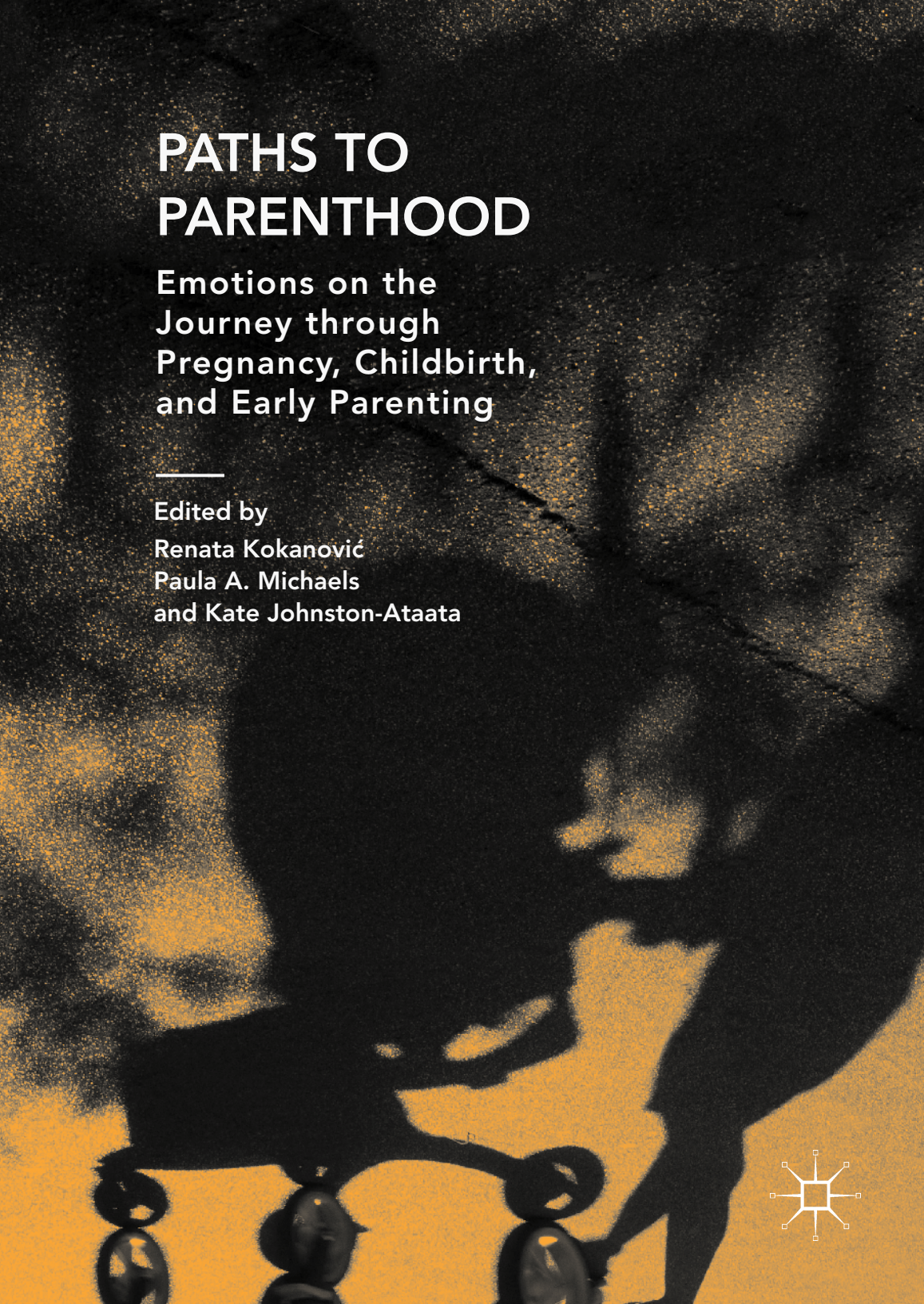

PATHS TO PARENTHOOD

Emotions on the Journey through Pregnancy, Childbirth, and Early Parenting

Edited by
Renata Kokanović
Paula A. Michaels
and Kate Johnston-Ataata

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Kate Johnston-Ataata
Editors

