and on the other side, I almost feel like everyone's judging me and because I'm young and because - I do feel like a single parent."

Both of these narratives reveal the women's concerns about public perceptions of their competence and expertise in fulfilling the mothering role. Not feeling like a mother and not trusting themselves to respond correctly to their infants can result in women regulating their behaviour in accordance with what they consider to be appropriate. Again we see the juxtaposition of their private experience and public expectation – Wilma provided an example of this when she described taking her baby son to a 'toddler group'. She had breastfed him before leaving her house and was confident that he was not hungry. However, when he started to cry, the other mothers suggested she go into the kitchen to feed him, which she did even though privately she 'knew' he was not hungry, her response to his tears was circumscribed by her perception that the 'better qualified' mothers 'knew best'.

"Well they just said, "Go in the kitchen and feed him" so I thought, OK... so anyway this boiler was filling up with steam and I thought, I'm going to have to stand up and turn the boiler off so I stood up... the whole kitchen was engulfed in steam... and (the baby) *threw up everywhere so I appeared out of the kitchen in this puff of steam, we had to go to the*

loos to get some loo roll to clean him up because he's been sick and I just thought I'm not coming here again, I was so embarrassed."

9.3.12 Concluding thoughts

This section has sought to demonstrate the difficulty one can have in distinguishing those women who are suffering from PND and those who are not. Narrative accounts are remarkably similar, often with the same frustrations, uncertainties and distress described by the women. Furthermore, research findings obfuscate rather than clarify the situation by failing to agree on a distinctive symptomatology, aetiology or number of sufferers. Even when women are identified as being at risk of developing PND, treatment and support are generally unsatisfactory, if available at all. However, having compared my study with those of women who have been *diagnosed* as suffering from PND and found them to be remarkably similar, I still feel no compunction to declare that distress after birth is a 'myth'. On the contrary, my conclusion is that *all* women struggle to a degree with the transition to motherhood – they will encounter comparable problems but respond to them uniquely and with huge variation and differing degrees of resistance, ambivalence, acquiescence and compliance. Arguing over the particulars of PND as a medical diagnosis might ultimately be fruitless and instead the majority of research may be more productive if directed at constructing a composite picture of the myriad ways women come to embody mothering – not as an 'either/or' but as a process of negotiation and assimilation. Becoming a mother involves all women in a process of adapting to enormous change, both personally and socially as well as accepting the paradoxical

nature of their new role – that with mothering comes both joy and sorrow and the new mother must come to embody this paradox and move forward when she is ready.

9.4 Embodied mothering

9.4.1 Introduction

This section develops an ontological account of the way in which women 're-order' their lives, seeking to re-establish coherence and orderliness whilst assimilating the needs of the child and the intensity of the mother-child relationship. It aims to examine the variations in the way the different women came to embody mothering and suggest reasons why some women find the transition problematic and others not so. The final part is an explication of one woman's transition, in light of previous discussions.

9.4.2 A process of 'encounter'

Following analysis of the narratives, it seems that the transition to motherhood (whether it includes a period of 'depression' or not) could be better understood as a process of *encounter*, during which different women's experiences are located within a similar framework of disintegration and re-emergence. These encounters do not occur in any sequential order but instead 'all at once', a tapestry of interwoven experiences that sometimes stand out in sharp relief and other times blend together. This idea of a tapestry is adopted from Qualls' (1998) moving phenomenological study on "being with suffering" in which she uses the image to 'describe' her experience working with Romanian orphans,

"When I say 'interweave' I imagine a beautiful rug or tapestry in which the threads move back and forth across the width of the rug, sometimes touching in just the

right place to make a connection. At other times the threads do not touch, yet are connected by still other threads. Sometimes the exact colours repeat themselves, while at other times a totally different colour appears, or something of a lighter shade makes itself known. In their weaving together they offer us a pattern to perceive. Whatever the variant forms, each thread is a part of the whole." (p342).

The image of a tapestry opens up infinite possibilities for understanding the process of a phenomenological study and the phenomenon itself. The weaving continues and the tapestry grows in richness and texture. New stitches for new mothers, mimicking the old and creating new patterns, a circulatory movement that I hesitatingly describe as a more 'womanly' way of articulating this complex experience. The issue of 'womanliness' is enormously complex and unless great care is taken, any discussion results in a conflation of gender, sex and reproductive capabilities. Unfortunately there is not the space to examine this issue in the detail required. However, careful elucidation is necessary. It seemed to me that in seeking to illuminate the transition to embodied mothering for the women in my study, motherhood needed to be 're-visualised'. Not as a series of achievements or as a temporal, linear progression of role attainment but as an organic, evolving process, a re-embodying that affected every aspect of women's 'being'. Although the process was unique for each woman, the experience of becoming a mother was framed by the general structure, a 'patterning' that was both ancient and still evolving, fashioned by the familiar strands (the essential constituents of the phenomenon) running through each story as the women interwove the new experience of mothering with their old lives and strove to find coherence within the complexities and

contradictions of this process. As Quall (1998) says of her research, there is no beginning or end to the experience – similarly, the women in my study did not 'finish' the process of 'becoming'. Mothering is responsive, dynamic and evolving and this phenomenological study can at best examine a small piece of the pattern, hold the colours to the light to reveal the slight variation in tone and texture and 'draw out' the weave to reveal the essential pattern through which all other threads are sewn.

This process of encounter takes in several factors that were identified in my research as essential constituents of the phenomenon. There is the beginning of the transformation when the women encountered their babies, the 'intimate stranger' who has lived within their bodies and their imaginations. This led to a dramatic change in the way in which the women were embodied as that which was once familiar and taken-for-granted was obscured by the presence of the baby 'filling their vision'. Their 'lifeworld' was filtered and assessed for any perceived threat to the baby's wellbeing – generating feelings of anxiety and the burden of constant responsibility. The women were no longer in the world as individuals, instead they were inextricably connected to 'an-other', who was at once separate and the same. May describes this as a 'shell',

"... it's like you're in a little shell the two of you and you speak to people at the shops but they're not actually coming in the shell with you – that's how, it's almost like the two of you and no one can get in to that, and that's why it's lonely."

The women in my research began their process of encounter by 'meeting' their baby, the 'intimate stranger' who has been enfolded within their bodies for nearly ten months. As Yvette described her feelings when seeing her baby for the first time,

"You're wondering what they're going to look like for nine months and all of a sudden they're out and you can actually see what they look like (laughs) which is quite a weird thing".

The moment of birth signalled the 'becomingness' of motherhood for most of the women in this study, in so much as actuality replaced expectation. As Bergum (1989) said in her phenomenological study on the transformative experience of becoming a mother, **"A woman does not make herself into a mother - it happens through coexistence with the child. The presence of the child transforms."** (p53) and it is at this point of 'meeting' that the women encounter the physicality and profundity of motherhood. May is overjoyed at this moment,

"...and the moment I saw my baby I felt like I was a mother, the minute I saw her, I just fell in love with her straight away, absolutely immediate, the most incredible experience."

This baby that was only imagined had become real with an immediacy that was startling. For the majority of the women the intense feeling of love was so utterly compelling that they were completely overwhelmed; in an instant recognising the baby as belonging to

them and feeling unprepared for such a profound sense of intimate knowing. However, sometimes the love grew softly at the moment of birth, becoming deeper as the child ceased to be a stranger and the women 'came to know' her or him. May felt like a mother immediately she saw her baby, whereas Yvette described loving her son *"more later"* although she added that she had bonded with him during her pregnancy and her narrative revealed the birth as essentially a positive experience.

Kristeva (in Clement & Kristeva 2001) suggested that the purest love was rooted in **"that archaic and fundamental, unique and universal, experience of maternal love...the least ambivalent kind."** (p57). Kristeva's account is particularly poetic, but the intensity and immediacy of maternal love (if it experienced like that at the moment of birth) is as much of a shock as a delight. Betty began her narrative by making this point,

"I was absolutely amazed at the instant love I had for (the baby), *it was frightening in a way... one minute you didn't have him and the next minute you didn't want to let go of him, didn't want him out of your sight."*

For the women in my study, this love seemed to be a tacit, sustaining force, even in the darkest hours of mothering. Some women implied it was compensation for all the disruption they had endured and others that the love grew stronger as the weeks passed, reinforced by their infant's development and growing responsiveness. Furthermore, it seems to be only in the most severe cases of postnatal depression/psychosis that women

sometimes become utterly disconnected from their babies, barely aware that they exist or require love and nurturing (Shaw 1997).

Shaw (1997) wrote about her own psychosis after the birth of her second baby. She was 'sectioned', spent weeks as a psychiatric patient and eventually had ECT in a final attempt to 'cure' her. But although she bleakly describes her catastrophic loss of self, she also writes in her diary (as the psychosis 'takes hold') **"Jesse is ten days old and I am passionately in love with her."** (p28). However, as time passed she described utter blankness, an erasing of most of her early mothering memories and incoherence (obviously exacerbated by her ECT treatment). Later, it is only at her daughter's insistence (at three years old) that she placed a photo of the child on her desk, **"I couldn't bear the pain that that still tiny face reminded me of."** (p199). In Aiken's (2000) collection of narratives , 'Gail' describes her profound lack of connection to her son, she feels she is **"faltering"** and that **"part of me really wanted nothing to do with him...I couldn't tell this baby I loved him. I hardly liked him."** (p63). 'Gail' recovered with the help of hormone replacement therapy. However postpartum psychosis can have disastrous consequences as the case of Andrea Yates demonstrated (Burkeman, 2002). Although she had a long psychiatric history, she was found guilty of drowning her five children in the bath in Texas in 2001 after confessing to jurors that Satan had ordered her to kill her children. Though diagnosed with postpartum psychosis, she was judged capable of discerning right from wrong and sentenced to life in prison.

The examples above suggest that one should be cautious of making any assumptions about the fortitude and universality of maternal love. Even allowing for the honesty with which the women in my study recounted their experiences, I would suspect that most mothers would feel reticent about voicing a lack of love for their babies, fearful that it would be met with abhorrence rather than sympathy. One of the drawbacks of a cross-sectional interview study is that the women are not able to 're-view' their narratives at a later date when the pressure to conform to acceptable accounts of mothering may have diminished. The women in my study revealed much that was negative about becoming mothers, voicing both resentment and even dislike of their babies. However, Miller (2005) in her book exploring the narrative structure of mothering and the way in which new mothers adapt to their role, identified the dissonant voices of those women for whom motherhood was difficult to adapt to, but who were only able to speak of this ambivalence in their third and final postnatal interview,

"(T)he difficulty of voicing different or unhappy mothering experiences...(g)iven the moral minefield in which motherhood is lived out...Women who had previously spoken of their immediate 'natural' identification with being mothers, now produced contrary narratives of their experience." (p121).

This does not undermine research like mine as all data is contextual and countless interviews with each participant would not reveal *everything* about the phenomenon. Becoming a mother does not have a conclusion and there will always be textures, depths and variations that a particular study will not reveal. This is the fundamental nature of

any phenomenon, it is always 'greater than' an individual's experience of it. However, what Miller's (2005) study does reveal is that participants may be constrained by psycho-social expectations of their new role and it is the sensitivity and perspicacity of the interviewer that may encourage the participant to feel safe and share a revelatory story.

9.4.3 Ambivalence

In her book examining the complexities of mothering and motherhood, Parker (1995) draws on interviews with mothers, clinical material from her practice as a psychotherapist and a wide range of theoretical and popular sources to argue that women's response to mothering is most accurately understood as one of ambivalence. **"Maternal ambivalence is the experience shared variously by all mothers in which loving and hating feelings for their children exist side by side."** (p1). She confirmed the difficulty that most women experience in voicing ambivalent feelings about their babies,

"Accepting that hatred, resentment and hostility are unavoidable components of the full range of feelings for a child throws doubt on the reality of a mother's capacity for love in her own and other's eyes." (p49).

This struggle to rationalise the complexity of emotions that motherhood aroused is passionately described by Rich (1977) in her blend of personal memoir and historical discussion of mothers and mothering.

"My children cause me the most exquisite suffering of which I have any experience. It is the suffering of ambivalence: the murderous alternation between bitter resentment and raw-edged nerves and blissful gratification." (p21).

Sue described forcefully the need to escape from her baby sometimes *"... and yes I might think, why don't you get lost, why don't you just go away."* But she is able to reflect upon the demands of her new role and recognise the inconsistency of the myth of the consummate mother who sets impossible standards of devotion to duty

"... as per usual I make sure everyone else is alright and I'm bottom of the woodpile. But I think that's one of those mythical things that mummies do – you expect to do that, you do come last."

Chris described her ambivalent feelings towards her daughter, *"It's hard to come to terms with, the conflict of feelings – knowing deep down you still love them but also on the surface resenting them. It's a very emotional time, very, very emotional".*

This ambivalence was prominent in the women's descriptions of adapting to life as a mother but was not necessarily acknowledged as such by them. As has already been commented on above, this is possibly due to society's disapprobation and censure of any reference to motherhood that implies it is anything other than fundamentally fulfilling. Possibly the only 'acceptable' way for this dissatisfaction to be generally understood is for it to be pathologised as PND and 'safely' circumscribed by medical discourse,

therapeutic intervention and ideally a resumption of normative mothering. Accordingly ambivalence is marginalised and becomes an 'exceptional' reaction to a 'normally' happy event.

9.4.4 Re-experiencing the mothering body

All of the women I interviewed made some comment about their experiences of feeding their babies (particularly those who planned to breastfeed). For some, this was not problematic and they found it to be a pleasure but for others it was frustrating and ultimately, a disappointment. During the analysis of the narratives the issue of feeding contributed to the way in which the women re-experienced their bodies following the birth. In other words, the new mother's encounter with their own lived body, a dimension that changes on several levels following the birth of the infant.

Reflecting upon Merleau-Ponty's (1995) notion of the lived body may prove to be illuminating when considering the way in which new mothers re-encounter their changed bodies. An individual does not experience their body as one of many objects in a world of objects, instead they are an embodied subject for whom their body as they live it, represents their particular **"point of view upon the world"** (*ibid.* p70). It is not a *thing* that they can move away from, it is what they are, and when they are in good health, it seamlessly mediates all their interactions with the lifeworld. Toombs (2001), in her essay on her own lived experience of disability describes the phenomenon of the body thus,

"I experience myself as the Here over against which everything else is There. As orientational locus in the world, my body both orientates me to the world around by means of my senses and positions the world in accord with my bodily placements and actions." (*ibid.* p248).

She goes on to explain the **"body disruption"** caused by disability and the way in which this disturbs the 'taken-for-grantedness' of the lived body – no longer is she unaware of her physicality, instead she is intensely aware of its restrictions and failings. Although not as acute, the concept of bodily *disruption* relates well to the experience of new mothers. Young (1990) in her paper on pregnancy and embodiment, argues that existential phenomenologists assume a **"distinction between transcendence and immanence when discussing bodily being"** (p164). Merleau-Ponty (1995) considered the body to be that through which consciousness pursues and achieves successful acts and projects, **"Consciousness is being-towards-the-thing through intermediary of the body."** (p138). As such, bodily awareness only occurs when there is a breakdown in connection – illness or exhaustion. Straus (quoted in Young 1990) says of this phenomenon,

"If, suddenly, I am no longer indifferent to my body, and if I suddenly give my attention to its functions and processes, then my body as a whole is objectified, becomes to me an other, a part of the outside world. And though I may also be able to feel its inner processes I am myself excluded." (p164).

However, rather than awareness of one's body being experienced as an obstacle in the accomplishment of one's projects,as it is assumed to be in illness, Young (1990) proposes that in pregnancy, instead of **"alienated objectification"** (p164), the body can be experienced in an aesthetic mode and awareness of the body is lived as a **"fullness"** (*ibid.*) rather than an obstruction. I would argue that this continues after birth, with the infant propelling new mothers into acute and ongoing awareness of the physical 'memories' of giving birth ('written on the body') and the amorphous nature of the body's boundaries – in so much as the child that was contained within the One is now in the world and an/other. The composite relationship between mother and child compels an altered state of being in the world, a bodily awareness that contradicts the notion of the **"transparent mediator for our projects."** (Young 1990, p164). This altered state is ongoing although gradually becoming assimilated into 'who we are' as the child grows up and away from the mother.

This theme is taken up by Johnson, A. (2000), in her paper discussing the concept of embodiment in pregnancy, **"Similar to illness, pregnancy forces the recognition of loss of agency. Control is decentered, the self watches helplessly from the sidelines."** (p170). On the physical level there is the aching, leaking, empty body of the newly birthed woman, often with perineal stitches and sometimes with a caesarean scar. These physical constraints compel the women to be mindful of their new 'becoming-a-mother-change-of-body-subjectivity'. Before pregnancy and birth the women's bodies had required only superficial maintenance. Following the birth, the integrity of the body is breached, both by the 'sharing' of bodily functions with midwives, doctors and other

mothers and by the profound connection between the woman and her baby. Yvette described her surprise at her physical condition after the birth,

"The size of my stomach; Oh dear, that is something that did shock me straight after birth going to the loo and sitting down and thinking that my stomach was going to fall away and holding onto it ...I didn't think it would feel like that - weightless or, I don't know, it was weird...I didn't expect all the blood as well, not that it really worried me either but you don't really think about the gory bits that are going to happen."

Sue recalls her initial discomfort when feeding her baby,

"... my back was absolutely agony with feeding him because I had such huge breasts, it was so far down I had to have him propped up on this huge cushion and I was sort of like this hunched over thing all the time and the backache was incredible." (Sue).

9.4.5 'Turning towards' the child – an entwining

The mothers' bodies have already been effectively colonised during pregnancy by another subject and following the birth, the boundaries of the women's bodies are blurred and there is permeability where before there was boundedness. The process of breastfeeding contributes to this. However, women do not need to be breastfeeding to experience this phenomenon as I would suggest that the new mother's body is turned *outwards* towards the infant at all times. Her responsiveness to her infant's needs means that **"the skin as the boundary line between two bodies is breached again and again..."** (Simms, 2001, p24). Mothers who do not breastfeed their babies are still caught

in the process of repeatedly turning towards the infant – a reaching for and enfolding within - entwined in the dyad of mother/child. Drawing upon the work of Merleau-Ponty (1995), Simms (2001) reflects upon the coexistence of mother and child and the way in which the child's body transcends its physicality by **"having an intentionality that ties it to the body of the (m)other"** (p30). There is a dyadic entwining between mother and baby that although generally welcomed by the new mothers, is inescapable and was often referred to by the women who participated in my research. Analysis of the transcripts revealed two essential constituents that encompassed these elements of the experience: "The baby fills her vision" and "Anxious loving". The women found their thoughts repeatedly returning to their babies and even when they were absent they were unable to suspend their feelings of responsibility. Motherhood brings 'mind-ful-ness', in other words, a mind that is forever turning towards the child. Sue wondered if she *"would ever...get time off again, to just, to not only have to do nothing but to not even have to think about anything."* Chesler (1979), in her evocative diary about becoming a mother for the first time, would recognise these sentiments when she said of her son, **"Ariel: Wherever I am, you're there too, hovering around my shoulders, I'm never alone. Not even when I'm lonely, and quite alone; in my study or in an other city."** (p190). And Yvette found it impossible to 'tune out' from her baby and rest, *"... luckily I had my Mum to come round ... she'd often come and take him out for a couple of hours so that I could sleep without him being here because what I often found, I'd have an ear open nearly all the time to start with... if you left him with grandparents for sort of half an hour to go for a walk with them and though you trust them you worry about him and worry what he's going to do."*

Johnson, A. (2000) described the way in which **"the self is doubled and multiplied, both familiar and alien."** (p171) She described a **"shift in the mode of knowing"** (*ibid.*), referring specifically to women's experience of pregnancy and the way in which their 'knowing' became sensory rather than visual. I would argue that there is a similar shift for the new mother as she attempts to decipher her baby's needs, **"(t)his shift creates an essential anxiety...(and) a bodily language of love and anxiety."** (*ibid.*) Although the baby is no longer within the woman's body, it is not an 'other' in the way of other individuals to whom we have no true access. As Husserl (1960) explained, individuals function within their "ownness" as this exemplifies the way in which our subjectivity is singular and bounded. To further clarify this singularity, other individuals are perceived as "alien" and Husserl is clear in his reasoning when he says, **"I obviously cannot have the 'alien' or 'other' as experience."** (*ibid.* p96). But for the women in this study, their bodily sameness and continuity had been breached as their whole being becomes referenced by that of the child's. Their glance strayed repeatedly to the child as their hands reached to touch, in a heightened state of alert lest they failed to respond appropriately. Adapting Johnson's, A. (2000) argument that the problem of "access to the other" is reversed in pregnancy where the woman cannot escape the "alien" within, these new mothers mourned the loss of their **"sphere of ownness"** (*ibid.* p172) and sought **"...any part of the self that is truly solitary and self generated."** (*ibid.*)

9.4.6 A child on her mind

The child was always 'present' to his/her mother and the connection could not be severed. When the baby was physically with them they were constantly distracted by its needs, whether it was in danger, whether it needed to be pacified or entertained or was just about to wake. Although Betty had experienced illness in other people, the immediacy of her baby's sickness and the thought that he might fall victim to a serious condition was too unbearable to contemplate.