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To my mother, Katerina
—Renata Kokanović

As always and once again, to my sweet Misha
—Paula A. Michaels

To all the families whose stories appear in these pages
—Kate Johnston-Ataata

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The Complex and Contradictory Emotional Paths to Parenthood

Paula A. Michaels and Renata Kokanović

Within ten months of her wedding, Ayesha's life had been turned upside down. Arriving as a migrant to Australia from her native Afghanistan, she was eight months pregnant. She found the thought of giving birth in a clean, safe hospital reassuring, but, longing for her family, cried throughout her labour. An adverse reaction to the epidural anaesthesia and haemorrhaging compounded her emotional upheaval after the

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birth of her twin daughters. Less than a year later, Ayesha was pregnant again. Fearful that she would not be able to cope, she considered having an abortion, but ultimately decided against it. She gave birth to a boy, vowing to wait before having her fourth and final child. Five years later, she bore another son. When he was 18 months old, Ayesha sat down for an interview as part of a study on pregnancy, childbirth, and early parenting experiences. She attests to being 'very happy,' but strains under the physical, emotional, and financial burdens of rearing four small children a long way from her extended family, with only her husband for support. Asked what she would advise other migrants from Afghanistan, she shrugs off her own struggles with hard-won laughter and says, 'be fairly strong because it is hard far away from your family.'

Relative privilege and proximity to family are no guarantee of smooth sailing for a new parent. Born and raised in Australia, 37-year-old Brett is a middle-class, white, heterosexual man. At first glance, he would seem to have little in common with Ayesha, but their stories overlap in a few respects. He, too, became a parent within a year of partnering. They experienced a miscarriage eight weeks into their first pregnancy but, like Ayesha, Brett now has a young family, with children ages four, two, and a mere 12 weeks old at the time of his interview. With their third child, his partner had a 'textbook' quick, easy labour; given his partner's prior experiences with postnatal depression (PND), Brett expresses obvious relief in her immediate bonding with their youngest son. She is 'just thoroughly smitten with him and it's—it's just awesome.' The couple's adaptation to their rapidly expanding family has been crucial, as he and his partner have not been able to lean on Brett's family for any kind of consistent support. They live in the same state, but Brett's brother, diagnosed with schizophrenia, requires his parents' continuous care and support.

Neither Brett nor Ayesha has extended family to which they can turn. With this fact as one consideration, they have had to make choices about how many children to have and how to space them. As parents to young children, they struggle with the many demands of parenting, while also having a clear sense of its joys. But for all this common ground, there are, of course, major differences in their experiences. Most obviously, for Ayesha becoming a mother was a deeply embodied experience, as she carried and birthed her babies. Perinatal medical complications compounded the physical strains that are common in pregnancy,

labour, and delivery. Fathers, too, go through significant trials as they adapt to their new roles and work to support their partners; Brett bore witness to his partner's struggle with PND. But the physical reality for mothers is distinctly different. As an at-home mother, Ayesha did not share in Brett's struggle to reconcile the competing obligations of work and home. She faced other hurdles. A new migrant with limited English language skills, she grappled with social isolation. Ayesha wishes she could study further, which would help her to move about more freely and easily in her new country, but childcare is prohibitively expensive. With a well-paying job, Brett and his family live with none of the financial precariousness that Ayesha experiences, though he nonetheless frets about providing adequately compared to others in his social circle.

This book explores some of the complex and contradictory emotions that women and men weather on the journey through pregnancy, childbirth, and early parenthood. Ayesha's and Brett's narratives illustrate just a few of the varied factors—gender, migration status, education level, mental and physical well-being—that contour these experiences. At first glance, reproduction appears to be a universal biological process. Across time and space, humans have coupled, fallen pregnant, and birthed children. Those of a traditionalist bent might assert that nothing could be more natural than the desire for and process of procreation. But for both social and technological reasons, the reality of that process is—and always has been—more complex. Human reproduction is a biosocial experience. The path to parenthood cannot be traversed independent of the social, cultural, economic, and legal contexts in which it takes places. Those structures condition gender roles that find expression in courtship, marriage, family life, and work. While it is and always has been true that the norms arising from these institutions and practices shape pregnancy, birth, and parenting, the last century has witnessed imbricated social and technological changes that have given rise to unprecedented possibilities and unforeseen tensions. Most recently, assisted reproductive technologies (ART) have expanded the possibilities of who can become a parent and how. For some heterosexual couples facing fertility challenges, ART has opened the doorway to parenthood. These same advances have also enabled single individuals, including single men, as well as same-sex attracted people to become parents.