"...and it's worry, it seems to be worry from the minute they're born all the time and it's strange – with his illness...with his cough and cold, there was one night he was really bad, really phlegmy and I just cried, I sat here and – I phoned the doctor, I phoned Mum...and I cried and cried... the doctor came twice that night...The helplessness you feel as well, I mean you see people ill, you see babies ill and you don't really think anything of it... " (Betty).

Although the women in this study did not explicitly discuss their fear of the child dying, it was alluded to through their fear of their baby being ill or "disappearing" and this theme recurs in Bergum's (1989) research where a new father describes his feelings of "terror", when his daughter did not respond immediately after birth. New mothers are shocked by their helplessness in the face of the utter vulnerability of babies and the reality of possible illness or death. **"What has been a self-regulated, self-defined and self-contained life is suddenly broken by the experience of the Other, the child."** (*ibid.* p84).

Jane is fearful that her son is only with her for an unspecified period of time and one day he will disappear, *"At the beginning I was so frightened that he was, that I'd wake up one morning and he'd be gone again, because he can come like that and he'd be gone again the next day or whatever and there was that real feeling that perhaps he's only here for a little while."* (Jane).

May struggles with her need to have her daughter so close she can see her at all times, particularly when she returns home from hospital, *"...although our house it quite small I felt like it was huge. I got really upset and thought I must have (the baby) by my side the whole time and I didn't know how I was ever going to let her be apart from me...like we'd been in hospital really... but still, that protection instinct is still so huge and that is something I've never experienced before."* (May).

The women had to confront the reality that the baby is entirely dependent on them, twenty-fours hours a day – it is as though they have to accustom themselves to the 'full weight' of the baby and allow themselves to feel burdened rather than struggling to extricate themselves from the bind. Of the seven women interviewed, one wholly embraced her 'burden' whilst the others struggled with varying levels of resentment and acquiescence. Jane expressed her surprise at the way in which her life now revolved around her son,

"I didn't envisage how, to what extent it would tie me to routines, to being inside, to having to be in the warm and to having things like that on my mind, something I didn't even worry about before ... but now I'm just constantly thinking is it too hot for him, is it too cold for him, where I go will there be – will it be alright for him? So yeah, I think it's just all part of that, your horizons kind of – you just sort of re-examine your life ... "

May was unable to concentrate on any task unless it involved her daughter and at times she despaired at what she described as part of her brain "not working" as it had done prior to the birth,

"I'm worried that I'm not going to get back to how I was ... I just can't think straight... the forgetfulness it's just, it's because I think it's just where I'm focused on (the baby) *all the time and if I'm trying to write Christmas cards she, I've got ten minutes... then I've got to focus my attention back to her – I presume that's what it is really but that's quite tough."* (May).

9.4.7 'Babytime'

To accurately describe the way in which women's lives are changed by motherhood, we must consider what it is that replaces that which is lost - otherwise motherhood would be defined primarily as a loss, an absence. My research as well as countless other studies has revealed that women surrender much that is familiar, enjoyable and reassuring when they become mothers – with the aim (whether deliberate or not) of being able to devote as much time as possible to mothering – in other words their time becomes 'babytime'.

Different women in my study had varying ways of describing time with their babies. Sue is forthright in her evaluation of the way she enjoys her son's company,

"I think being a mother is what you want to make of it and my idea of being a mother is part of us two being part of a unit and that we interact together and make that unit work and to enjoy ourselves"

Within this study, the concept of 'babytime' has been adopted by me to ensure that a balance is maintained between the negative aspects of becoming a mother and the times when being with the baby is a pleasure. I would suggest that even mothers struggle to describe what exactly they 'do' that takes up so much time with a baby. Stadlen (2004) in her book on this subject says of one of the mothers, **"She is most aware of what she is *not* doing...housework she has not managed to do yet. She lists all the chores that lie head of her"** If asked what she had been doing, Stadlen argues that the woman is most likely to reply, **" 'Nothing,' or 'Nothing much,'...Nothing? Has the time simply 'gone'? I can see she is being present to her baby...we are looking at a baby who is being generously mothered"** (p18). The author makes the important point that whilst precise language is available to describe practical activities, **"It is much harder to find another word that describes the giving-up-things mode of attention a mother is giving her baby."** (*ibid.*) Although Stadlen's book is directed principally at mothers rather than scholars, it does address a neglected area of how women articulate 'baby time' – and considers it in a positive rather than a depreciative manner. Weaver and Ussher (1997) echoed Stadlen's sentiments when they noted that the women who

contributed their mothering stories to their study struggled to put "**the abstract emotional nature of 'overwhelming love' into words.**" (p60). They speculated that the more material limitations were "**easily expressed, being grounded in practical issues like time and social life.**" (*ibid.*).

If my study failed to acknowledge that babies are often experienced as providing purpose and a sense of meaning to their mother's lives, then it could be challenged on two counts. Firstly, for not paying sufficient attention to the complexities of the mother/child relationship and "**the intense co-existence of both positive and negative feelings towards children within motherhood.**" (Parker 1995, p55). Secondly, on phenomenological grounds for failing to 'set aside' assumptions about the phenomenon – in this case, that adapting to motherhood is experienced primarily as a chaotic loss of self and of agency. An example of 'baby-time' from Chris' narrative reproduced above demonstrates how, within the '*nightmare*' of coping with a new baby, she was able to find time to enjoy her daughter. Betty surprised herself by how much pleasure she experienced in being a mum

"I never thought I would, I love being at home with him. I love waking up, just playing with him on the floor, going for walks, all the things that I thought, how can people do that 'cos that is just so boring. I mean, I've got friends that have got kids and they do exactly what I do and I thought I never could do that and I love it."

Although Sue's narrative contained several ambivalent comments, she also spoke with pride and pleasure about her son's development,

"He's an engaging baby, he's very smiley, he loves being made to laugh so there is a two-way in that and there's a pride in that – you know, he's now starting to cruise around furniture."

9.4.8 The child as the 'other'

Bergum (1989) proposed that it was the woman's responsiveness to her child as "other" that was fundamental to the process of women becoming mothers, and she goes on to highlight the difficulties of this process – **"How does a woman come to live as mother – for her child – and yet for herself? How does a woman act responsively toward the child in her life and yet be true to herself and her own project of living?"** (p85). May echoes this conflict when she says,

"I think, maybe it's because I feel like I've lost part of me. Because I'm giving so much to another person who can't give anything back to you, I think that's what makes me feel so lonely. Doing everything I can for her, giving her so much love and attention, so much from me I'm giving to her and she can't do that back and I feel I need something back, so I think that's partly while I feel so lonely."

Kristeva (in Clement & Kristeva 2001) also described the child as the 'other', originating in the mother as part of her. Her perspective is one in which the mother's primordial

connection to her child is one of 'being'. She described a romantic **"serenity of Being"** (p56) which she mused may be similar to that imagined by Heidegger,

"*She is* simply *there*: the mother with a part of her that is already an *other. Being there with*: the dawn of difference. Peace, recognition, devotion. It is not that she "does" nothing, but the eagerness for action is suspended in a capable tenderness." (*ibid*).

Kristeva does not enlarge upon these comments in great detail but I would suggest that there is an element of loss of self and loss of structure in this image. The notion of the mother just 'being' rather than engaged in activity may be cherished by some new mothers but experienced as frustrating, monotonous and isolating by others. Some of the women in my study felt as though part of their real selves had been lost in the process of becoming a mother. Moreover, there were times, for most of the women who took part in my study, that the closeness of the baby came to *signify*, rather than alleviate this loneliness as babies are unable to reciprocate the outpouring of emotional energy that motherhood engendered in the women. It was as though the babies 'drained' the women and often their infants' first smiles were experienced as a reward for their dedication. Chris mentioned this, *"it is rewarding knowing that you've brought her into the world - her first smile, her first giggle."* Similarly for Yvette, she felt reassured when her son responded positively to her

"Before, you're just there to feed them and change them and do everything and you don't, sort of have any gratitude (laughs), *there's no response, no feedback at all ... perhaps they cry for their feed but afterwards they're giggling and smiling and happy again so you know that you're doing something right."*

Some of the women in this study struggled to establish identities that were not wholly tied to their children and this may have involved rejecting the traditional role of remaining at home with the baby on a full-time basis. Ultimately, it was a question of how to be more than 'just a mum' – although ontologically, every aspect of their 'being' is 'steeped' in mothering. It is not a state of being that they can 'leave at home' or be absent from (as has already been illustrated above). It is intrinsic to every choice and decision they make.

Possibly PND might be better understood as a level of distress in relation to some parts of the encounter, which causes some women to consider that they are not managing as they should and that they are sick. The essential difference is that some women seem able to confront and gradually adapt to their new role whilst others are overwhelmed by what they experience as a devastating and wholly unexpected assault on their personhood.

9.4.9 Merleau-Ponty, the 'flesh' and motherhood reconsidered

This notion of profound transformation seems to be both unwelcome and unexpected by nearly all new mothers, both in my study and others that have been discussed. In my essential description of the transition to motherhood this was encapsulated in the phrase,

"Becoming a mother introduces some fundamental changes into the woman's manner of 'being-in-the-world'. Essentially this concerns the development of a new 'becoming-a-mother-change-of-body-subjectivity' in which the women are required to 're-order' their way of 'being' in all its existential dimensions." If we reconsider Merleau-Ponty's idea of 'flesh', **"...this flesh of my body is shared by the world, the world reflects it, encroaches upon it and it encroaches upon the world...they are in a relation of transgression or of overlapping."** (Merleau-Ponty, 1968, p248), then we understand that the woman's body is 'entwined' with the world, that it is 'enscripted' with the changes that are occurring, both to her physical manner of being (boundaries of body/other combined with her experience of space and time) as well as psychologically, emotionally and in her spirit or soul. Using the word 'soul' is problematic due to its obvious religiosity. Dahlberg (2005) describes it thus,

"The flesh is neither material not idea, it's neither biological body nor transcendental spirit, the flesh is the world as lived, the body as lived...the soul is intertwined with the body, i.e. if you focus on the body, the soul is also there at the same time. If you want to address a person's soul...the body is there as well. These 'aspects' of a person cannot be separated, they are always there." (Dahlberg, 2005)

In the context of the phenomenon of becoming a mother, it is the fracturing and displacement of the woman's subjectivity, her 'flesh' reconstituted at that point of entwining, where 'being' and lifeworld merge. The new mother's lifeworld changes dramatically so that her unique horizon against which and within which she is defined,

shudders and jars as it is required to incorporate an/other into the intrinsically separateness of 'being'. From the time that a woman discovers her pregnancy, there is a primordial intimacy established between mother and child that repeatedly transgresses both the physical and ontological boundaries of 'being'. Merleau-Ponty proposed a clear distinction between '*my*' body and objects in the external world and he uses the analogy of being able to turn away from a table or lamp whereas one's body is **"constantly perceived"** (Merleau-Ponty 1995, p90). He goes on to say that his body is **"therefore an object which does not leave me."** (*ibid.*) I would argue that the birth of a child causes a radical rethinking of this special status granted to the body because for the new mother, the child cannot **"ultimately disappear from my field of vision...Its permanence is not a permanence in the world, but a permanence on my part..."** (*ibid.*)

Clearly Merleau-Ponty is not discussing the implications of motherhood in this introduction to the status of the body and thus I acknowledge a degree of impertinence in employing his arguments for different ends. The transformative nature of pregnancy and motherhood inevitably confront and 'open-up' his carefully structured analysis of the centrality of the body to his philosophy. Bergum (1989) describes being 'with child' as a primordial relationship and although she is particularly discussing pregnancy, her description perfectly encapsulated the way in which a mother always has the child on her mind, **"Being "with child" is a co-mingling, an entanglement, an interlacing that goes beyond companionship. It is a mysterious union that goes beyond any other."** (p53). One could argue that an unsatisfactory outcome to this reintegration of woman-as-mother with baby-as-other may cause the woman to be cast adrift, unstructured where

before motherhood she was 'securely' embedded within her lifeworld. This may manifest as 'symptoms' of depression and anxiety.

9.4.10 Reconciliation, assimilation and acceptance

Beck's (1982, 1983) studies focus on the experiences of PND, rather than the women's experience of mothering generally. Aiken's (2000) book is also constructed around the retelling of ten women's struggle with PND and one would have to conclude that they had no positive memories of the transition to motherhood either. This may be due to restriction of space or to the fact that the women were so overwhelmed by their negative experiences that motherhood contained very little that was fulfilling or rewarding. This demonstrates a notable variance from the women I interviewed, none of whom identified themselves as suffering from PND and all of whom spoke, at times with love and enthusiasm for their babies and motherhood. During my analysis of the narratives it became clear that all of the women, to differing degrees, re-established a sense of order in their lives. This was an ongoing process, unique for each woman but within the data was discovered varying degrees of assimilation, reconciliation and acceptance of their new role. This essential constituent is entitled, "Acceptance: from crisis to comprehension." As new mothers the women made gradual, hesitant progress towards understanding the transformation wrought by motherhood. This process was influenced and exemplified by their recovery of a sense of control over their lives. Barclay and Lloyd (1996) (see also Barclay *et al.* 1997, and Rogan *et al.* 1997) used a grounded theory approach to better understand the way in which fifty-five Australian women became mothers. Their study involved first time mothers recruited from mothering support groups, none of whom were

identified as having PND. Their results revealed a core category of 'becoming a mother' which was different from the physical act of giving birth (which signalled the *biological* beginning of motherhood) and mothering in an embodied sense. They concluded that 'becoming a mother' takes time, it is a slow, complicated process. As one of the women responded, **"I felt like I was walking into someone else's life...this isn't my life anymore, it's someone else's and I'm watching a film,"** and it took time for her to realise that, **"it was actually mine and that it was my life that was changing."** (Barclay *et al.* 1997a, p721). They conclude that the transition to motherhood involved a **"profound reconstruction of self"** (p727) and that women had to discard their old self and their familiar world for one that is unknown and initially at least, discordant and chaotic. The women in their research felt isolated, exhausted and consumed and it took time for them to be able to successfully renegotiate relationships to include this new sense of being a mother. The women in my research undertook a similar journey and gradually came to embody motherhood.

9.5 Medard Boss and a 'Daseinanalytic' perspective

9.5.1 Introduction

This section will examine the work of Medard Boss (1903-1990) a psychoanalyst who expanded and developed Heidegger's theory of 'dasein' and 'being-in-the-world', resulting in an enlightened theory that offered a framework within which physical and mental pathology can be understood in existential terms. This was called 'Daseinanalysis'. The analogy of light played an important part in Boss' theory as he considered dasein as a 'lumination' - bringing things to light. In other words, an 'uncovering' of how things truly are which, one could argue, is the aim of phenomenological research.

9.5.2 Introductory thoughts on Boss and motherhood

Although Boss paid scant attention to motherhood in his writings, the unconventional model of illness that he proposed appears to offer an alternative framework in which to contextualise and account for PND (as it is defined within a medical model of health). The new mother, embedded within the world, is (in varying degrees) challenged by the transgression of her subjectivity and the consequential radical re-organisation of her 'existential possibilities'. This is caused by the needs of the infant (the Other) demanding ceaseless mindfulness from the mother. Dramatic modification of all her existential possibilities is required as she struggles to integrate and make sense of this transformative life event. Inevitably, she will embody both resistance and acceptance within her disarrayed subjectivity and this in turn may result in, either successful assimilation and

re-evaluation of existential potentialities, or catastrophic erosion and a sense of misplacement of her existential ways of 'being'. This can lead in turn to the manifestation of physical/mental symptoms of dis-equilibrium and 'dis-ease'.

9.5.3 Daseinanalaysis

Boss was initially influenced by Freud and then Jung. He sought a more satisfactory understanding of human beings through the work of Binswanger and then finally Heidegger, who became his greatest influence and guide. Uncomfortable with a mechanistic explanation of human behaviour, Boss argued that, in existential terms, understanding and responding to pathogenesis is less about cause and effect (as natural science explains the aetiology of illness) rather it is about the individual having been born with her/his own specific potentialities and the way in which these potentialities are lived or alternatively, obstructed or limited. Existential motivations, in the form of what has already happened in the person's life compel them to behave in a particular way. Boss called this

"...motivational genesis...a Daseinanalytic study of pathogenesis does not aim to trace phenomena back to causes, but is concerned with discovering biographical incidents which then motivated a human being to conduct himself in a certain way and which still motivates him to perpetuate these modes." (Boss 1979, p192).

He goes on to explain that pathogenic incidents circumscribe the individual's inborn possibilities, drastically constrain their potential and modify their ability 'to be'. The

existential modes become 'blocked' and this obstruction reveals itself through the modification of the individual's experience of space and time, 'bodyhood', coexistence with other beings, 'attunement' and historicity. The individual's bodiliness and the interpersonal realm are truncated and this pathogenesis induces **"...a person to restrict, or partially blind him to, the abundance of his inborn possibilities of relating so that he fulfils only a few neurotic modes of relation to his world."** (*ibid.*).

Boss developed an approach to treatment that emphasised the inter-relatedness of human beings and the world and the inextricability of one from the other. For this he employs Heidegger's principal ideas of dasein. This is the 'being-there' of person and world, without a person who is by definition 'world-open' the world has no meaning, as it remains 'unrevealed' (Moss 1978). A person brings-to-light the world and this complementary relationship means that a person cannot be extracted from the world and still exist. **"The world-openness of man receives its being from the world it discloses."** (Moss 1978, p310). Boss developed Daseinanalysis as a therapeutic technique, as a means of acknowledging that every person occupies their own unique world which is ceaselessly transforming and as one person encounters another, the complexity of their world is disclosed by the other's existence at this moment. **"This is a level of *being-with-the-other* which precedes all explicit efforts to communicate"** (Moss 1978, p311). Whereas traditional Freudian psychoanalysis was concerned to explain *why* individuals behave in particular ways, Boss chose instead to focus on the way in which we are connected to the world. He offered analysts and 'patients' freedom from their struggle to circumscribe their behaviour by referring to innate instincts or

drives. Instead Boss directs their gaze to 'world relatedness' – in other words, the individual *is* their relationship to the world and those other persons in it, not a separate mind that has to reach out and wilfully make connections - and the body *is* this fundamental realm of existence (Boss 1979). A further way in which Boss subverted the traditional subjectivist approach of humanistic psychology was his rejection of the basic assumption that all individuals are essentially isolated from the world and all other individuals. This state of being necessitates their deliberate and continuous efforts at communication or 'self-disclosure' and a crude understanding of psychoanalysis is that its principle is to assist in this project. This is contrary to Daseinanalysis in which, fundamental to humans is primary contact with the world. Indeed without this essential connection to the world and other people, the individual would cease to be. Therefore Daseinanalysis as a therapeutic approach does not seek to enable the individual to *establish* contact; instead its aim is the freeing or removing of any obstacle to the primary contact that is intrinsic to the person's being. Clearly, daseinanalysis as a therapeutic technique would merit further discussion, but unfortunately this cannot be done within this thesis

9.5.4 'Potentialities'

In relation to my research this discussion will now focus on the concept of 'potentialities' and its relationship to illness. Boss conceptualised 'dis-ease' as needing to be understood within the context of healthy functioning or pursuing one's existential possibilities in the world. Drawing on Heidegger, Boss conceives of these possibilities in terms of existentials,

"In beginning the attempt to describe the character of possible modes of illness as disturbances in fulfilling basic features of human being-in-the-world, we list once more those traits or Existentials most important for medicine. They are the spatio-temporal character of *Da-sein*, its attunement, its bodyhood, its coexistence or being together with other people in a shared world, its openness and, finally, the unfolding of inherent potentialities into existential freedom." (Boss 1979, p199).