Older norms prove remarkably resilient, if only as a cultural backdrop, rather than the lived reality of pregnancy, birth, and parenthood for most women and men in today's developed world. Many of us carry with us the image of the heterosexual dyad in the suburban idyll, even as we live a different life, whether by our own choice or not. We experience a sense of rupture between what is and what 'should' be. Feminist scholar Sarah Ahmed argues that 'feelings might be how structures get under our skin' (Ahmed 2010, p. 216) and perhaps at no other juncture in life are the mix of feelings so complex and contradictory as when we reproduce. The disjuncture between the norms of traditional structures and our lived experiences contributes to an array of emotions. There are, of course, love, passion, attachment, and devotion; but there are also guilt, shame, uncertainty, stress, and anger. In the journey to parenthood, women and men experience deeply ambivalent feelings that need to be acknowledged. Recognition of the full range of emotions that can accompany the joys and challenges of pregnancy, childbirth, and early parenting normalises them and undermines the power of sociocultural expectations that for many are unattainable.

Narrating the Journey

In 2013 and 2014, Renata Kokanović, co-editor of this volume and co-author of this chapter, led a team of qualitative health researchers, including editorial associate Kate Johnston-Ataata, in conducting narrative interviews with 48 parents in the Australian states of Victoria and New South Wales. A key aim of the original research was the creation of an online resource on Healthtalk Australia, a web-based repository of narrative accounts of health, illness, and associated experiences. This resource was developed to support and inform new parents, their families, and members of their social networks about emotional experiences of expecting a baby, labour and birth, and early parenthood (http://research.healthtalkaustralia.org/early-parenthood/overview). Participants included a diverse cross section of parents in terms of socio-economic background, cultural, and religious heritage, sexual

orientation, marital status, migration status, and a range of other factors (see Appendix 1). Interviewees included 38 women and 10 men, aged 18–48 years old. Thirty-three participants were born in Australia and self-identified as being from a range of European ethno-cultural backgrounds. The 15 interviewees born overseas hailed from countries in Europe, North America, South Asia, Africa, and Oceania; some migrated as youths and others in adulthood. Forty interviewees were partnered (27 married and 13 in cohabiting relationships), and eight were single, including five who were separated or divorced. Ten participants were in a relationship with someone born in a different country. Three of the four same-sex attracted interviewees were in cohabitating relationships. The number of children interviewees had ranged from one to six, but the average was two. Interviewees' domestic arrangements were diverse, including nuclear, sole parent, blended, step, large, and multi-generational families. Parents narrated embodied experiences of conception, in vitro fertilisation (IVF), miscarriage, pregnancy, stillbirth, surrogacy, and adoption, and a range of birthing experiences, from home births to deliveries by caesarean sections. Our interlocutors attested to their adjustment to early parenthood, including experiences of emotional distress, changes to relationships, and the balancing act between parenthood and paid work.

Paths to Parenthood makes a unique methodological intervention in the diverse literature of medical humanities by approaching a single dataset from a range of disciplinary perspectives. The tools of sociology, history, feminist studies, cultural studies, general medicine, and psychiatry are brought to bear on the interpretation of these rich narratives in an effort to probe the sometimes common, sometimes unique affective experiences. Lines between these disciplines are not always sharp. Historians Paula Michaels and Charlotte Greenhalgh, in Chapters 4 and 10, respectively, are not alone in their attention to change over time. Though Camille Nurka (Chapter 2) examines the experience of ART principally from a cultural studies perspective, the history of fertility treatment and of gender roles provides important background for her analysis. In her exploration of embodiment and self-surveillance (Chapter 3), Kate Cregan uses the past as a launch pad for her exploration of the present. The feminist perspective, too, cuts across multiple

chapters. It is foregrounded perhaps most explicitly in Kate Huppatz's examination of new mothers' ambivalence (Chapter 7), but it threads its way through the entire volume.