Boss cautions practitioners desiring to formulate a general Daseinanalytic pathology by reminding them to base their investigations only on what is manifest in and on the body – not the **"abstract or theoretical"** (Boss 1979, p199) but that which is apparent and observable as a discreet entity. For the fundamental features of human being are not **"...suppositions extraneous to the ontic, sensorily observable, particular phenomena of human existing."** (Boss 1979, p199). In other words, one must focus on the Existentials and the way in which they are interrupted and unfulfilled as the basis of tangible, concrete, distinctive disturbances of health. Boss is clear in his guidance that one must consider Daseinanalysis of pathology as a three dimensional issue.

1. How is a person's freedom to carry out their potentialities diminished?
2. What are these potentialities?
3. With respect to which entities of the person's world does this impairment occur?

(adapted from Boss 1979, p200).

Boss applied his Daseinanalysis to inheritable diseases and to those originating during pregnancy. He aimed to demonstrate the way in which dasein is disturbed and how this translates into world-openness and world-relatedness. In developing a more comprehensive understanding of the complexities of the transition to motherhood, what follows is an application of Daseinanalysis to that which is termed PND by natural science. It is only with this full contextual description that we can understand phenomena like 'post-partum depression' --not just as something 'abnormal' but as a manifestation of the struggle to integrate a challenging life event within one's total context of living-in-the-world. Although Boss is not discussing PND in the following quote, he recommends a Daseinanalytical perspective as a way of preventing **"medical understanding from losing the connection of these phenomena to the context of the whole bodily lived existence of the ill person."** (Boss, 1979, p203). In other words, without an understanding of the existentials of the individual woman's 'being-in-the-world', the 'symptoms' she experiences will seem as isolated properties of a material body, unconditional and decontextualised. It follows that **"understanding of that context** (in this case, the context is the transition to motherhood) **is inevitably lost."** (Boss 1979, p203). Furthermore, although Boss was not involved in phenomenological research, his criticism of Freud's refusal to define what it is to be a woman (rather choosing to explain the process of intrapsychic development, from bisexually disposed child to gendered woman) unintentionally describes the fundamental process and intrinsic value of a phenomenological study. **"If we want to understand what it really is, we will have to find out from the afflicted person exactly how his ability to relate himself through perception to what reveals itself to him in his world has been impaired."** (Boss

19779, p201). One must return to the things themselves to achieve a greater understanding of the phenomenon, gathering the information from the source for, as Boss says, **"The phenomenon itself should take precedence over any investigations into its origins."** (Boss 1979, p196).

An additional concern, when exploring methods to more accurately and responsively contextualise 'symptoms' that could indicate a psychological pathology in postnatal women, is the issue of who is the 'expert' in defining and authenticating the woman's experiences. Whether a traditional or Daseinanalytical approach is taken, one would need to acknowledge the new mother as being the 'primary source' of her own experience. Several studies (Robinson & Young (1982), Whitten *et al.* 1996a, 1996b, Shakespeare *et al.* 2003) have demonstrated that some women are resistant to a diagnosis of PND, even when raised scores on screening questionnaires suggest they may be 'at risk'. They are inclined to relate their dysphoria to socio-economic factors for example and feel disempowered if their distress is defined as an illness. An existential approach to understanding this phenomenon is both enlightening and challenging, but in trying to provide an ontological framework for the transition to motherhood, one should be vigilant that the women's voices are not marginalised or silenced and furthermore that one screening tool does not simply replace another.

9.5.5 Existential foundations

One cannot reasonably discuss Boss'contribution to our understanding of pathology without clarifying precisely what is meant by the term 'existentials'. These will be

outlined below and discussed further in the context of the transition to motherhood. Boss described them as the **"fundamental characteristics of human beings."** (*ibid.* p85) and argued that unless they were convincingly established, an existential basis for illness and medicine was tenuous. Likewise, these existentials must be coherent with the experiences of women becoming mothers otherwise Boss' ideas are of little value for this study. Ashworth (2003) equated Boss' 'existentials' to his own **"fractions"** or **"parameters"** of the lifeworld that he argues, are fundamental to 'being' and as such it is not suppositional to approach a phenomenological study with this framework in mind. In other words, one can expect them **" to reveal themselves without hazarding the epoche...these fractions are inevitable structures of the lifeworld – part of its essence."** (p20). Ashworth (2003) emphasises the inter-relationship and inclusive nature of the 'fractions'. They are not 'bits' of the lifeworld that can be separated into distinctive parts. Likewise, Boss' (1979) existentials are inextricably linked together, one within the other. In the following commentary it should quickly be apparent that an example from the narrative to illustrate the women's lived existential experience of spatiality is also relevant to the discussion on temporality or human bodyhood.

9.5.5.1 Spatiality

Everything in the world is present in space, both inanimate objects and individuals, but the spatiality of human beings is profoundly different from that of, for example, a chair or mountain. Boss (1979) equates 'making space' with a variety of ontic possibilities in which individuals strive to 'make room', to approach the world with 'expansiveness', 'openness' and **"readiness for the appearance of others."** (*ibid.* p88). At our most

authentic, the **"clearness of space"** (*ibid.* p89) allows other beings to 'be' – to dwell as themselves and address us in their 'imminent significance'. However, rarely is this achieved as most individuals are unable to realise their deepest existential possibilities as we are all existentially flawed, subject to the vagaries of our emotions, moods and passions. For human spatiality to come into being, there must already be **"openness and clearness...reigning there** (in the world). **These constitute the true nature of human spatiality in the world."** (*ibid.* p89). Human existence can respond to the spatiality of its lifeworld with optimism, encountering and assimilating each 'object' in a spirit of openness - receptive to the 'beingness' of what is perceived (this applies equally to other individuals as well as inanimate objects). But with openness there is also the possibility of detachment, indifference and hostility – there are endless ontic possibilities contained within the ontological structure of spatiality. However human existence is not an empty, luminescent space passively processing information, rather it is responsive, questioning, capricious and relational. As Boss (1979) explains, we can feel intimately close to a loved one who is some distance away and no intimacy at all with the road on which we walk. He called this **"a world-spanning receptive realm of perception"** (*ibid.* p90). This is uniquely human and this receptivity explains the individual's **"...ability to be simultaneously here and there with whatever it is he perceives. Human beings are, *as* an open, clear realm of perception, so essentially spatial that they dwell from the beginning *with* whatever is accessible to perception, and in a way suited to the meaning they perceive."** (*ibid.*).

The spatiality of human existence is best understood (in its most successful manifestation) as an openness to encounters, a readiness to be addressed by phenomena and a 'being-with' that which is perceived. The spatiality of the individual extends beyond the physical body, across space, back through time and into the future. It is intrinsically tied to temporality, which I will turn to once I have discussed the concept of spatiality in relation to motherhood.

9.5.5.2 Spatiality and the transition to motherhood

The women who shared their experiences with me demonstrated varying degrees of spatial disruption during their transition to motherhood. Betty provided an interesting example of the way in which her perception of space had changed. Too much space between her and her son – or even the *perception* of too much was experienced as perilous, lest she was unable to reach him in an emergency. Her description is focused on her use of a new car seat which entailed her baby 'moving' from sitting next to her in the front passenger seat, to sitting on his new seat, in the back of the car,

"He's always had his little car seat... he's sat in the front and I've been able to see him and I've put this big one... and the step to putting that car seat in the back of the car when I'm in the front of the car. At the moment I find it hard to do because I'm so used to looking to my side and knowing he's alright and I know it's only in the back of the car but that seems like, sort of ten miles."

Although her son would still be very close to her, because he was not in her 'line of vision' it is as though he was absent, outside of the space she inhabited and therefore causing her acute anxiety. I think it is acceptable to speculate that Betty quickly realigned her boundaries to restore her sense of 'a safe space' and her son contained therein.

For May, her familiar home space was distorted and temporarily experienced as threatening and cavernous, requiring that her baby be very close by at all times. Home space also came to signify separation from 'normal life' and confinement – a place from which May, Wilma, Sue and Chris wanted to 'escape',

"because you do just sometimes feel like saying actually I'm going, even if it's just for an hour just to get out of everybody's way" (Sue).

Until becoming mothers, home was reliably unconditional and comforting, somewhere to retreat to at the end of the day. But with the birth came an unexpected inter-contextualisation in which home space was now 'home space with baby'. For Betty and Jane this was not problematic but for the other women in my research it was, at times, unbearably claustrophobic, oppressive and unequivocal. This was further exacerbated by their removal from public space (in the form of the work place) and their consignment to domestic space. Chris and Betty craved the sociability and adult space of work, whereas Jane felt that motherhood had signalled her entry *into* an adult space, that of parenthood,

"And the same with motherhood...you become aware that you share this experience with so many thousands of people and you're one of them suddenly...you become one of a massive big club of people."

Betty also felt herself propelled into this adult space of parenthood but for her the experience was less positive, instead she felt undermined and that her mothering capabilities *might* potentially be disputed. This caused her to be circumspect in her dealings with those she perceived as being in authority (even though her fears were unfounded).

"I don't want to go the doctor because I don't want him to think I'm an inadequate mother... because I'm young...I do feel like a single parent. I know (her partner) *is his Dad and I know he's still there, but I do feel like everyone's judging me that bit more because I'm on my own* (her partner was in the forces and worked away). *"Is she doing it right? Is she doing this right?"...you see people think, "Is he wearing the right clothes?"...and whereas before if I thought somebody was judging me for something it didn't bother me because I knew what's real, now it does bother me."*

Applying Boss' Daseinanalysis of existential spatiality to new mothers leads one to reflect upon the disturbance and intrusion caused by the baby's presence in the world of the new mother. If spatiality is openness and illumination, then for the new mother, this openness has become shadowy and obscured. However this is not wholly negative because the openness has been filled with the baby. The woman's physical space is now

determined and obstructed by 'babyness' (this refers to both the child and associated equipment) and her mental space is taken up with thoughts of the child. This was named above as 'babytime' and represented the way in which, having closed off to certain existential possibilities, the women have opened up to others. This openness is fraught with difficulties for some of the women in this study, whereas others embraced 'babytime' as a gift. The intimate conjunction of the woman and her child surpass all other closeness and even when the children are away from their mothers, the women are still inextricably connected to their children. The body's boundary is breached and the women's existential spatiality is no longer self-contained – it is 'extended' across two beings: 'herself' and the child and this compels the women to reconstruct their existential possibilities. Sue described the moment of profound recognition and openness to this new being, shortly after the birth. At the moment of giving forth she is also 'taking in' – a bodily enfolding

"I could 'see' this little boy walking towards me and he did walk right into my heart... it was like that, it was sort of an acceptance... and I did love him right from the start...you do just feel this huge connection, he was a part of me, he is a part of me and one of the big things for me of being a mother is he is first and I will protect him with my life and that is how much I love him."

Later on, she described the way in which this connection continued after the birth for many months, *"because nothing could be more a part of you than a baby could it, it's the*

only thing that's ever come from within you ... and feeding him for months it was like we were still very connected."

9.5.5.3 Temporality and historicity

The everyday, familiar concept of time is reconceptualised by Boss (1979) as more than a quantitative calculation contained within a timepiece, rather it is a qualitative concept with four fundamental characteristics and these are

- Significance – meaning time is always 'for' something, even if the activity or event is not directly referred to, time has either been or has *not* been intended for use
- Datability – whenever phrases like, "now...", "back then..." and "when" are used we are specifying a date in time.
- Expansiveness – time does not reside in discreet units, it expands over days, activities, lifetimes
- Public character – time is never for one person alone. 'Now' is never rooted entirely in one isolated individual.

(adapted from Boss 1979, p94-95).

When time is considered by an individual, it is not time itself that is the focus of his/her thoughts, it is the activity for which time has been allocated. The individual is "expectant" and within that expectation is the present moment and all that has gone before,

"Any time I "have", I have in such a way that I am expectant of which (*sic.*) **is to come, aware of what is present, and retentive of what has been. This threefold mode in what I am constitutes "having" time for this or that."** (*ibid.* p98).

This conceptualisation of time as a threefold manifestation is, according to Boss, **"a mode of human *being*"** (*ibid.* p99). It is intrinsic to the project of 'being-in-the-world' – the individual has *time* to accomplish **"potential ways of being"** as her **"existence develops and matures"** (*ibid.*). Eventually the individual will have **"used up the time appropriate to an existence"** and life will end. Boss emphasised the crucial nature of time for human existence,

"Thus, the "having" in the having of time is the actual temporality of human being in that what matures...in this "having" is what we may designate as man's being-in-the-world, or his worldly dwelling..." (*ibid.*)

We are always extended over three dimensions of time – past, present and future and these dimensions displace each other so at any one time we may occupy one and be unaware of the other two. However, as Boss explains, all three are always present in our 'being', two may be concealed and denied but never permanently replaced.

Although Boss does not group temporality and historicity together, they have a certain resonance that suggests one is concealed within the other. The past is not lost, it is instead always present in the present, **"...it is retained in the human *Da-sein*"** (Boss 1979,

p118) and as such it influences all human behaviour. Boss argues that human memory constitutes what he calls tradition and history, in which all individuals dwell and this dwelling he calls 'historicity'.

9.5.5.4 Temporality, historicity and the transition to motherhood

Women with very young babies have a complicated, often problematic relationship to temporality. The lived-time of the women in my research, and by this I mean the way time passed for them, was more often than not fractured, convulsed and either intolerably long, repeatedly interrupted or frustratingly short. The women spoke about how their experience of time had changed. The baby absorbed *all* of their time – other projects had to be 'squeezed' into the margins of their lived experience and activities that, prior to motherhood were of primary importance, no longer merited more than a brief 'glance'. This marginalisation was most obvious in their having stopped paid work, a loss that Wilma and Chris felt most acutely. May had stopped horse riding and found completing even the most mundane task frustrating as her baby would inevitably interrupt and require her time and attention. Sue had no time to read and Wilma and Yvette were both unable to complete their housework before being distracted by the baby. *"Trying to get the washing up done, which is about as much as you can – well I often didn't do it..."* as Yvette ruefully explained. The baby brings a sense of boundedness in so much as the new mother's existential potentialities are restricted – her time is not her own but this is not entirely a negative experience. As has already been referred to above, temporality comes to be embodied as babytime, sometimes reluctantly by the women in this study but often

with great pleasure. One must keep in mind that when one existential potentiality is concealed, another is revealed – prior to giving birth babytime did not exist for the women in my study. Once they were mothers, their familiar lifeworld receded and new horizons appeared.

New mothers are possibly uniquely disadvantaged in their experience of night time – wrenched repeatedly from insufficient, snatched intervals of sleep by the baby or conversely, lying awake worrying about the baby, unable to sleep even when the child is quiet. As Betty described,

"... it was every two hours he'd wake up guaranteed and I was surprised how lack of sleep really effects you, yeah, even when he was sleeping you'd sort of wake up to see if he was all right."

The night is generally understood as a time for uninterrupted sleep, for recovery and replenishment and although 'broken nights' are generally recognised as being synonymous with feeding a baby, the reality is an indisputable shock. The women's temporality comes to be defined by tiredness, which is both expansive in its insidious undermining of the woman's existential potential and exquisitely focused as 'time out of time' – as May's poignant description of feeding her daughter during the night whilst her partner is away working, illustrates

"I find (it) *so lonely. Feeding her in the night I absolutely hate it when he's* (partner) *not here. Because I'm so aware of the darkness and the quietness and also I feel like I'm the only person doing that... it is so isolating..."*

Clearly, the relationship of the woman with her baby intrinsically reflects the 'public character' of temporality, albeit not quite as Boss had anticipated. There is a contradiction at the heart of this public manifestation of time: mother and baby are so deeply intertwined that they present as an exclusive unit that can seem indissoluble – therefore although the mother's temporality is public, it is only so insofar as the baby's 'being' and no further.

"it's like you're in a little shell the two of you and that you speak to people... but they're not actually coming in the shell with you ... it's almost like the two of you and no one can get in to that." (May)

During the first weeks of motherhood the women struggled to direct their attention and time to anyone else, including their partners, although they did also describe their partners as supportive and devoted to the infant. However, it is as though the baby has displaced the partner in space and time, edging him out – *"He's a thing in the middle"* as Sue describes her son. There was no time to pursue their existential possibilities and the 'significance' of time is that it is time *for* the baby.

To further expand upon Boss' theme of the threefold manifestation of time as a **"mode of human being"** (Boss 1979, p99), the women in my study commented on their relationship to the past since becoming mothers. They described it as another life, another place now irrevocably changed, a misplaced existence that is recalled as if a dream. Often, it was difficult to remember details of life prior to motherhood as this memory felt as though it belonged to someone else. The women they were before motherhood were now strangers dwelling in an orderly world where meals and relationships were not constantly disrupted, where they were free to act spontaneously or simply sit and daydream. A time where arrangements could be made and shopping, socialising, travel and sleep were not determined by the needs of a baby. As Chris declared

"... initially I did resent her because I didn't have any time. Even simple things like washing your hair, it's like a luxury (laughs) *or having a bath or shower... you try and think how it's going to be, how you'd like it to be but it never actually is how you expect it to be, you could never ever have planned enough or expect enough."*

The women did have a sense of the future, as representing a time when life would become easier and the chaotic muddle of life with a baby would settle into an orderly routine. This was sometimes based on what they had witnessed with other people's children, or changes that were happening in their own lives. May and Wilma spoke about specific time periods since the birth (two weeks, six weeks, the present) and that as time passed, life with their babies was improving. Sue looked forward to her child becoming more independent and engaging and Chris equated her return to work with better times.

As the weeks passed their experience of time shifted and transformed. Initially it was as though the women lived only in the present, with only a vague sense of the three dimensions of time. But gradually most of the women found themselves able to reflect upon their mothering experiences and find reassurance in the changing pattern of the baby's development – they took comfort in the knowledge that life with a baby happened in phases and even the most difficult and perplexing resolved eventually. Gradually the debilitating tiredness subsided, a sense of order was re-established and the women become more authentically present both temporally and spatially, to themselves, to the baby and everything else within the lifeworld.

9.5.5.5 Human 'bodyhood'

In attempting a definition of individual bodyhood, one might tentatively suggest that it is circumscribed by physical being, however this assumption is belied by the fact that dasein is essentially unconstrained by physical boundaries and instead dependent on maintaining relationships with other beings in the world. As Boss (1979) explained, **"We can never grasp the phenomenon of bodyhood if we continue to imagine it as a self-contained physical structure existing in itself and of itself, in isolation from the world."** (p102). He continues to clarify the essential difference between the concept of a physical body and the qualitatively different 'bodying forth' of dasein's immersion in the world.

When the individual perceives and reaches out towards something they are extended far beyond their physical body. **"In fact, bodily I reach out even further than this to**

touch all the phenomenon of my world," and in the intentional gesture of reaching out, **"...I am inherently settled into the open space of my world to the extent that I, with everything I am, actually dwell in my perceiving relationship** (with the 'reached for' object)" (*ibid.* p102). In other words, this moment contains both the seeing of the object across space and time as well as the gesture towards it. Boss calls this the ***"bodying forth*** **of this existential relationship."** (*ibid.*).Our being in the world is never still, it is active, inquisitive, and responsive and the boundary of my bodyhood corresponds with my openness to the world.

Healthy humanness presupposes bodily unawareness. In other words, when the individual's attention is absolutely immersed in a project, her bodyhood is completely engaged in that activity and she has no mindfulness of herself as embodied. Boss (1979) referred to this as a total engagement of **"body and soul by something that claims one"** (*ibid.* p101) and fundamental to being human. The individual does not have to be engaged in a discreet, measurable and observable activity such as building a house or completing a run, all manifestations of human existence are bodily and this is resonant of the key concept of intentionality in phenomenology which was discussed in an earlier chapter. **"Visualisations of things the senses do not perceive are also bodily, though what we visualise may be visible only to the mind's eye."** (*ibid.*) All such imaginings have colour, texture and shape and are present to us. Even abstract thought is seen in the mind's eye and as such is seen **"with the senses (and) is seen bodily"**(*ibid.*).

9.5.5.6 'Bodyhood' and the transition to motherhood

It is indicative of the way in which the fundamental characteristics of human beings are interwoven that issues of bodyhood and mothering have already been touched upon in the preceding two sections. Arguably nothing confounds the traditionally perceived rigidity of bodied boundaries like the birth of a child. Boss' scrupulous explication of dasein as being 'more than' physically present in a body in the world (rather it is bodying-forth and seeking active human relationships) is encapsulated in the ultimate bodying-forth of the mother with her baby. From the moment of birth the women's entire 'being' is turned towards the infant, even at rest she still bodies-forth mothering, the child is under her skin and inextricably entangled in her existential possibilities.

For Jane this entanglement was assimilated with ease. She experienced her son's presence as a blessing, and felt no resentment at the restrictions of her existential capacity, "*...because really you can't do anything but look after them. So I've been as happy as can be since he's been born...and now all my fulfilment is coming from looking after* (her son)." In fact, Jane's narrative implied that her existential projects had been temporarily suspended rather than irrevocably closed off by motherhood and although her priorities had changed, she still considered herself to be very much the same person, as she confirmed, *"I don't think I've changed"*. However, most of the other women in my study were not so sanguine about motherhood. They described it as a *"shock to the system"* and *"a bit of a shock"* as well as *"exhausting"*, *"really tough"*, *"terrifying"*, *"stressful"*, *"very lonely"* and *"desperate"*. They shared positive experiences with me as well, but their initial resistance to the constant demands of their babies was variously

described and reflected upon. As May revealed, when she arrived home from hospital with her daughter,

"... it was just dawning on me I've got her forever and she was going to be with me twenty-four hours a day, seven days a week for a long, long time and I suppose there was a part of me, a little part of me that was worrying how I was going to cope with that."

Boss (1979) turned to examples of accidental harm to illustrate how the individual can experience themselves as acutely bodied, in an instant being 'reawakened' to their physical self, with all but the painful limb obliterated momentarily by the shock and discomfort. As has been previously discussed, malfunction, disablement and disease immediately catapult the body into the foreground of 'being' and motherhood is no less a physically transforming event, for which most of the women in my study were unprepared.

The once familiar body is no longer dependable or immutable but is instead distorted, leaking, aching and amorphous. Yvette assumed that she would quickly return to the same physical size and shape as well as level of physical fitness and both her and Sue described being unprepared for the earthier aspects of the postnatal period such as the blood loss, the stretched abdominal muscles, the perineal pain and backache. These physical impairments **"...are not simply material phenomena but bodily events to be understood in context with a changing relationship to the world."** (Boss 1979, p103). Although the women in my study did refer to physical problems they had encountered

during the transition, they had, on the whole resolved. Sue experienced painful backache that improved following manipulative intervention. However, it had been disabling initially.

"... my back was absolutely agony with feeding him because I had such huge breasts, ... and I was sort of like this hunched over thing all the time and the backache was incredible... it was things like that that made life an absolute misery."

Yvette's hips ached and she felt dowdy and overweight as well as being shocked by the blood loss in the first few days after the birth. It is possible that had I questioned them directly about physical recovery, more problems would have been identified. However, I can only speculate that this may have been because, on the whole, their physical recovery was successful and any ailments fairly transitory. Bodily changes concerning their transformation from woman to mother and their 'existential-being-in-the-world' were implicit in much of their narratives and negotiated with varying levels of success.

9.5.5.7 Attunement and coexistence

As has already been discussed, human existence is defined as **"a clear and open realm of understanding"** (Boss 1979, p109) that is by its nature, innately 'attuned'. By 'attuned' Boss is describing the way in which individuals are always **"permeated by some disposition"** (*ibid.*) (mood, emotion, feeling, affectation) that is apparent, identifiable and accessible for other beings to describe and respond to. This attunement is a fundamental ontological characteristic of human beings with limitless ontic variation.

One can not accurately speak of an **"unattuned existence"** (*ibid.*) that requires external stimuli to provoke a particular mood as **"All the dispositions or moods of which a person is capable are given to him innately as existential possibilities and as such are always making up his existence."** (*ibid.*).

To alleviate what Boss (1979) considered to be the human capacity for loneliness, human beings embark on joint projects with other individuals of **"perceiving and responding to whatever is jointly encountered"** and **"sustaining and maintaining the openness of the world they clear in common."** (*ibid.* p106). The image of coexistence he is proposing is complex. He rejected the notion of individuals as self-contained units, consolidated and demarcated and able only to reproduce the **"image each has in his isolated psyche."** (*ibid.*). Instead he proposes that individuals perceive other beings directly because they are jointly and inherently dwelling in a shared world with objects that are familiar to them both. Together they sustain a world-openness, which defines the essential coexistence of humanness. Furthermore, this is not just a philosophical, ontological argument; coexistence underpins all dealings between individuals and all expressions of, for example love, hate, anger.

The essential nature of existence is openness and whatever enters this **"realm of openness, shines forth within it and so comes to be present as a being with its own meaningfulness."** (Boss 1979, p109). Boss emphasises the crucial nature of this openness – without it, being could not reveal itself as 'phenomenon', it could not pursue its existential possibilities – there would be no world, as we know it. Using the example

of a young woman meeting with her lover, Boss (1979) explains that the man is not the *cause* of her happiness (as one might assume) since her happy mood already existed as **"an innate potential of her being"** (*ibid.* p109) rather, his presence opened up the *possibility* that this potentiality was carried to fulfilment. Furthermore, previously the woman had reacted to the appearance of her lover with **"catastrophic anxiety"** (*ibid.*) thus demonstrating that, at this meeting, a radically different disposition had been realised by the same stimulus. Boss describes this phenomenon thus, **"Whenever we see someone enter a particular mood, what we are actually witnessing is only a *re-*attunement of his existence from an old reigning disposition into a new one."** (*ibid*, p110). Moreover, these moods and inclinations are not 'possessed' by the individual, they are modes of 'being-in-the-world', in which existential attunement is accomplished.

9.5.5.8 Attunement, coexistence and the transition to motherhood

Employing Boss' theory of coexistence to motherhood, one might be tempted to declare that the women and their infants coexist as Boss described. However, I would argue against this proposal, as coexistence requires a *common* encountering and *shared* way of perceiving which is not the way women embody motherhood. Mother and child are not equal participants in a relationship. The baby relies absolutely on the mother and the woman carries the baby, literally and ontologically as part of her 'being-in-the-world'. The infant is intrinsic to her dasein and as such they are not coexisting. On the contrary, to varying degrees, the baby is an obstacle to the women's coexistence because so much of her being is turned towards the child, her utter absorption in every mode of the infant's

being necessarily constrains her openness to other beings, including those closest to her – partner, family and close friends.

However, as has so often been the case with this study, the opposite of this argument is also true and demonstrable. Although the women were deeply absorbed in their child's 'being', several of the women in my study spoke of the way in which motherhood opened up the potential for new relations with both family members and 'strangers'. Jane described the way in which the insularity of life was 'thrown open' and motherhood was like being initiated into a 'club' – a shared co-existence of parenting

"You become one of a massive big club of people who have children and then you relate to them in a different way... you've shared this massive human experience ... if you haven't got any other things in common with the person you can still relate to them because you've got children."

My understanding of Jane's narrative reveals her world-openness to what it means to care for a child and her pleasure in discovering this openness in other individuals. Sue expresses her surprise at this aspect of motherhood

"He already has brought me things that I never would have done previously... we went to a Christmas party, the church do it with all sorts of people I've never met and I've lived here eight years and it makes you think, there are still people out there who do nice things and nice children who enjoy playing musical bumps."

Boss (1979) concluded his discussion of attunement with an analysis of certain dispositions. For the purpose of this research I will focus on three of the **"basic human states"** (*ibid.* p113): love, anxiety and sadness, as these were frequently exhibited by the women in my study. Boss (1979) says of great love that,

"(A) passionately loving existence sees in the loved one the potential for a togetherness that would offer a much greater store of human possibilities than its own single existence could ever compose by itself." (p112).

Encountering the child at that first moment after the birth opens up the existential potential in the woman for a great love to be fulfilled – it is a disposition that is already present for the woman but how it will be realised depends on the openness and receptivity of her relationship with the world. For the women in my study, the birth symbolised the 'becomingness' of motherhood and this was either directly spoken of or implied. Although once born, the baby is embodied and is a separate person in so much as it is a tangible, physical being, present in space and time, the women often retained a deep connection with him/her as though they remain as one.

"I held her and looked at her and it was just so overwhelming the feeling of love for some little person I'd just met." (May)

"But the moment he was born, the most huge amount of love…I loved him as soon, as soon as he came out." (Jane)

"God he's mine, and I, I just couldn't believe this little person is mine…it was like I'd had a love drug." (Wilma)

Betty described the love for her baby as eclipsing that which she felt for her parents and partner, *"…but it's a love that's just, bang! As soon as you see them…it's never gone and it, it is so strong."*

Yvette's experience varied from the others in immediacy, for her the love grew steadily and unwaveringly over the first few weeks after her son's birth, *"I don't think I had that instant overwhelming love, although I did…but I think as they grow up you tend to feel more love for them rather than straight away."*

Chris struggled with her feelings following her daughter's birth. Although it was obvious when I was sitting opposite her during the interview that she loved her daughter very much, her narrative revealed her bewilderment at her conflicting emotions and the way in which her feelings of tenderness were obscured by the resentment and exhaustion that overwhelmed her for the first weeks of motherhood.

"When …I first held her I did love her and then, I dunno, although I never stopped loving her…I thought, "I resent you because I didn't get much sleep"…I did resent her for the

first sort of month or so – I don't know why (cries a little) *I really, really hated her... although deep down I knew that I still loved her...* " As her daughter got older, the rewards were more tangible, *"Now she's that much older, I love her more now, she's a little star."*

The way in which Chris responded to her baby's birth merits further discussion, as it is the most revealing in terms of openness and attunement. It would seem to be the case that Chris was unable to immediately effect her existential possibility of happiness and she struggled to re-attune her disposition to that which was expected of a new mother. As Boss (1979) argued, **"The prevailing attunement is at any given time the condition of our openness for perceiving and dealing with what we encounter; the pitch at which our existence...is vibrating"** (p110) and when the individual's possibilities for being open are unfulfilled, **"They are at the same time the modes in which this perceptive openness can be narrowed, distorted or closed off."** (*ibid.*). Chris' form of attunement was partially constituted by her previous expectations (perhaps culturally laden) of the unmitigated 'joy' that motherhood is 'supposed' to be and there were moments in the narrative where she described genuine pleasure at being with her baby. But the study also revealed a more complex narrative picture of the process of existential re-embodiment and demonstrated that the new mother's mood/attunement is compounded by the assault on her personhood, the dissolution of her boundaried self and the truncation of her existential possibilities. So, not only do we have the existential dimensions affecting mood but also (often), the cultural overlay of disappointed expectations. Although Chris

may have demonstrated this conflictive response most acutely, it is evident in all the women's narratives in varying degrees.

Boss' (1979) 're-framing' of anxiety reveals an elemental fear of losing that which is loved – to the point of **"...being thrown back entirely upon itself, and ceasing to be, in total isolation."** (p112). He reminds the reader that human existence **"consists solely in its possibilities for relationships"** (*ibid.*) and, using the example of a mother and child, explains the way in which the woman's existence has merged so completely with her child's, that losing the child would be tantamount to destroying her own existence. Such rudimentary fears seem to be an essential structure of the transition to motherhood for the women in my study. They perceived their newborn babies to be very small, extremely vulnerable and essentially reliant on their mothers for survival. It was as though they were barely embodied. However as time passed and the baby was perceived as more robust, the women's uneasiness usually lessened.

"I was always worried that I was going to go to the cot and find him dead...are you breathing, is your chest going up and down?" (Sue)

"At the beginning I was so frightened that he was, that I'd wake up one morning and he'd be gone again, because he can come like that and he'd be gone again the next day." (Jane)

"You'll never know the love you've got for them, the fright that you get when they're not around and it's worry, it seems to be worry from the minute they're born, all the time." (Betty)

Initially the women responded to their fears of the baby dying or 'disappearing' with constant vigilance and anticipation of danger. This caused the women in my study to be encumbered by anxiety – a re-attunement as Boss (1979) described it, to a particular mode of 'being-in-the-world' that although disabling at times, ensures the baby's wellbeing. Gradually this anxiety became more manageable as the women recovered a sense of control over their lives, developed greater confidence in their mothering skills and felt that their babies had become more robust.

Boss (1979) describes sorrow as occurring when the individual experiences

"a break or rupture in its relationship to a close human acquaintance...the rupture perceived in sorrow concerns some actual particular mode of being with the object which the rupture no longer allows. Gone is the possibility of ever again being with and at that object in mind and body." (p112).

In an example he provides of a person engaged in analysis, there is the distressing realisation by the patient that there are a **"multitude of possibilities lost forever and torn away from their existence because their actualisation has been blocked in the past."** (*ibid.*). Clearly, this loss of possibilities does not *just* equate either to analysis or to

the transition to motherhood. Boss (1979) makes clear that it is not just through separation that people experience sorrow, it permeates human existence, due to the inevitability of death. However, becoming a mother does cause a profound rupture both in the woman's relationship to her past and to her future as Yvette described how time had passed since her baby was born,

"It seems to sort of whiz by but then it seems an age, it does seems a long time ago since I was in hospital – I can't really explain it properly... since before he was here seems an age, you can't imagine life before, life before baby – that was a distant memory."

The women's world-openness has been obstructed and immutable changes have occurred to their 'being-in-the-world'. Now she dwells in the world as mother, whether this is an identity she recognises as belonging to her or not. As Sue commented when she commenced her narrative, *"To me still 'mother' is my mother; I don't feel like a mother at all."*

9.5.6 Concluding thoughts on Daseinanalysis and the transition to motherhood

All of the existential characteristics discussed above are intimately connected to each other and the disruption, dissolution and rupturing of existential relationships challenges bodyhood and the way the individual dwells in space and time. Furthermore, it will be encountered and responded to by each person in an infinite variety of ways. They are not hierarchical and are all of fundamental ontological importance. Whatever aspect of dasein

is studied, it will be composed of these essential characteristics which achieve **"unification in the openness and clarity peculiar to human existence"** (*ibid.* p122). Boss (1979) reiterates the crucial understanding of this openness as an **"open realm of perception"** (p123) rather than an empty space into which **"beings may fall, be present and be stored there."** (p122). To exist is to perceive and respond to the phenomenon that presents itself to consciousness and by doing so, the person enters into a relationship with that 'object' that **"permits it to fully evolve its particular meaningfulness"** (*ibid.* p123).

Considering the effect of motherhood on the existential possibilities of the lives of the women who took part in my study provided a unique insight into the way in which the women adapted to their new role. Boss (1979) has provided a way of understanding the struggle that many women experience when they become mothers which, although more complex than the traditional medical model, provides an ontological, deeper, more contextualised and embodied response to what is often experienced as a difficult transition. Becoming a mother can be viewed as a transition that makes a host of demands on the woman, compelling her to make radical changes to every aspect of her lived experience of 'being-in-the-world'. What is of particular interest is the way in which some women (like Jane and to a lesser extent, Betty) came to embody their new role with relative ease, whereas the other women (and the multitude of voices recorded in other studies on motherhood and PND) struggled to re-order their existential possibilities and initially found certain aspects of life with a baby almost intolerable. It is also true that although every aspect of an individual's existential existence is inextricably integrated,

and it is contradictory to even think of modifying one whilst leaving the others untouched, certain existential re-framing may be more challenging for one woman than another. For instance, the discontinuity that I described in the general structure of the phenomenon could refer to the way in which one woman's relationship to spatiality seems irreconcilable but she attunes with generous openness to the world around her. For another she may struggle with her self-in-relation-to-others (coexistence) but feel comfortable in her mothering temporality and spatiality.

As has been the pattern throughout this study, the women accommodated change in all their existential dimensions with differing ease. Some portrayed considerable resistance and resentment whilst others came to embody mothering with relative ease and equanimity – within this process certain existential foundations may have proved more malleable whilst through others the women exhibit the greatest sense of loss and discord. As Boss (1979) has made clear, these existential foundations are not discreet, extraneous entities or 'characteristics' of dasien that can be quantified or examined, they are fluid, interwoven, intrapsychic ways of 'being-in-the-world' and it is contradictory to speak of them as existing in isolation one from the other.

In translating this theoretical approach into practical and accessible advice for women becoming mothers and the health professionals who provide care, one must be cautious. Clearly, it might be mystifying and intimidating to explain to new mothers that their transition was difficult because their existential possibilities were being obstructed. The ontological language would possibly alienate them from the health professionals who

were trying to help them (as well as quite possibly alienating the health professionals from researcher). However, Boss' (1979) radical re-appraisal of the ontology of existence is both perceptive and valuable in that it further confirms the intrinsic challenge that a life-changing event such as becoming a mother poses, both to the women in my study and those in similar studies. In the same way that it is impossible to extract and examine one existential characteristic from a person's fundamental being, it is not possible to disentangle the experience of becoming a mother from the individual woman's 'being-in-the-world', the intricately woven fabric of her existence. It has to be understood within the context of her lived experience, as something she has to embody and integrate into her most fundamental being. As my study has demonstrated, some women find this assimilation to be relatively painless, but the majority experience major existential disruption. It is only by understanding the experience of the transition to motherhood within this broad existential context that one can understand its possible variations and difficulties. Such sense-making is at a different level to understanding its 'chemistry' or 'neurology' for it is understood in terms of the person living her existential life historically, spatially and bodily. Within a Daseinanalytical framework, PND would be reconstructed as a disturbance of the woman's existential potentialities. This disturbance constrains the possibility of her realising the basic ontological nature of human existence, which Boss describes as, **"freedom and openness towards other human beings and towards all the other beings encountered."** (Boss 1979, p223). On becoming a mother for the first time, the woman's perceived existence is assailed by powerful, constant, new demands from a profoundly significant 'other' – the baby, and she is expected to assimilate these new demands into her existential possibilities. This causes abrupt and

unexpected disarrangement, as has been demonstrated in the narratives from my research and other studies on the transition to motherhood and of PND.

9.6 May's transition to motherhood

To illustrate this I will examine in close detail the way in which May experienced her transition. It is important to be clear that May is not 'typical', in so much as her transition was unique to her and phenomenology does not seek out the typical to represent 'everywoman'. However, she provided a rich narrative, evocative and moving with remarkable depth and vivid clarity.

During her pregnancy she did not experience herself as a mother and it was only at the moment of birth that she felt completely overwhelmed by the baby's presence, *"I felt like a mother the minute I saw her. I just fell in love with her straight away... the most incredible experience."* This first encounter between mother and baby established a profound sense of connection, unlike anything she had experienced before. Her daughter is exquisite and barely embodied in her newness. Whilst in the safety of the hospital May felt cocooned with her child, blissfully untroubled and able to concentrate unimpeded on her baby. On returning to her home she found her lived experience of familiar space had altered, the house felt vast and she was inexplicably beset by anxieties about her baby's wellbeing – constant vigilance was required and every aspect of May's being was turned towards the infant. No longer able to ensure her safety unless the baby was close by, May struggled to retain the completeness of pregnancy when her daughter and her were one. *"I must have* (the baby) *by my side the whole time and I didn't know how I was ever*

going to let her be apart from me." Interwoven with this irrepressible love was a quiet, unsettling sense of loss – of her past life, of her freedom and a growing awareness of the relentless responsibility and enduring interdependence that motherhood represented. No longer was she a 'person-for-herself'. Since the moment of birth she always had an/other on her mind, already the child was more present to her than she would have considered possible. Temporarily, May's love for her partner had entirely refocused on the baby, *"I wondered whether I could ever love him again or love him as much as I loved* (the baby)." Once her feelings resurfaced their relationship had to be renegotiated to allow for the baby's constant interruptions and demands. What was once sacred was disrupted and there was conflict and resentment as well as gratitude and shared joy. Although May's partner was overjoyed at becoming a father and was very supportive and caring, ultimately his life had not been transformed in the way that May's had been and this contributed to her sense of isolation and seclusion.

The ability to concentrate on anything other than her child caused May to feel both exasperated with herself, and anxious about how she would adapt to her impending return to work. Immersion in her lifeworld was moderated by the constant presence of her infant. There was no time when May could simply 'be' without 'being-with', *"I need something to change – basically it's not going to at the moment...just some time when I'm not having to think about somebody else."* Mundane tasks were half completed as her concentration was diffusive and fragmentary. Always the child, the sweetness and exigency of her existence, required that her mother responded, *"I've got ten*

minutes…and then I've got to focus my attention back to her…you spend all day totally devoted to the baby."

During her pregnancy she was confident that after the birth, life would not alter drastically and she would still be 'May' – confident, organised, poised – only now with a baby. Instead, it was as though her life was no longer familiar and 'comfortable'. It had become precarious, all that was customary had disintegrated and there was chaos and disorganisation *"…it's desperation, it's feeling desperate."* . May felt overwhelmed by the intensity of her experience, by the boundless complexity of maternal love which was compounded by debilitating tiredness and the sense that something infinitely precious had been lost and would not be recovered *"I'd be feeding her and crying because I was so tired…I was a zombie really…I don't know how I'm going to get through the day."* There was no 'space' for May, she could not escape from being a mother whether she was physically present to the baby or not. Although the baby is delightful, time with her could be stultifying, monotonous, lonely - at times a veil of tears that separated her from the reassurance of 'normal life'. *"… having a baby is very isolating and lonely…although you've got someone with you all the time…well I've been desperate at times…I have to have something planned* (to do everyday) *and if I haven't I go round the bend."*

May's physicality was no longer contained – giving birth and then breastfeeding has caused a rupture in the boundary of body/other and the child on her mind was also under her skin. Always receptive and responsive to the baby, she yearned for some reciprocity from the child, *"…when she started smiling that made a huge difference…she just gave*

something back." Her lived experience of time had changed – it was disjointed, rushing by too quickly or paradoxically slowing to an intolerable rate, *"... everything takes so long."* She was marooned in a present that stretched out before her – her past like a dream from another lifetime, her dispossessed self an emblem for the woman she once was and now must mourn, *"I feel I've lost part of me"*. Mother and baby so intertwined that they are like one, *"... it's like you're in a little shell the two of you and you speak to people but they're not actually coming into the shell with you."* This stifling relationship was conversely also one of perfect rhythmic coexistence and this visceral, intuitive connection defined May until she started to 'make space' and acceded to her own particular sense of herself as an embodied mother.

As time passed May tentatively began to assert some control over the intense inner disequilibrium and external upheaval that motherhood represented. May experienced a sense of both sadness and relief at the slow dissolution of the exclusive mother/child dyad. Gradually she disengaged from her need to be the only source of goodness for her baby and was able to 'open up' and allow others to help her, *"I felt as though I was the only one who could cope... I was the only one I trusted... it's only now that I'm letting people in that I can see... "*. Other family members were able to care for the baby, for short periods initially, and May had time for herself, *"I really need time on my own... some space... she's not going to come to any harm, just being able to let go a bit."* She found herself able to speak honestly to those closest to her (*"And people say it's OK to feel like that, it will get better and it does and the next day is OK."*) about how much she had struggled with the **"emotional permeability...expected to be on-call – to**

process reality for the baby, to be the recipient of her infant's unbearable feelings..." (Raphael-Leff 2001, p354). This had left her raw and emotionally dishevelled but now she was beginning to re-order her becoming-a-mother-change-of-body-subjectivity in all its existential dimensions – in other words, to make sense of her world. *"I don't know I'm ever going to get back to being the same person... the intense feelings of caring so much about the baby and my priorities are way different now."* She was able to rediscover humour and to reflect upon the way her life had changed. The baby became more responsive, she smiled at her mother, reacted to her voice and was pacified by her presence and this reinforced May's sense of herself as a mother. This was an organic, ever-evolving process, motherhood was not a unitary experience, it was multi-layered, contradictory and always incomplete. Overall, May's transition was successful – at no point did she suggest she was suffering from PND and all her experiences were transient, albeit profoundly destabilising physically, interpersonally and ontologically.

When May described her experiences to me, she was seeking to encapsulate a fundamental change in her sense of 'being'. She was trying to articulate an experience of co-existence that was ambiguous, diverse, paradoxical, and quixotic. Her cyclical, spiralling style of narration, one could also describe it as a 'forward-back' motion, as with all the women who spoke to me, demonstrated that the **"bodily depth of what one has lived through is "more than words can say". Yet such experiences look for words."** (Todres 1999, p289). In other words, each woman's experience of becoming a mother is held both in the memory, a concept with which we are familiar, but also in the

body which is **"intimately implicated in what things mean in that we live meanings through bodily participation in the world."** (*ibid.*) and as they told their stories to me, they revisited them to ensure their authenticity, to distil as much purity as possible within the constraints of language and conversation.

9.7 Birth as a rite of passage

9.7.1 Introduction

The contribution of cross-cultural analysis to an understanding of the transition to motherhood is often valuable albeit contentious, as claims are sometimes made that fail to take into account the complexities of comparing different traditions and value systems across profoundly different cultures. This section will discuss this issue, focusing particularly on customs that honour and protect the new mother and the way in this may ease her transitional experience.

9.7.2 A 'state of becoming'

Clearly, there is not the space to discuss in detail the extensive anthropological transcultural variation in rituals and taboos that signify the transition to motherhood around the world. The important point is the contention that industrialised nations have all but abandoned any illusion of honouring the newly birthed woman and instead the popular representation of a new mother is a woman who rushes to return to 'normal life' with as little disruption as possible. As Sue commented in my research,

"I think I rather overplayed the getting back to normal bit. I was real proud of myself that we went to the shops on day four and now I think, my God, I probably shouldn't even have left the house for two weeks, at least... "

However, Jane instinctively recognised and acknowledged the rite of passage of motherhood and the way in which this constructed and affirmed her place within her lifeworld

"I think it's part of... the cycle of life... it's like when ... you first start your period or if you first have sex... there's a kind of step you go through and after that you feel differently about things – it's a kind of moment of passage...And the same with motherhood, it brings a lot of things you didn't know about into focus, changes you... "

In many cultures the newborn baby is considered to be in a 'state of becoming' – it is not immediately embodied and there are many traditional customs and ceremonies to entice the baby to remain on earth and not return to the spirits. Likewise, the woman is considered to be caught within the process of becoming a mother – she is in an 'in-between' state of being where she requires special nurturing and protection to assist her in successfully completing her rite of passage from woman to mother (Kitzinger 2000). In developing countries poverty is not necessarily a barrier to the parturient woman entering a period of enforced rest and pampering. She is not required to undertake any household tasks, she is cared for by female friends and relatives and there is often a traditional ceremony to mark her entry back into the social world as a mother. Laderman (quoted in Rice 2000, p31) argues that the postnatal period is the last stage of the rite of passage from woman to mother,

"The postpartum period is the liminal stage in the woman's passage through the rite of childbirth. As in all such transitional stages, the person on the threshold is in an extremely vulnerable position and must be segregated from her community."

Rice enlarges on this quote in her interesting discussion on the behaviour of new mothers amongst the Hmong in Melbourne, Australia. Their seclusion during confinement is attributed to their polluted state and arguments have been heated amongst feminist academics about the oppressive nature of such restrictions. However, the practical benefits are obvious – the women can rest and recover from the birth – something that May, in my research, craved, *"just wanting a little time to recover from the birth and, you know, everything that had happened... "* They are relieved of household duties, are fed a protein rich diet and are not expected to resume sexual relations with their husband for a month. This period of undisturbed seclusion has significant implications for the relationship between the woman and her baby. The new mother can focus exclusively on the infant, unhindered by the need to fulfil any other expectations and this could have particular implications for breastfeeding where the woman would be able to put the baby to her breast without interference or interruption.

In her cross-cultural investigation of childbirth, Jordan (1993) highlighted the way in which there are *no* societies in which birth is treated as a purely physiological event. It is everywhere defined within a social context. She goes on to say

"In most societies, birth and the immediate postpartum period are considered a time of vulnerability for mother and child...in order to deal with this danger and the existential uncertainty associated with birth, people tend to produce a set of internally consistent and mutually dependent practices and beliefs that are designed to manage the physiologically and socially problematic aspects of parturition in a way that makes sense in that particular cultural context."(Jordan 1993, p3).

9.7.3 Tradition, custom and postnatal depression

Aside from the giving of gifts following a birth and advice from health professionals, post-industrial Western society has preserved very few traditions or customs to ease the transition of the woman, her baby and partner into family life. Emphasis is placed on re-establishing normality, on individual independence and promulgating the myth that motherhood is primarily a joyous experience. Recovery from birth is defined as physical recovery and this includes the restoration of mental equilibrium. With this in mind, postnatal care is concerned with recognising and treating physical or mental deviations from normal. Scant attention is paid to the change in women's existential 'being' as they become mothers. In his seminal publication on rites of passage (with particular reference to birth) Van Gennep (1960) argued that social acknowledgement of this critical transition sustained the woman and enabled her to successfully negotiate this rite of passage, **"It is apparent that the physiological return from childbirth is not the primary consideration, but that instead there is a *social return* from childbirth."** (Van Gennep 1960, p45).

Furthermore, this rejection of traditional ceremony is felt *possibly* to be implicated in PND. Stern and Kruckmann (1983) in their anthropological review of PND tentatively concluded that women in pluralistic, post-industrial societies become depressed after giving birth because their transition is unacknowledged and negotiated in isolation. On this point I would add that depression after childbirth would seem to have a multi-factorial aetiology and single-issue solutions might be seen as indicative of a biomedical approach to health disequilibrium that aims to identify a problem and provide effective treatment to return the person to 'normal'. However, they base their conclusion on the theory of **"culture bound syndromes"** (p1036) or **"folk illnesses"** (*ibid.*) by which is meant an illness from which members of a particular group suffer (in this case parturient women) and for which their culture provides aetiology, preventative measures, diagnosis, and treatment. Further discussion proposes that such manifestations originate in **"role helplessness"**(*ibid.*) and that it may represent **"legitimate deviance"** (*ibid.*). Restrictions of space prevent me from discussing this in greater detail but the conception of 'role helplessness', of new mothers stranded between two roles, does resonate both with the first person accounts of the transition to motherhood, and the more theoretical arguments thus far encountered.

However, Stern & Kaufman (1983) are cautious in their analysis and point to the **"confounding of behavioural and experiential (emotional) criteria in the Western conceptualisation of 'depression'** (p1033) which make cross-cultural comparisons difficult. Likewise, ethnographic descriptions tend to be **"trait cluster samples"** (*ibid.*) unclear about sample size, methods of data collection and details about those who took

part in the research. Whilst the reader must consider both sides to this debate, Stem and Kruckmann (1983) make a valuable point in reminding us of the complex interaction between biological and sociocultural factors as contributing to women's responses to motherhood.

A postpartum ritual often referred to in discussions on this topic is the Chinese custom of 'doing the month' (Pillsbury 1978). For a month after birth Chinese women lead a secluded life during which they and the baby are cared for by female relatives. Pillsbury (1978) speculated that this custom may reduce the probability of Chinese women suffering from PND. **"Neither the Chinese translation of the term 'postpartum depression' nor the concept itself makes much sense to the majority of my informants."** (Pillsbury 1978, p18).

Kitzinger (2000) suggests that in the United Kingdom, the 'lying-in' familiar to our grandmother's generation is the last vestige of a period of seclusion for the new mother and her baby. Seel (1986) discussed the issue of unsatisfactory, piecemeal postnatal rituals within the United Kingdom. A flurry of visitors who offer very little in terms of practical assistance, perfunctory visits from health professionals for whom the priority is physical wellbeing, concluding with a visit to the general practitioner at approximately six weeks. As Wilma described,

"...we had loads of visitors which was lovely...everything was lovely those first few days the room was full of cards and presents for him...From suddenly everyone, everybody disappears and you're on your own."

Likewise Sue commented about visitors, *"...I didn't really have anybody that said, can I put the washing on? Let me make you a cup of tea or anything like that, it was just like, here I am, I'm here to be entertained with you and the baby and that was difficult".*

However, women who have regular contact with female family members do draw on their advice, even if it is obtained via telephone or email. This communication may be seen as replacing traditional 'hands-on' support and structured ritual. The women I spoke to held such advice in high esteem and were in regular contact with their mothers in particular. Sue spoke with warmth about her regular telephone conversations,

"...my Mum and sisters (have) *been an enormous help...you can only learn by example and my Mum's a very much 'take everything in your stride'- oh yes, babies have that, don't worry about it and you sort of think, oh that's alright...I ring my Mum every day and I never did that before...but I do now and...I'll tell her what* (the baby) *has done and it's something I do still need to do."*

Seel (1986) argued that the absence of routine, symbolic rituals may relate to the onset of PND because it could be experienced by the woman as representing society's ambivalence about mothering as well as a lack of social support, thus increasing

exhaustion and contributing to the mother's low self-esteem. Seel's (1986) paper raised important issues regarding the socio-economic response of the industrial West to rites of passage. Unfortunately such traditions cannot be administered and managed externally – such customs and celebrations are invariably an ancient complex organic response to a particular event that requires psychological and physical support. Van Gennep (1960) proposed that major change caused both individuals and society to feel anxious and insecure. To compensate for these potentially disorderly effects, the processes of change are often circumscribed by ritual, which reduces the feeling of danger, establishes coherence and imparts meaning. Within this context, Seel's (1986) well-intentioned suggestion that mothers are given a medal and flowers after the birth is simplistic and meaningless.

However, one should be cautious of referring indiscriminately to Van Gennep (1960) as the focus of his research was with pre-literate societies and he was concerned primarily with how societies were maintained rather than the complexities of individual transitions (Littlewood & McHugh 1997). His theory combines three sets of rites – those of separation, transition and finally, incorporation. If this theory is applied to contemporary post-industrial management of childbirth then what is revealed is the dubious nature of our 'rituals' situated as they usually are in doctor's surgeries, antenatal clinics, delivery suites and the postnatal ward (Jones & Dougherty 1994). Whether individual women experience this as helpful or unhelpful may possibly depend on whether they have had a 'good' birth or a 'bad' birth experience. Although some of their descriptions of hospital birth are outdated, the general argument presented by Jones and Dougherty (1994) in

their application of the theory of rites of passage to hospital birth is illuminating in that it reveals the inadequacy of the medical model in facilitating a successful transition to motherhood.

"It is on the postnatal ward that the woman begins to be reincorporated into her network of relationships with other people. She begins to become a mother...After about a week the mother leaves hospital and is physically reincorporated into her home with her baby." (*ibid.* p272).

9.7.4 Contrasting rates of postnatal depression in traditional cultures and the developed world

In his paper discussing the sociocultural aspects of PND, Cox (1988b) reviewed available evidence for the importance of sociocultural explanations for PND and concludes that if **"intrapsychic and biological considerations"** are excluded they will inevitably lack credibility. He goes on to say, **"It is naïve, as well as inaccurate, to conclude that postnatal depression is not found in a non-western society which has more complete postnatal rituals."** (Cox 1988, p79). Huang and Mathers (2001) compared the rates of PND in Taiwanese and British women using the EPDS and a six part questionnaire developed by the researchers. Fifty women from Sheffield and 101 women from Keelung who were at low risk of a problematic labour, birth and postnatal period took part. A majority (72%) of the Taiwanese women confirmed that they had followed almost all of

the dietary restrictions and traditional taboos for the month after birth. However, modernisation and industrialisation in Taiwan have resulted in families becoming more disparate and only three women in this study could rely on help from parents (or in-laws). Some went to private nursing home and others cared for themselves. The prevalence of PND was almost equal: 18% in the Sheffield women and 19% in the women from Keelung. Due to the decline in traditional postnatal rituals it is difficult to draw any firm conclusions from this research. The fragmentation of these rituals might explain similar levels of PND amongst Taiwanese women (compared to the UK) or it may be incidental. The authors suggest that their findings support the view that PND has important biological factors as well as cultural ones.

In his comprehensive review of transcultural perceptions of postnatal mental illness, Kumar (1994) investigated the proposed relationship between social and cultural factors and psychotic and non-psychotic reactions to motherhood. Having reviewed all available studies he concludes that **"somewhat surprisingly, therefore, there are no major differences in rates of postnatal depression in the few cross-cultural comparisons that have so far been reported."** (p256). Similar findings are reported for incidence of postpartum psychosis. Kumar warned against simplistic explanations for high rates of PND in societies where rituals are fragmented and perfunctory and advocated further cross-cultural comparison to provide a more accurate picture of depression after birth.

Anthropological data confirms the fact that such rituals and traditions are declining in the face of technological and medical advances as well as economic necessity and migratory

patterns. However, I would argue that these transitional rites serve to define and regulate the passage from one social status to the next. Transitional rites incorporate notions of separation and loss, transition and finally adaptation, which precipitate re-entry into a newly defined social state. For the majority of the women in my research, their loss was manifold. Most of them experienced a loss of income, indeterminate employment status and described themselves as less physically attractive after giving birth. Their freedom of movement was drastically curtailed, they were less able to achieve adequate sleep patterns and their normal social life dwindled to nothing. But a more recondite loss is that of *themselves*, as a separate being from the child. The women they were had been displaced and their focus had been 'clouded' by the presence of the child. The women described this loss in various ways. Wilma and Chris emphasised how much they missed working, having an income and socialising with other adults at work. Chris (who had returned to work by the time of the interview) was reassured that her return to work safeguarded her pre-motherhood identity, *"When I'm with* (the baby) *I'm her Mum, but when I'm at work I'm myself"*. Although Wilma expressed pleasure at being home with her son, she also felt envious of her husband's participation in the workforce. Sue admitted to craving her new identity but being unsure as to who she is as she is resistant to the idea that she is 'just' a mum – there has to be more to life she explained and gave her husband as an example, *"he's got a job and he's a daddy and a husband and he's alright in all of that lot."*

Using cross-cultural examples of the way in which the transition to motherhood is contextualised and 'buffered' by custom and tradition provides an interesting contrast to

post-industrial Western society but too much reliance on the former to construct a critique of the fragmentary practices of the latter, is simplistic. As this research has demonstrated, mothering is enormously complex and composite and the aetiology of PND is multi-factoral and consistently defies simple explanation. The infiltration of Western ideology and values, socio-economic factors and changing migratory patterns in the developing world have dispersed families, changed women's employment status and constrained their activities after a baby is born, making comparisons even more unreliable. Furthermore, one cannot transpose a tradition that seems to be effective, from one culture to another – customs are not imposed, they are responsive and purposeful. However, a cross-cultural/anthropological approach to the transition to motherhood does merit further discussion. New mothers are undergoing a radical role change for which they repeatedly describe being wholly unprepared, whilst socio-cultural discourse 'glosses over' the social and psychological upheaval and for which conventional postnatal care is often inadequate to address.

10.0 Conclusion

10.1 Intoduction

This study has been an expansive project that has generated a vast amount of information as I have sought to illuminate the journey from woman to mother for the seven women who shared their experiences with me. In this chapter I will review their narrative stories and the way in which the data has caused a 're-framing' of the idea of PND as well as a re-conceptualisation of the way women come to embody mothering. Fundamental to this study was the discovery of the general structure of the phenomenon and the essential constituents and although, at times the discussion has ranged 'further afield', I would argue that one of the advantages of a phenomenological approach is that it opens up unforeseen horizons, prompting the researcher to peel back the layers of the experience and seek a true understanding that is often concealed and defied initial analysis.

This chapter will begin by re-visiting the essential constituents and 'drawing together' the different themes contained therein. The general structure of the phenomenon will be reviewed in light of this and finally an alternative existential understanding of the experience of PND will be proposed.

10.2 Welcoming the intimate stranger

This was the moment that the imagined baby became real. Up until that instant, the women had barely contemplated the way in which the baby would disrupt their existential being and throw their familiar lives into chaos. Although this constituent is

invested with the deepest joy and celebration, already their lives are slipping out of their control - an experience for which none of them were prepared. Traditional customs appear to offer some protection for the women during this intensely vulnerable period, but Western culture emphasises 'getting back to normal' rather than a time of separateness and recovery. The women are thrust into their new role with a startling immediacy, amidst a panoply of 'good mothering' advice. They are perceived by family, friends, health professionals and wider society as changing from women to mothers *as the baby is born*, and there is scant recognition of the pains-taking progress most of the women will make as they gradually come to embody motherhood. Daseinanalysis leads us to consider the way in which the birth of the baby will engender both resistance and acceptance in the woman's disarrayed subjectivity. This 'intimate stranger' disrupts all of the women's existential possibilities and of critical significance is the way in which different women assimilate these changes. Some women (like Jane) embrace all of the 'assaults' on their 'being' – remaining open and expansive in/to the world and greeting new challenges as potentially enriching and restorative. The majority of the other women embodied greater resistance and hostility, seeking to preserve that which was familiar and reassuring whilst struggling to integrate a challenging life-event into their 'being-in-the-world'. The degree to which they successfully assimilate motherhood may come to be circumscribed by pathology and a diagnosis of PND given. However, this constituent embraced all that was wondrous about meeting their child for the first time and whatever followed, the moment of birth was exemplified by complete openness to the child and the potentialities that mothering embodied.

10.3 Anxious loving

Fundamental to mothering and tempering the joy of the birth, is a fear that the baby will disappear (or 'die', although this word was avoided by the women). This 'burden' is insidious in its appearing and tenacious in its influence and was apparent in all the narratives in my research as well as all the qualitative studies on PND discussed above. Convergent with this fear, is the anxiety that they are mothering 'incorrectly'. Cultural constraints and beliefs that mothering is 'natural' and instinctive circumscribe their experiences causing anxiety and loss of confidence that they are deserving of 'good mother' status. The need to have their babies close by signified the way in which the women still nurture a profound connection to their babies – the infants are barely embodied and as such transgress traditional philosophical principles of being and other as absolutely distinct entities. New mothers are unique in so much as their ontological personhood is not bounded but instead is entwined with an/other so that instead of 'looking out into the world' (with openness), their gaze is 'caught' and their 'being' is always alert to danger. The child is initially enfolded within their mother's 'being' and, as is the case with all the constituents, there is an infinite variety of responses to this. A 'successful' assimilation is experienced as an 'opening up' of this profound level of attachment as the baby becomes bigger and the new mother gains confidence in her mothering. Alternatively, such acute anxiety can obstruct the woman's potentialities and threaten to overwhelm her personhood as she experiences a growing helplessness in the face of perceived threats to the baby.

10.4 The baby fills her vision

Following on from the previous constituent, whilst the acute anxiety gradually dissipated, the women remained inextricably bound to their infants. They are always 'bodying forth' mothering, it was inescapable and defining. The women's thoughts constantly returned to their babies and this was entirely unexpected prior to the birth. Every moment of the day and much of the night is caught up with responding to their often inscrutable baby, who remains a mysterious bundle of needs. Moreover, the constant interruptions contribute to their inability to re-establish orderliness and re-assert a feeling of control over their lives.

Being a 'good mother' requires endless patience and forbearance as there is no 'time off' and at any moment the women may be 'wrenched' from an activity to comfort and respond to the immediate needs of their child. Once the baby is born, the women can never be 'without child' or 'not mother'. Even if physically separate from their infants, the child on their mind is as 'present' as if s/he was a child in their arms. For some women this degree of responsibility was embodied with minimal resistance as quintessentially defining of their new role. For the majority, it was experienced as variations of bewildering, boring, frustrating and even intolerable and this ambivalence is implied and explicit in the narratives from my study and in those of women identified as having PND. They are struggling with the same challenges and yet one group of women will conceptualise it as normative (albeit difficult) and others as a sign that they may be suffering from an 'illness'.

10.5 Exhaustion, recovery and the physical body

The debilitating tiredness experienced by new mothers was a familiar theme in all the studies discussed. It appears to be fundamental to caring for a new baby and is exacerbated by the way in which women are expected to 'return to normal life' as soon as possible. Not for women in the West a time of 'enforced' seclusion where they can gently recover and rest with the baby, unhindered by the requirements of running a home. As I have already made clear, traditional postnatal customs are controversial, linked as they often are to beliefs about female 'pollution'. However, if adhered to, the women do appear to benefit from a period of recovery which was denied to the women in my study.

The tiredness and physical sequelae of giving birth bring the body to the forefront of the women's consciousness. The women were acutely aware of bodily discomfort and this, along with the tiredness, clouded their 'clear and open understanding' and restricted all existential possibilities – to the point where they sometimes felt disengaged from everything but the baby, barely 'existing' through a fog of exhaustion. Time is reconceptualised as being 'stolen', they do not have any time to recover and sleep properly. When they do fall asleep, the baby often wrenches them awake prematurely, so compounding their distress and exhaustion. It would not be an over statement to describe new mothers as *embodying* tiredness and whilst it is undoubtedly debilitating, it is not abnormal and I would suggest, is not indicative of pathology.

10.6 Relationships: re-evaluation and conflict

Embodied mothering required so much from the women that they often describe being unable to respond to their partners – at least initially. They are both irritated by their presence and reliant upon their support. Their relationship often becomes discordant and partners are perceived as being ignorant of the dis-equilibrium that the women are experiencing as they (the women) struggle with feeling that life has fallen out of their control and they are unable to accomplish even the most prosaic tasks. The baby appeared to threaten the 'coexistence' of the women and their partners as the women were utterly absorbed by their babies. However, this seemed to be counterbalanced by the new parent's shared pleasure in their babies, as gradually the women 'reconstruct' their relationships with varying degrees of success. This re-framing of the parent's relationship is fundamental to the transition to motherhood and such an acute 'falling away' of the women's affections was almost always temporary whilst she integrated the child's needs and her partner's needs into her new mothering role. Again, this 'turning away' from partners is described in all postnatal narratives and should be considered normative and to be expected, rather than disastrous.

10.7 Isolation, ambivalence and tears

It was rare to find a narrative that presented a seamless journey from woman to mother where the child was encountered with complete openness and receptivity thereby ensuring that the woman was immediately attuned to the existential possibility of 'a great love to be fulfilled'. Apart from possibly Jane, all of the women described many moments of resentment, ambivalence, deep distress, irritation, isolation and hostility.

Their lives had 'fallen apart', nothing was recognisable and efforts to re-establish order were constantly defeated. Their existential possibilities were profoundly disrupted and chaos surrounded them. They were lonely and the cries of a fractious baby were at times unbearable. This was compounded by feelings of guilt and failure – that rather than experiencing profound satisfaction they were struggling to *escape* from being mothers, their expectations disappointed. There was no time to mourn what had been lost and no time to recover a sense of coherence and stability. However, one would expect such a challenging life event to cause, at times acute distress and resentment. Indeed I would go so far as to argue that it would be unusual for women *not* to experience these emotions, and this is born out by countless studies and accounts of this period; women *do* struggle, it is normal and not indicative of an unusually problematic transition. As with all these constituents, describing the women's experiences as normal does not imply that they do not require both practical and psychological support. What is implied is that pathologising the transition is counter-productive as all mothers are required to negotiate similar challenges.

10.8 Acceptance: from crisis to comprehension

Gradually the women came to embody mothering – a hesitant progression that required compromise, reconciliation and acceptance and saw the intricate conjoining that had come to symbolise complete immersion in mothering, 'open up' to other possibilities. The women were able to locate themselves within the process and re-establish a feeling of control over their lives. Their past lives were indeed past and new horizons were opening up that required a fundamental change-of-body-subjectivity in all existential

dimensions of being. Although most of the women struggled with what they experienced as the ambiguous nature of their new role and sought to establish order in their disordered, discordant lifeworlds, this assimilation was aided by a realisation that they were becoming more attuned to mothering and their babies were less perplexing. There was often a move away from reliance on experts to 'authorise' their mothering skills and instead a greater reliance on their growing expertise.

It is as though there is a weaving together of the multi-faceted aspects of being-with a new baby and out of this 'jumble' of experiences, a coherent pattern emerged within which the women are more embodied and more able to realise their existential possibilities. Critically, their babies become more rewarding and responsive – although much has been surrendered and lost, time spent with the baby ('babytime) is less of a 'chore' and more of a pleasure. This embodying was achieved with varying degrees of success and involved different strategies and procedures for the different women. Some of them struggled particularly with one constituent rather than all of them and rarely, the transition was unproblematic in all its dimensions. All of the women were profoundly changed in all their existential dimensions by the process of coming to embody mothering.

Although the narratives from women diagnosed with PND are often bereft of any descriptions of regaining control of their lives or of starting to enjoy motherhood, it is possible that their narratives are limited by the focus of the research or that they have not yet reached a point when life is beginning to 'embrace' orderliness. However, as with the

women in my study, not all women established an unambiguous relationship with their mothering role. Much that had been lost (freedom, spontaneity, a sense of self as a separate being) was keenly felt and mourned for and ultimately these women had to compromise their expectations, seek practical solutions to mitigate their frustration and, over time, come to a sense of themselves as embodied mothers.

10.9 The general structure

The general structure provided a thread of commonality that was woven through the experiences of the women who shared their stories of early mothering with me. Mothering required that they restructured their manner of being in the world. There is no aspect of life that remained unchanged and although this may be negotiated with ease, there is an acute 'falling away' of all that has been familiar and for most women this propels them into a chaotic, inchoate period of 'being'. The women's mind-fullness and sense of co-existential responsiveness is unique to this period and is greeted with differing degrees of acquiescence and resistance as the women accede to the reality of the their own unique mothering experience. The narratives have demonstrated their faltering re-emergence as mothers. They are always 'bodying-forth' mothering and this is now fundamental to their 'becoming-a-mother-change-of-body-subjectivity'.

10.10 An alternative understanding of PND

Throughout this thesis evidence has been presented suggesting that PND represents a particular discourse within which the transition to motherhood is understood. Implicit in this discourse is the belief that women can succeed or fail in becoming mothers and

numerous assessment scales have been developed and tested to identify the women who are failing in their new role so that (in principle at least) support and treatment can be offered. At this point I wish to make it clear that I am not seeking to malign or undermine medical or psychiatric treatments, merely to suggest that in all but the most severe cases of clinical depression/psychosis, they may be short-sighted interventions that fail to consider the unique complexity of the individual women's lives. Becoming a mother is a transition that compels women to make radical adjustments to every aspect of their manner of 'being-in-the-world'. It would be extraordinary if this did *not* cause significant levels of distress, dis-equilibrium and a sense of chaotic disorganisation. All of the women in my study and in the other studies discussed, demonstrated varying degrees of resistance and acceptance to becoming mothers. Classifying some of these women as suffering from PND seems fairly futile. What I am proposing is that PND is re-conceptualised as a manifestation of the challenges that women confront when becoming mothers.

10.11 Implications for practice and further study

The expectation that motherhood provides women with all that they need to feel completely fulfilled, needs to be abandoned. It serves only to compound new mothers' feelings of having failed to achieve what they assume every other mother but themselves has successfully accomplished. Women (and their partners) need to be much better prepared for the unique challenges that will confront them as soon as the baby is born. The predicament confronting all those involved in caring for and educating women

during their pregnancies and in the early weeks of motherhood is how to disseminate this information in a way that is integrated, accessible and constructive.

My professional experience suggests that antenatal clinics are 'awash' with information leaflets and I would suggest that adding further to the selection available would have minimal impact. A more interactive approach might be more effective, such as antenatal education groups. However, there are limitations with such classes: both within the NHS and private sector it is generally acknowledged that only a proportion of women attend and these tend to be a self-selecting group comprising predominantly middle-class white professionals rather than a wider spectrum of expectant parents. Furthermore, even with higher rates of attendance there is considerable anecdotal evidence that expectant parents are unable to 'see' further than labour and birth and give little thought to the tremendous changes about to occur in their lives (Evans 2001). Consequently, providers of antenatal classes might be sceptical as to the value of lengthy discussions about the potential problems of adapting to life with a new baby. Pregnant women and their partners might also feel less inclined to attend the session on 'life with a baby', having ensured they were present for discussions on labour and birth.

The efficacy of antenatal classes in reducing levels of postnatal distress requires further evaluation as results from studies are inconclusive, with some interventions seeming to reduce rates of PND and other studies showing no improvement in outcome (Parr 1998, Brugha *et al.* 2000, Hayes *et al.* 2001, Zlotnick *et al.* 2001). A further problem with evaluating the success of antenatal interventions is that PND rates are measured to

indicate success or failure rather than a more comprehensive evaluation of the way in which new mothers adapt to life with a baby. Studies such as these fail to question the fundamental belief that postnatal distress is indicative of an abnormal reaction to motherhood rather than an appropriate response to a life-changing event.

Postnatal interventions such as those established and recommended by Milgrom and colleagues (2003) (discussed above) and The Tamworth Postnatal Depression Support Group (Gutteridge 2002) which facilitates group support for women suffering from PND using psychotherapeutic techniques over an eight week period, seem to be providing some new mothers with an opportunity to articulate and re-order their experiences in a 'safe' environment. Endorsements from women who have attended one or other of these groups suggested that a high level of satisfaction, support and reassurance was experienced by them. Improvements in the women's EPDS score after a period of attendance were taken to be further indicators of success. However, this is problematic as such screening restricts access to these facilities, as only women who have been screened as being 'at risk' of suffering from PND are referred to these services.

Likewise, I have had personal experience of informal postnatal groups, facilitated by a group practice of midwives based in a deprived area of South London. These were very well attended by women from diverse cultural, ethnic and economic backgrounds and provided an opportunity for all new mothers in the area to come together and discuss any aspect of mothering that was causing them concern. Testament to the popularity of these groups was the fact that some of the women came with babies that were over a year old!

If centres of this calibre, whether offering formal programmes of support or informal support and advice could be available to *all* postnatal women, possibly on a self-referral or 'drop-in' basis, then a potentially problematic transition might seem to be less abnormal both for the woman, her family and primary care providers. However, there are obvious problems of funding, location and self-selection. The issue of self-selection would have to be addressed and attendance could possibly be improved if women received a 'personal' invitation to attend from their midwife or health visitor. Specific sessions could be provided for young mothers for example. The venue would have to be accessible and attractive and ideally purpose built.

Whilst cultural perceptions of motherhood prevail, many women will feel ashamed at their struggle to adapt 'successfully' to motherhood. And herein lies the core of the problem of improving women's experience of early mothering. Primary care providers cannot deconstruct cultural paradigms without broader, more populist dissemination such as through television, popular magazines, radio and the internet. Changing the way in which early mothering is perceived is an enormous task and not one that can be achieved by midwives alone. However, further research into the way in which more realistic expectations could be engendered in pregnant women and their partners is vital. This could involve the development of a programme for midwives, health visitors and students to increase awareness of the way in which women adapt to mothering, moving away from a focus on PND and instead introducing a more holistic framework within which

midwives can provide postnatal care that acknowledges and responds to the dramatic changes negotiated by all women when they become mothers.

Appendix one

Information Sheet for Prospective Interviewees

Experiencing the Transition to Motherhood- information sheet

- The purpose of this study is to learn more about what is like to go through the transition to motherhood. In other words, what it is like to become a mother.
- 7-10 women, over the age of eighteen, who have given birth to their first baby, will be interviewed for the research, approximately four to six months after the birth.
- The study is being organised and carried out by myself, Jo Hartley. I am a registered midwife working at Exeter Hospital. The research will take 3-4 years and completion should be in 2003. I have been awarded a research grant from the Hospital Savings Association to cover my fees. My supervisors are Prof. Jo Alexander (a lecturer in midwifery) and Dr Les Todres (an expert in my chosen research method) - both based at Bournemouth University.
- You will need to take part in one interview during which I will ask you to tell me, in as much detail as possible, what it was like to become a mother. I will start by saying "Please tell me everything you can about what is it like to become a mother". The interview will be conducted in a place of your choosing. However, to encourage you to talk to me as freely as possible, I would prefer you to be alone, although obviously you will be most welcome to bring your new baby.
- The interviews will then be typed out (transcribed) by me and analysed. This involves carefully looking for themes, ideas and concepts that are relevant to the research. Finally a detailed description of the experience of the transition to motherhood will be produced. I will offer you the opportunity to read the transcribed interview so that you can remove any comments that, on reflection you do not wish to be included.
- The study will improve midwives' and doctors' understanding of how demanding it is to become a mother. With a more realistic understanding we can improve the care we provide and respond more effectively to the needs that mothers have. On a personal level, I hope you will enjoy talking about this very special time in your life and will find the interview to be positive, useful and fun.
- Very occasionally you might find certain memories distressing. If this happens the interview will be stopped at your request and follow-up care or a referral to a doctor or counsellor could be arranged, at your request.
- The tape on which the interview is recorded will be allocated a number. Any references to you will be by that number and, in the written report I will give you a

false name (pseudonym) if I quote your words directly. Any features that might identify you will also be changed. All personal details will be securely stored in a locked drawer to which only I have access and the tapes will be destroyed at the end of the research. I am not planning to look at your maternity or medical records for this research.

- Once completed, my research will be available in the form of my doctoral thesis and probably in selected professional journals. I will contact you following completion and offer you the opportunity to read my final research report.

- If taking part in this study harms you, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for legal action. Regardless of this, if you have any cause to complain about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms are available to you.

- Permission to carry out this research has been obtained from the Local Research Ethics Committee. They can be contacted on 01305 254645.

- Should you have any further questions, please feel free to contact Jo Hartley on 01297 443673 or Prof. Jo Alexander on 01202 504360.

- Consumers for Ethics in Research (CERES) publish a leaflet entitled "Medical Research and You". This leaflet gives more information about medical research and looks at some questions you may want to ask. A copy may be obtained from CERES, PO Box 1365, London, N16 OBW.

Thank you very much for taking the time to read this information.

Appendix two

Stage two - Interview with May – meaning units

This is the complete interview with May, divided into meaning units. Nothing that she said has been omitted or changed at this point.

1. I didn't feel, although when I was pregnant I felt very close to the unborn baby I didn't actually feel as though I was a mother, which was quite strange really. I quite enjoyed being pregnant, I enjoyed the feeling of the baby inside me but didn't actually – and I was bonding to it but didn't feel like a mother.
2. The same really when I was going through my labour as well. I found labour an absolutely magnificent experience and it was quite exciting to know that a baby was going to be born at the end of it but I had no idea what I was going to feel when she was born.
3. The labour was very painful and I remember, my Mum was there through the labour and she was saying to me, just to get through each contraction, she was saying, "Just think what's going to be at the end of it, a beautiful baby"" and that just, at that point I couldn't care less really.
4. When it came to actually pushing I would say that's when I started, I started to feel my God, this is really happening and the moment I saw my baby I felt like I was a mother, the minute I saw her, I just fell in love with her straight away, absolutely immediate, the most incredible experience.
5. I held her, I mean she was passed to me very quickly, she was well and I was well so she wasn't actually taken away from me at all. I held her and looked at her and it was just so overwhelming the feeling of love for some little person I'd just met
6. and it was lovely because my Mum and J were there and they had some time to hold her and things and then they both went home and that night in hospital was absolutely incredible, I spent the whole night looking at her.
7. I was so high but also very, very calm about everything which for me, I'm normally quite an anxious person who gets quite, kind of neurotic about things and to have a new baby I thought, if I'd imagined what it'd be like I'd have thought I'd have been

worrying about everything and be in quite a state and I hate hospitals and I thought I'd be panicking about that. I was *so* calm and I just felt completely peaceful about everything.

8. E slept on and off throughout the night, she'd wake up and cry and then go back to sleep and (pause) I just couldn't believe what I'd produced.
9. For the first, while I was in hospital probably for the first three or four days I had an intense calmness about me which everybody was aware of and I guess, probably looking back part of that was some shock after giving birth and the trauma of that but also it just felt so right to have my baby with me.
10. I think what I found to be really significant was that protection instinct that was there from the word go and it became really apparent when we came home.
11. I was really keen to come home; I stayed in hospital for two nights and when we came home, although our house it quite small I felt like it was huge. I got really upset and thought I must have E by my side the whole time and I didn't know how I was ever going to let her be apart from me. I didn't want her upstairs; I didn't want her in the kitchen I wanted her with me all the time, like we'd been in hospital really.
12. That obviously started to subside after being home for a bit and getting used to it but still, that protection instinct is still so huge and that is something I've never experienced before, about anybody. It's incredible and it grows, it's growing day by day as she's getting bigger
13. and the other thing, when I first came out of hospital was that I didn't want her to get any bigger, I didn't want her to grow. I didn't want her - I wanted her - I think it was the feeling of her needing me, she needed me 100% and I didn't ever want that to change – it was really, really odd
14. and that's something, I still feel that now but I wouldn't want her to be that little baby again, so that's weird because, I don't want her to grow up, I don't want her to get older, I don't want her to become independent and yet, I actually like the way she sleeps through the night now more or less, my Dad taking her off for an hour now, I like that. I suppose it's just something that changes as she gets older.
15. And what were the first few days like when you were home? It was like, the only way I can explain it, at the time I remember talking to my Mum about it, I felt homesick

and I said to Mum, I've got that feeling in my tummy like a homesick feeling and it was where, I really loved my baby but it was just dawning on me I've got her forever and that she was going to be with me twenty-four hours a day, seven days a week for a long, long time

16. and I suppose there was a part of me, a little part of me that was worrying how I was going to cope with that and just wanting a little time to recover from the birth and, you know, everything that had happened and so, I just felt homesick, which was really odd.
17. I didn't experience feelings – I wasn't worried about how I was looking after her, I suppose I've got some experience of looking after children in the past and that kind of helped really and I had J with me as well so I could share any anxieties.
18. The biggest anxiety was her dying at night. I've still got that now. When she was asleep, I just wanted to watch her, make sure she was still breathing and I still have that feeling now when I put her to bed I have to really force – because she sleeps in her own room now and I have to force myself to leave and not keep going in and checking her. That was my biggest anxiety
19. and also worrying about whether she was happy because she cried so much as a new baby, and didn't smile obviously and so I didn't ever know whether she was happy and that was a big thing for me. I was worried that she, I suppose adults you associate crying with being unhappy, whereas with a baby she's cry to communicate but when you're there looking after her and she's crying all day long I just. I was really worried that she was miserable, that I wasn't getting it right – so that was a big worry.
20. I wouldn't particularly say that I had many anxieties. I think what, my relationship with J as well, when I first came home from hospital, J has been fantastic with her from the word go, he's been very confident so in that respect he's been brilliant
21. but those first few days, it was almost like I'd stopped loving him and I wondered whether I could ever love him again or love him as much as I loved E and that really worried me. Those first few days I just wanted to be with E and hold her and wrap her up and protect her and love her and it was *intense* that love and I couldn't love J as well those first few days and didn't know how I was going to, but then that love for J obviously came back when I kind of got over the initial intense feelings for the baby.

22. I suppose having E, I wasn't prepared for the fact that we wouldn't be able to sit down and have a meal and talk at dinner and when we went to bed we wouldn't be able to cuddle up and chat because we're too tired and so that has had a huge impact on our relationship.
23. It's very positive because she's a joint enterprise really and we're both working so hard to make her happy and do everything for her and work together. We don't argue as much as we did, so it's been really positive in that respect
24. but it worries me that, oh, it doesn't worry me but we used to always, mealtimes were always really important thing for us both where we'd talk about anything and it was a really close time, special – we're starting to get that back a bit now but those first few weeks we didn't sit down and eat together because you could guarantee every time we got a meal prepared E wanted to be fed or she cried, every time – absolutely incredible, every time so that was quite difficult because there were things we needed to talk about and we just weren't able to do it and
25. in bed as well we used to cuddle up and have a chat every night before we went to sleep. Whereas I mean, quite often initially we'd sleep separately, one of us would have the baby.
26. That's the other thing, I couldn't sleep in the same room as E and because she was a really noisy sleeper, grunting, groaning, snorting and I, literally as soon as she made a noise I'd be awake thinking she was going to wake up and want to be fed and the only way I could get any sleep was if J took the responsibility of looking after her so I knew she was safe and he could sleep through those grunts and groans and so on.
27. So quite often I came down to sleep on the settee but for me it was quite odd really, I know she was safe, I knew that he'd hear her if she was in trouble or needed something that I used to put earplugs in down here and that used to make me feel ever so guilty. All the other mums that I knew were having their babies in bed with them, sleeping with them, with the cot next to the bed and I just couldn't do it
28. and in fact it got to the point where I thought, I suppose it was quite significant really that I had to put J and I before E and we put E in her own room at about four weeks which I felt terribly guilty about too. Why did you feel guilty? Well, because of the risks of cot death and I read that you shouldn't put them in their own room before six

months and I felt guilty that I was putting me and J before E and I felt guilty that I should, I just felt that I should be having her with me all the time but recognising that it just wasn't healthy to do that as we just weren't getting any sleep so she went into her bed at four weeks, a cot in her own room.

29. I'm normally a really organised person, quick thinking, I like to plan things and well, since the baby's been born basically I'm forgetful, I'm late for everything. I can't do things in sequence, which is just not me at all, I feel like part of my brain is not working and umm, that I'm finding a real struggle.
30. I mean while I was pregnant I was a bit like that but now, things like writing Christmas cards, I can't do, I can't work out how to write them logically, I'm literally, I'm writing half a card, or for example I wrote the envelope to a card and put a card that I hadn't written in, sealed it in the envelope, posted it off, I mean (much shared laughter). And things like, I've forgotten, if I'm writing to a family I've forgotten one of the children's names and I can't think of one of these child's names so I've written, left a space and having to remember that I've got to fill that space and daft things like that. Cooking a meal, I can't do things logically and that's so different for me. I mean,
31. I had a career before that involved being very organised and astute and I just feel like all that's gone out the window at the moment.
32. If I've got to do anything for the baby then I can focus on what I'm doing and I can do three or four things at once and that's fine, if it's about E I can do it but anything else and that's really hard to cope with
33. and I don't know how, I'm worried that I'm not going to get back to how I was and I don't know how I'm going to cope if I, when I go back to work because I just can't think straight – I don't know if it's where I'm not sleeping and I'm still really tired but the forgetfulness it's just, it's because I think it's just where I'm focused on E all the time
34. and if I'm trying to write Christmas cards she, I've got ten minutes while she'll sit and watch me, or she'll play and then she wants bed or, then I've got to focus my attention back to her – I presume that's what it is really but that's quite tough.

35. **And did you assume you would just be how you were but with a baby?** Yes, absolutely, I thought once I wasn't pregnant anymore I really did think, well where I used to look after children years ago I just thought it would be like that but I was detached then, that's the difference whereas now I'm not, I'm totally involved with her
36. and I think the other thing I hadn't planned for was how I'd lose all of my freedom. I think that will gradually come back but I hadn't planned for that at all.
37. The biggest thing I think is where you spend all day totally devoted to the baby, you don't get time to sit down for a cup of coffee or to watch TV or to read or to talk on the phone or whatever and by the evening you're exhausted and you just want to have a few, or just sit down and relax or go to bed and sleep through the night and that doesn't happen and that, that's the hardest thing for me,
38. I can do it all day but by the evening I'm shattered and I just need to go to bed and when she's – I go to bed and she wakes up five minutes later, it's *so* tough and that I hadn't thought about, hadn't even thought about it and the other thing that I hadn't considered was that I knew I'd have to get up in the night and feed her but I hadn't realised how many times and I didn't realise how long it would take
39. and you know you can read in all the books and talk to other mums but nothing prepares you for that does it
40. and I mean, I thought I'd be able to feed her in five minutes I just had not realised it could take an hour and when she was first born I didn't know about swopping sides when I was breastfeeding and she was latched on to one side for *two* hours in the night - oh dear...
41. When I was first, the first few weeks, the first two weeks when J was at home and wasn't working it was lovely because I couldn't wait for her to wake up because I just wanted to be with her and see her and talk to her and cuddle her. When J, and so I would be, I enjoyed feeding her and enjoyed everything about it.
42. When J went back to work so he was less willing to help wind her or go and get her I found that then really difficult
43. I think by then the tiredness had reached, well at the time I thought it had reached its peak at two weeks after she was born, I found that really hard, sometimes I'd cry, I'd

be feeding her and crying because I was so tired and I couldn't believe she just still, she wanted to feed and feed then she'd go back to bed for an hour then she'd wake again and want to feed and that, I just felt like I was a zombie really and looking back I don't know how I got through that stage and then, well I did,

44. but then at six weeks was another peak, it was worse then at two weeks really because she was still wanting to, she was not feeding for as long but she was feeding every two hours through the night and that was so hard.
45. I used to, I always fed her in bed, so that's the thing I had the duvet round me and J next to me and that made me feel quite secure to have J next to me although he was sleeping it was nice to have the warmth of his body there.
46. When he stays away sometimes, when he's not here, that I find so lonely. Feeding her in the night I absolutely hate it when he's not here. Because I'm so aware of the darkness and the quietness and also I feel like I'm the only person doing that and also it really helps to think that there's hundreds of other mums out there doing exactly the same thing
47. but it is so isolating and I think having a baby is very isolating and lonely at times. I mean, although you've got someone with you all the time, it can be just so, well I've been desperate at times
48. and I find that I have to go out everyday, I have to have something planned and if I haven't I go round the bend and she does to. I find that she doesn't sleep very well in the day unless we go out and she falls off asleep and that gives me a bit of space while she's sleeping,
49. but I didn't realise how lonely it would be, even though I've got friends who've got babies and my antenatal group was fantastic and we've all kept in touch and meet up frequently, but it's still, it's still very lonely.
50. Having a baby who can't talk, who's just totally taking really. I think, when she started smiling that made a huge difference, it really did because she just gave something back.
51. But nothing prepares you for that does it and that was significant for me. Read it, talk to people about it, but you don't take it in, you can't, you can't imagine what it's like having a baby

52. and I think that's the same with J as well, J can't understand because for J he comes back from work and he cuddles her and she's lovely and she smiles at him and he does, he dips in really. He'll give her a bottle of milk or he'll bath her, whatever, but he's never, he hasn't got her all the time, he hasn't got the responsibility. He doesn't wake up in the night, doesn't hear her crying and I'm so tuned in to her.
53. I mean the other week, I was trying, I was expressing milk and collecting it so I could get one feed, I was expressing it and freezing it and I had about four ice-cubes of it and I left J with her crying one day. I'd just got to the point where I couldn't cope anymore, I just needed him to see what it like to have a baby you couldn't pacify and I said she doesn't need to be fed J, she's just crying, I don't know why she's crying but I'm just going to the supermarket and I'll be back in an hour, whatever
54. and I left her and I didn't feel guilty. It had really got to that point when I couldn't cope and I wanted J to realise what it's like to not be able to settle her and I knew he couldn't settle her because she wasn't taking milk out of a bottle at that point and I was the only one who could feed her.
55. And I got home expecting her to be crying and him tearing his hair out and he'd defrosted this milk and fed it to her! And I was *so furious*, I absolutely, I lost my temper big time with him, at the time because for me that was my milk, it was precious, it had taken so much to collect and I wanted to be part of seeing her, helping her take this from a bottle, I wanted to say when she was going to do that.
56. When I look back on it, the biggest thing was that he's been able to settle her, stopped her crying and that wasn't the point, the point was I wanted him to realise what it was like to have a baby that you just, you know you bounce around, you push it in the pushchair, you try everything to stop it crying and he did, so it didn't work.
57. It was the feeling. J couldn't understand why I got so upset, I was crying, it was my special milk, he couldn't understand, he thought he'd used his initiative and I felt really guilty afterwards because everyone said "Oh, you know you're awful to have been so upset because he used his initiative and that's brilliant" but that wasn't the point for me.
58. **Can you tell me a bit more about the isolation that you mentioned?** It's weird that, I don't normally have the television on. Before she was born I was quite happy

to listen to music. I now have the TV on most of the day and I'm sure that's because I feel so on my own when I'm here. I like to have the television on so I can see people. Having a radio on doesn't help because I want to see people, which is really strange.

59. I think, maybe it's because I feel like I've lost part of me. Because I'm giving so much to another person who can't give anything back to you, I think that's what makes me feel so lonely. Doing everything I can for her, giving her so much love and attention, so much from me I'm giving to her and she can't do that back and I feel I need something back, so I think that's partly while I feel so lonely.
60. I don't feel so lonely, I think if I'm at home all day that's when it's very isolating and less so now, I think I felt more isolated when she was younger and I think it's even, like to go round the shops it's like you're in a little shell the two of you and that you speak to people out the shops but they're not actually coming in the shell with you – that's how, it's almost like the two of you and no one can get in to that, and that's why it's lonely –
61. so even this, because certainly those first few weeks, even though there were people here and J was here and I was going out seeing people, no-one could get into that and maybe now she's getting a little bit older, I'm gradually letting people in to that shell, so I'm feeling less lonely. For example my Dad's been able to take her or J does more with her or, yeah, yeah I think that's right...
62. **So, is the "letting in" literally letting someone else do something with (the baby)?** No, no it's an emotional thing, it's me, I'm, well because, maybe it's where I was breastfeeding but it was just me and the baby and I didn't want to let, well it, I couldn't let anybody into that to help me, to talk to me, it was an emotional thing, psychological.
63. I felt as though I was the only one who could cope, who could look after her, I was the only one I trusted, I was the only one who could comfort her and to a big extent that's still the same really and yeah...but you don't, you can't recognise that when you're in it. It's only now that I'm letting people in that I can see but I hadn't thought, until talking to you now I hadn't though about it like that either.
64. **How do you let people in?** By being able to recognise the feeling, to be able to say I'm feeling really down, or I really need some company or I really need to go out on

my own, I really need some space. It's being able to let, being able to acknowledge that I'm not superwoman and she's not going to come to any harm, just being able to let go a bit, to let people in is letting go a little bit and just realising that she'll be OK and if she cries for half an hour with somebody else, at the end of the day it doesn't matter, although it breaks my heart (laughs)

65. but I can let her go now a little bit so I think that's how I'm letting people in, by letting people physically do things but also by telling people how I'm feeling.
66. **How did you move from wanting her to be with you all the time when you first came home to being able to being apart from her?** I don't know, I don't know how – it wasn't something I was aware that I actually did, it was a gradual thing. It was so intense that feeling when I got home, of the house being too big. I just burst into tears. I said to J, I don't want her away from me.
67. I don't remember the time that it was OK for her to be away from me, it was probably sheer desperation I suppose when I needed to have an hours sleep and I couldn't sleep with her, it was probably then. I don't really, I don't remember when it became OK for her to be away from me – no.
68. It was so intense though, that feeling, almost wanting to be back in hospital with her right next to me, it was lovely because there wasn't anywhere for her to go.
69. And the midwives, I couldn't understand why the midwives kept offering to take her away for a bit in the night. There was absolutely no way I was letting her go anywhere. You know, ***no way*** would I let someone take her away from me and I can't understand how someone would do that.
70. **How different is your life, now that you have a baby?** First of all how I've changed and how I've stayed the same. It's been really important, right from when she was first born, I've put my makeup on and got dressed – or even if I didn't get dressed I still put some makeup on and did my hair because that was so – I had to keep part of me the same and you know even now when we're running late or we've got to go somewhere or she's having a bad day, I'll still get myself ready for the day. So that's been persistent really.

71. As far as me being different with like the forgetfulness and not being able to do things in sequence, I don't know if I'm ever going to get back to being the same person. I think, it infuriates me so it does matter, that bit,

72. but I think the intense feelings of caring so much about the baby and my priorities are way different now and that won't change, I know that won't change and that's something,

73. maybe that was part of the homesick feeling that I had because it was almost like I knew that I'd lost some of my freedom and that my priorities had changed and I knew that I'd never get that back again.

74. For example I used to be really into horse riding; now I'm not going to stop horse riding but I don't feel that same when I'm riding, in the back of my mind I'm thinking if I fall off and hurt myself, you know, what is that going to do to E, how am I going to manage and that's there all the time, ***she's*** there all the time in my mind, so that's a massive change.

75. And it's the same with my work, going back to work. My job, I've got potentially violent situations all the time at work and you know, E's there in my mind and I'm thinking, can I do that, can I go back to that, can I put myself at risk because of my baby? So that's, there are some things that have changed that won't ever be the same again.

76. I think once I'm not so tired I'll be able to get back to my old self with cooking meals and thinking straight, I think a large part of that is excessive tiredness. It's just been ongoing for months and months, I think I'll be able to get back to normal in that respect.

77. **Did you expect to feel so tired?** No, no I never realised, and I didn't think, I mean before I used to have nine hours sleep, needed nine hours sleep and if I get five hours sleep now it's brilliant and I didn't think that – if someone had told me that I'd have four months because I didn't sleep before much before she was born either so if someone had said I'd have four months of disruptive sleep every night I wouldn't have thought I'd cope but yeah, the way my priorities have changed is incredibly really.

78. I didn't realise how intense my feelings would be about her and that's, that's, I think I said before I think that's almost getting bigger, it's not something that's going to go away and, you know, it's quite scary.

79. The thought of having to go back to work and leaving her with someone else is daunting, I don't how I'm going to do that, I really don't. And I don't know how it's going to change me at work, that's something I imagine I shall be quite different at work and I should think that the way I approach my work is quite different too.

80. I suppose the other things that's different is not being able to do anything impulsively, not being able to nip out, not being able to, if I've forgotten something at the shops not being able to rush back to the shops, I mean everything takes so long and that's something that I've found really hard

81. and also that J's able to stay away, he's able to catch up on sleep, he's able to go out with friends, drink, stay in a hotel and I kind of resent that because I can't do that - I don't know if I'd want to but I'd like to have the opportunity (laughs). It's caused us a few problems that he's done that since she's been born, 'cos I haven't been able to, even just for a couple of hours, she's on my mind all the time and he can shut off from that.

82. I've been really lucky with my Mum and Dad, because they live locally, they've been fantastic really, they let me to have a break for ten minutes if I've needed it, they've come over when I've been, if I've been upset or feeling like I can't cope, or needed to sleep, they've been there, they've been fantastic and I mean it's so difficult because my Mum particularly tries to offer advice, she always seems to think E, there's something wrong with E, every time she sees E, because E cries if she's being held by my Mum or my Dad for some reason, I don't quite know why she does that, they think that there's something wrong with her. Everyone seems really keen to tell me she's got tummy ache, which really irritates me. I've also got my Grandparents who live fairly locally and I've used them when I've been feeling lonely and needed to get out of the house then I've gone there and that's been fantastic.

83. I also found that the professional support was excellent, the midwives and the health visitors and I felt quite, I was relieved when the midwives stopped visiting everyday and the health visitor started visiting once a week but I'd have liked to come, she only

visited for five weeks and I'd have liked that to be extended because I found that very reassuring to have her come here and that surprises me really because a lot of things I was asking her I knew the answers to but it was about reassurance. That was quite strange really.

84. I found, also there was one occasion where E wasn't very well, she had a temperature, it was a cold but I was absolutely paranoid that it was meningitis because she had quite a high temperature and I took her to the doctor and I thought I was treated really badly. The fact that I was a new mum, she was only six weeks old, she's just had her six weeks check, and the doctor, I just wanted reassurance again but didn't get offered that and I also felt very patronised by one of the midwives who I saw in the surgery. I'd just come out of seeing the doctor and he'd told me to stop being so silly and it's just a temperature and if she gets too hot then to make sure I cool her down because she could have a fit which had left me in a complete state.

85. So I got, but it was a really cold, horrible day outside and bear in mind that my baby wasn't very well and I had her in the, I was just getting her dressed to put her in the car seat and take her out to the car and I'm a professional, I'm a professional person myself and I've got intelligence and I wouldn't do anything to harm my baby not intentionally but I had to make the decision, you know, I was thinking, I subconsciously had to make the decision about getting her dressed and ready to go so because she wasn't very well I put her coat on, put her hat on and put her in her car seat, at least that was the plan and take her out to the car because it was cold and wet

86. and a midwife came out and asked me what I was doing there and I said that E wasn't very well and she ***whipped*** E's hat off her head and told me how ridiculous if she had a temperature that she had her hat and coat on and I thought that was outrageous and I felt very, very put down, I felt totally useless. Someone who's normally a very confident person, I'd made a decision based on what I thought was best and I just thought that was terrible really and I just thought someone who hasn't got so much intelligence or someone who hasn't got confidence or hasn't looked after a baby before, whatever, you know, I felt very put down.

87. And then I had to leave there, get her home, then I was on my own, I didn't know if the temperature in the house was right. I didn't know whether to have the heating on

or not, I didn't know whether to have her in a vest or a sleepsuit or, it just kind of, it made it all worse really. And all I wanted from that doctor's surgery was for them to say, OK, have the heating on but have her in a vest or have her in a vest and sleepsuit but don't have the heating on, just someone to give me some advice and I tried to use my initiative and then got told that was wrong.

88. And I think, that brought home to me just how... Talking about the professional support, sometimes it conflicted and that's a bit disappointing, again it comes back to using your initiative really and trying to see the people you feel that you can get on with.

89. But on the whole I think I've been very lucky with my support, the fact that J is so keen to take part in E's care, it's fantastic and I don't know how women on their own cope, I really don't.

90. **You've talked a little about feeling down. How do you experience feeling down, can you talk to me about what's it like?** It's, it feels like there's no hope, it feels like, if I'm feeling down, I'm feeling tearful normally, I'm feeling that I just, I need something to change – basically it's not going to at the moment.

91. By that I mean I need to have a proper nights sleep or a week of sleep or just some time where I'm not having to think about somebody else and that's not going to happen so it's desperation, it's feeling desperate. It's just; it's the only way to describe it for me, feeling desperate really. And people say it's OK to feel like that it will get better and it does and the next day it's OK.

92. When it's, I've found if she's been off colour that I really struggle with, when she had her injections or when she wasn't very well, that's really hard because she's just demanding my attention constantly and won't be put down and it makes me realise how lucky I am because she's, in fact she's a very content baby usually. She's happy to lie on the floor, she's happy to watch me or playing, or watching TV or whatever so she's, she's normally very good

93. and when she's demanding of me all day I find by the evening I have that desperate feeling, desperate.

94. But sometimes I do wake up with it, not very often, but I think it's if I've had a bad night where she's been up a couple of times in the night and then she's awake at half

past six and I, and I, that I feel desperate, I just feel, I don't know how I'm going to get through the day, I don't know how I'm going to get up, I don't know how I'm going to feed her, I don't know how I'm physically going to, be able to do what she needs for the day but then I see her and it, it helps to see her and she smiles and whatever and that helps

95.and if I'm really down like that I go out, I go shopping and spend money that I haven't got and that helps. So, in fact we've been shopping quite a bit in the last few weeks – I've got the excuse with Christmas coming up but that does help me, I think that's about, that's something for me, umm, buying clothes or buying presents for people that's what I did before, I can do that now and she's content when she's in her pushchair so....I just get palpitations afterwards when I see how much money I've spent (laughs).

96.**You haven't mentioned the feeding...** Yes, well, it has gone fine but initially it didn't and that was quite significant really. I always thought that, I knew I wanted to breastfeed and I always thought it'd be easy. I went to a breastfeeding workshop and I just and after E was born it was 11 at night and she was born at 7 in the evening and she, the midwife helped me latch her on and she fed from me and I thought this is great, this is lovely

97.but after that she didn't feed for about eighteen hours. I had real problems latching her on, she just wouldn't do it and that was so hard because I had so much, I felt, I was so desperate to breastfeed her and I really would have been devastated if I couldn't but it

98.the midwives were worried because she hadn't fed, they were worried about her blood sugar and I felt there was so much pressure there for me to feed her, not just because I wanted to do it, but because she needed it and they were talking about having to, well I don't know what they'd have done if her blood sugar had of been low but I just, it was so, the feeling, you know I was just so pleased to be able to do it and I felt really like I was failing her because I couldn't

99.and in fact I did manage to feed her with the midwife holding my breast and putting it in her mouth basically and holding her head against me and once she latched it was fine and it was just wonderful then that I was actually feeding her and then again she

went for another about twelve hours without feeding, couldn't latch her on, all through the night I was trying to feed her and it was so, so awful 'cos she couldn't do it and they weren't going to let me home until I managed to feed her on my own

100. and then in fact I found that having midwives watching me, or J watching me, I couldn't do it and also I was trying so hard to use the technique they'd told us and not actually do what felt comfortable and you know, again it's about doing what feels right and once everyone had left me to it I did it my way whether it was right or wrong and she latched on and it hasn't been a problem since.

101. I've really enjoyed breastfeeding...yeah, really enjoyed it and found I've been able to bond with her, I love feeding her, I love it and I love the way that nobody else can do that, it's nice because she's dependent on me although it's hard at times, and she does take a bottle sometimes now; when it suits me that's great but other occasions I'm glad when she refuses it (laughs).

102. The whole thing's just been overwhelming that's it, overwhelming and it was so, those first few days were so calm and at ease with everything, it was really strange

Appendix three

Stage three – Interview with May - Transformed meaning units

1. Pregnancy does not necessarily signal the beginning of motherhood, even allowing for the conscious awareness of the baby moving in the womb.
2. Labour can be empowering but as the birth becomes imminent, the woman feels confused as to how she will respond to the sight of her child.
3. The pain of labour consumes all thoughts - to the point where the baby appears temporarily, as an irrelevance.
4. In the final stages of labour the woman realises that motherhood is close at hand and the instant the woman and the baby meet, the woman experiences the 'becomingness' of motherhood and an intense, overwhelming love for the child.
5. Gazing at the child for the first time evokes such intense love and tenderness that the woman is momentarily struck by the enormity of her feelings for someone so small who is still little more than a stranger to her.
6. Once alone, the woman finds herself utterly absorbed in her baby, time slips by unnoticed as the woman watches the child.
7. The woman felt gloriously serene after the birth, no longer bothered by day to day anxieties and insecurities.
8. During the first night, the woman found herself marvelling at her creation.
9. Having the baby with her all the time in the hospital felt absolutely right and heightened her feeling of intense happiness. Later, the woman recognises this state of mind as a response to the shock of giving birth.
10. The force and immediacy of the protective instinct takes the woman by surprise particularly when she leaves the hospital and returns home.
11. Her memories of her home are not in keeping with her reaction to it when she returns as a mother – what once seemed familiar and dependable has become an unfamiliar, threatening place. The prospect of being apart from the baby fills the woman with

dread and she is overwhelmed by the need to have the baby physically with her at all times.

12. With time, the physical proximity of the child ceases to be of such major importance. However, the desire to protect the baby at all costs intensifies.
13. In the early days, thoughts of the child growing up caused the woman to mourn for the inevitable loss of the dependency and neediness that was integral to her relationship with the baby at that time.
14. The woman does not feel wistful about the very early days of motherhood. She feels positive about the point she has reached with the child, now that she is more settled and the demands of motherhood can be mitigated to some degree by the assistance of others. However, there is still resistance to the child growing up and becoming gradually less dependant upon her mother.
15. The gradual realisation of the inescapability of motherhood, the way in which the child fills every moment, bring on a feeling akin to homesickness.
16. From the moment of birth the woman is expected to become a mother with no time to reconcile herself to this acute change in identity as well as no opportunity to recover physically.
17. Experience of caring for other children improves the woman's confidence in her practical skills and a sensitive, sympathetic partner alleviates many anxieties.
18. Fundamental anxieties as to the baby's wellbeing can take on huge significance and crucially influence maternal behaviour.
19. Adult interpretations of behaviour should be dispensed with when trying to understand the baby. The initial inability of babies to smile coupled with their regular crying causes considerable unease when trying to establish whether the baby is content or not.
20. *Doesn't tell me anything new about L's experience.*
21. The birth of a child entirely eclipses all other relationships, even the most intimate and precious. The woman struggles to imagine loving anyone, including her partner, with a comparable intensity to the love aroused by her child. However, as time passed and the woman became more accustomed to being a mother, she re-connected with her feelings for her partner.

22. The impact of a baby on a couple's relationship is usually underestimated and can come as a considerable shock. Tiredness and time constraints resulted in very little quality time being spent together, as it had been in the past.
23. Parenthood has also been a positive experience. The couple are united in their desire to 'do their best' for the baby and the atmosphere is more conciliatory than in the past.
24. Babies have an innate ability to demand attention at a time that will cause major inconvenience and disruption to the parent's normal routine, which has resulted in the woman and her partner rarely having time to simply 'be together', causing considerable disquiet.
25. Caring for the baby often involved the woman and her partner sleeping separately.
26. The slightest murmur from the baby disturbs the sleep of the woman, as she wakes in anticipation of a feed. Transferring responsibility for the baby to her partner and feeling confident in his ability to respond to the baby as necessary allowed the woman an undisturbed sleep.
27. Leaving the child to sleep with its father caused the woman to feel tremendous guilt even though her decision was utterly reasonable. This was further exacerbated by her assumption that no other mother would sleep separately from such a young baby.
28. Prioritising anything over the baby's needs invokes strong feelings of guilt even when present arrangements are detrimental to both the woman's well-being and her relationship with her partner.
29. Since the birth, the woman feels as though she has become another person, one whose life is no longer her own. Her organisational skills have disintegrated and life has taken an unexpectedly chaotic turn.
30. Household tasks that were completed with minimal effort in the past now require enormous concentration if they are to be completed in a satisfactory manner.
31. The world of work feels totally alien to the woman now that she had become a mother.
32. The efficiency and ability to concentrate that the woman relied upon prior to having a baby are now fully utilised in caring for the baby to the detriment of any other matters requiring her attention.

33. Tiredness and her preoccupation with the baby may be the cause of the absent-mindedness and this causes the woman considerable concern when she contemplates her impending return to work and whether she will have adequate reserves to cope with the demands of the working environment.
34. Any activity not directly involving the baby has to be completed in a very restricted timescale due to the baby's persistent bids for attention.
35. There is minimal value to be gained in drawing on past experience of other people's children to assess the impact your own child will have on your life. The woman assumed she would establish a similarly detached relationship with her own child and that her life would remain relatively unchanged.
36. Motherhood brings with it an immediate, unanticipated curtailing of personal freedom.
37. The baby's needs occupy every moment of the day and this would be bearable if the woman was able to enjoy unbroken sleep at night. Unfortunately, her sleep is regularly disturbed resulting in her feeling even less able to cope.
38. The relentlessness of the night-time feeding as well as having to care for the baby all day, leave the woman feeling wretched as she is unprepared for such a exacting schedule.
39. There is no foolproof way of preparing oneself adequately for motherhood.
40. Breastfeeding is time consuming and inexperience compounds the problem.
41. When her partner was not working, the woman felt well supported and experienced great happiness and an intense fulfilment in caring for and interacting with the baby.
42. When her partner returns to work the woman experiences a sense of abandonment and caring for the baby becomes a struggle.
43. The constancy of the feeding and the crushing tiredness causes almost intolerable distress in the early weeks. The woman feels herself to have a 'zombie-like' existence that very nearly consumes her.
44. Problems with breastfeeding continue for some time, lurching from one crisis point to the next until the women feels desperate that life will never improve.
45. The warmth of her partner's sleeping body provides a sense of companionship for night-time feeds.

46. When the woman's partner is absent, the quietness and darkness of night-time feeding symbolises how lonely she feels. Knowing that she is sharing the experience with other mothers, who are feeding their babies in the night, counterbalances these feelings a little.
47. Essentially, motherhood casts the woman as a lonely figure. The closeness of the baby comes to signify, rather than alleviate this loneliness, and a feeling of utter desperation is not unusual.
48. 'Going out' provides a purpose and structure for the day. It lifts the woman's spirits and while the child sleeps, the woman can focus on herself for a change.
49. Although motherhood brings new friendships, it is still lonely at times.
50. The mother/child relationship can feel decidedly one-sided due to the baby's rudimentary communication skills. Consequently the significance of a baby's first smiles cannot be underestimated.
51. *Doesn't tell me anything new about her experience.*
52. Parents who work full-time develop a different perspective on parenting, invariably finding the baby utterly enchanting. This is based upon the relatively short periods of time they spend with the baby. Whereas, the woman develops an intuitive knowledge of her needs because she is with her constantly, as well as taking on the principal responsibility for her welfare.
53. Pushed to breaking point, the woman hands the inconsolable baby to her partner and leaves the house. She hoped to demonstrate how frustrating and demoralising it is when a baby will not be pacified.
54. The woman feels no remorse at her escape just satisfaction at what she knows will be a trying time for her partner. She hopes he will better understand the relentlessness of a baby's cries.
55. The woman reacts angrily at discovering her partner has calmed the baby by using the expressed milk. The milk was very precious and symbolised the time and effort that had gone into collecting it and the woman feels her partner should not have taken the decision to use the expressed breastmilk without first consulting her.

56. It was the fact of his being able to settle the baby without the woman's assistance that was most infuriating. He had not had to suffer the baby's incessant crying in the way that the woman had anticipated.
57. *Doesn't tell me anything new about her experience.*
58. To her surprise, the television provides company during the day. Specifically it is the people on the screen who help to counter the woman's feeling of isolation.
59. The woman has lost part of herself in becoming a mother and the inequality of the mother/child relationship only serves to emphasis her loneliness. The baby drains the woman of all she is, giving nothing back and leaving the woman feeling utterly forlorn.
60. Being at home all day heightens the woman's sense of being detached from the world and even when she is mixing with other people it is as though mother and baby are an untouchable unit that no one can break open except momentarily in a superficial fashion.
61. Gradually accepting help with the baby leads to the dissipation of the unit to a certain degree and a sense of companionship.
62. Breastfeeding fortified the separation of the mother/baby unit from the rest of society. It was as though a psychological barrier prevented the woman from interacting with anyone other than the baby.
63. In retrospect the woman is astonished at the intensity and exclusiveness of her relationship with her baby in the early weeks. During that time nobody else could be entirely trusted to care for and respond to the baby as intuitively as her mother.
64. As time passes, the woman reaches a point where she is able to break her silence and articulate her physical and emotional needs. She no longer feels under pressure to conform to a myth of an indefatigable "superwoman". Opening herself to others allows the woman to leave the child and temporarily relieve herself of the burden of responsibility. She no longer feels neglectful at the prospect of other people pacifying the crying child.
65. *Doesn't tell me anything new about L's experience.*
66. *Doesn't tell me anything new about L's experience.*

67. Driven to breaking point by her lack of sleep, the woman conquered her fear of being apart from the child, and put her in her own room.
68. Treasured memories of the first few days when nothing distracted the woman from her baby.
69. In the early days in hospital the woman feels astonished that any mother would be appreciative of time ***away*** from her baby, or would entrust her baby to the care of anyone else.
70. It becomes essential that certain rituals from before the birth be carried forward into motherhood as these daily rituals symbolise a connection to the person she was prior to motherhood.
71. The woman yearns for her rational, organised life whilst coming to terms with the fact that it is probably gone forever.
72. Motherhood brings enormous, lasting changes in priorities and an intense, overwhelming love for the child that compensates to some degree for the loss of mental acuity.
73. The feeling of homesickness is connected to the drastic curtailing of freedom and the seismic shift in priorities, engendered by motherhood.
74. No longer is it possible to be completely absorbed by her favourite pursuit as she was in the past as she is always aware that any potentially hazardous situation for ***her*** represents an indirect threat to the baby.
75. Responsibility for the child prompts the woman to re- evaluate the ramifications of her being injured at work and cause her to feel less inclined to return.
76. As the tiredness declines, the woman is confident that she will regain her practical and organisational skills.
77. Unsentimental accounts of life with a baby would have caused the woman to lose faith in her capacity to cope following the birth. As it is the woman finds it remarkable how effectively she had adapted to her new life.
78. The intensity of her feelings for the baby grows ever stronger and this growing intensity can seem almost frightening at times.

79. Motherhood has had a profound and unexpected effect on the woman's attitude to her career. She is dreading returning to work as this will involve handing over responsibility for the baby to someone else.
80. It is no longer possible to make impulsive excursions; even a quick visit to the shops has to be planned in advance and takes longer than expected to complete. The woman finds it difficult to reconcile herself to these restrictions.
81. The father's social life continues with minimal disruption and the woman resents this as her social life has been drastically curtailed. She feels he is able to 'switch off' from the child whereas the child is never far from her thoughts.
82. The support of close relatives is indispensable, particularly when she is lonely, exhausted or over-wrought. Sometimes, visiting them gives her a purpose to the day. However, their well intentioned but unsolicited advice can be irritating.
83. Professional support can be very reassuring, particularly when the midwife or health visitor confirms the woman's own instincts about baby care. When the regular visits ceased the woman felt less confident in her decisions.
84. On seeking medical advice when the baby was ill, the woman felt that the doctor had chosen to disregard her inexperience and obvious anxiety. The doctor rebuked her for what he perceived to be her foolish over-reaction to a minor ailment but heightened her anxiety by mentioning a more serious medical condition that the baby could possibly be at risk of.
85. *Doesn't tell me anything new about the experience.*
86. Having made her decision about how best to care for her sick child, she felt further ridiculed when another health professional addressed her in a brusque, condescending tone, undermining her confidence and leaving her feeling outraged and disheartened.
87. Without appropriate professional advice, the woman felt she was 'on her own' and utterly at a loss as to how best to care for the child. Her perceived lack of knowledge exacerbated an already stressful situation.
88. *Doesn't tell me anything new about the experience.*
89. *Doesn't tell me anything new about the experience.*

90. At times the woman feels despondent, she is tearful and frustrated that her life feels outside of her control at present, however great her motivation to change certain aspects of it.
91. The desperate need for sleep and a longing for the chance to think about no-one except herself could be seriously debilitating if it was not for the encouraging words of others who acknowledge the legitimacy of her negative feelings and assure her that her mood will improve. Often the next day, her feelings of desperation have diminished.
92. When the baby is ill or 'off-colour' she is particularly querulous and demanding of attention. This serves to highlight the fact that on the whole the baby is content, easily distracted and a pleasure to look after.
93. If the baby is unsettled and irritable than by the evening the woman feels utterly wretched.
94. A disturbed night can result in the woman feeling desperately unhappy on waking. She feels at a loss as to how she will find the energy to care for the baby. Getting out of bed requires an immense effort and the prospect of the day stretching out before her is almost more than she can bear. However, her baby's smile goes some way to dissipating these negative feelings.
95. Shopping represents indulgence and the opportunity to focus on herself and reconnect with her life prior to motherhood. It is an activity that lifts the woman's mood while the baby sleeps contentedly.
96. It is assumed that breastfeeding is a natural activity that will present no difficulties. With some assistance the first feed is accomplished and the woman feels a strong sense of delight and achievement.
97. What followed was a period when the baby would not feed although the woman persevered doggedly. She would have been distraught if she had been unsuccessful at breastfeeding.
98. The woman felt under considerable pressure to breastfeed successfully, particularly when the possibility of medical intervention was implied. This pressure 'overtook' her own motivation and although she felt a great deal of personal satisfaction when the baby fed from her, she felt inadequate when the baby would not feed.

99. *Doesn't tell me anything new about L's experience.*

100. Being watched and she felt, judged, made her tense and awkward. The realisation that she did not have to follow professional advice and instead could discover her own technique that felt natural and comfortable, meant that breastfeeding ceased to be problematic. Instinctively she knew what to do even if her approach was different to that which she had been taught.

101. Breastfeeding provides many opportunities for the woman and her baby to become ever closer and part of the pleasure is that the baby is wholly dependent on the woman. Although this can be demanding, the woman is secretly pleased when the baby rejects a bottle in favour of a breastfeed.

102. *Doesn't tell me anything new about her experience.*

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