This book aims to use narratives as an entry point into the critical analysis of pregnancy, childbirth, and early parenthood as emotional and embodied experiences. As psychologist Joanna Shapiro (2011, p. 69) writes, all narratives 'are themselves necessarily influenced by persuasive, at times coercive, external forces embedded in established power structures engaged in active ideology-making. People are deeply constrained by the power of the dominant narrative conventions,' which mould narrative construction. Ideological and moral structures shape how people tell their stories—what they (and their listeners) conceive of as valuable, believable, and authentic. Relationships of power condition what can be said and what meaning it carries.

Contributing authors plumb the seam between narrators' effort to craft stories of personal meaning and the specific sociocultural context that hems in and guides that construction. As sociologist Arthur P. Bochner asserts (2010, p. 147), 'narratives teach us about the struggle between personal and cultural meanings.' These creative endeavours enable people to organise their past, present, and future selves (Brockmeier 1994; Bruner 1990; Ricoeur 1984), bringing coherence to chaotic and messy lived realities (Andrews 2010, p. 152), even as they are always fashioned and constrained by context. Becoming a parent disrupts personal narratives and transforms the imagining of the future. Particularly for individuals who find these periods emotionally challenging, these experiences may destabilise parents' ability to construct a narrative for themselves as autonomous agents; they may impose certain limits or conditions on self-representation and how the self is read or perceived by others. As is evident throughout this book, experiences of expecting a baby, of labour and birth, and of early parenthood may also compromise a person's ability to interpret, explain, and 'imagine the worlds they are trying to convey' (Andrews 2013, p. 18). Stories serve diverse purposes that reflect shifting and complicated subjectivities, and do not always align with normative expectations of narrative coherence. The analyses of narratives that feature in this book seek to expose the occasionally submerged and marginal languages

of resistance to dominant discourses of expecting babies, giving birth, and transitioning to parenthood. They affirm that emancipatory narratives have the potential to be both individually empowering and socially transformative.

Our narrators tell a contemporary story that is not unique to Australia. Childbirth practices in Australia, in fact, offer an excellent case study of relevance to other Anglosphere countries, including the UK, Canada, and the USA. The experiences documented in this diverse sample reflect practices common across these countries. As in the UK, Canada, and Australia midwife-led maternity care within a broader biomedical model of health services is typical, while epidural and caesarean section rates are similar to those of the USA. Australia shares with Canada and the UK a suite of social welfare policies that benefit expectant and new parents: universal health care; paid parental leave; state-subsidised childcare. These commonalities make Australia uniquely situated to be a relevant point of comparison in multiple directions. Individual chapters make those comparisons explicit to varying degrees, but all engage the scholarly literature concerning other national settings to contextualise their findings.

Reflective of the state of the field internationally, there are moments in the text where we struggle with vexing nomenclature. For example, several authors and interviewees refer to 'postnatal depression'; others mention 'antenatal depression.' Of late, scholars prefer to capture both these periods under the umbrella of 'perinatal depression,' but even this term is a source of contention. Some argue that these labels unnecessarily stigmatise a common experience and suggest 'emotional distress' as a less clinical, less pathologising alternative. Despite sensitivity to these considerations, we nonetheless adhere to the common parlance for the sake of clarity and convenience. Moreover, recent scholarship has turned attention to the fact that fathers, too, can experience emotional distress and that not just depression, but anxiety may be a part of the perinatal affective experience (Miller et al. 2006).

Equally fraught, but less consistently resolved is how to describe what is variously termed the 'Global North,' 'West,' or 'neoliberal societies' as shorthand for the advanced industrialised economies of the world. Global North is a widely accepted alternative to 'Western,' as the latter

term connotes geographical boundaries that often do not make meaningful sense in the current world. Economic, social, and political practices that once centred on (but were never the exclusive domain of) Europe are now diffused around the globe. This observation holds true, as well, for biomedical practices, including those concerning conception and birth. There are instances when Global North fails to capture persistent cultural boundaries with respect to family structures, parenting norms, and social support. The somewhat awkward term 'Anglosphere' captures the idea that the dominant cultures in Great Britain, Canada, the USA, and Australia share common parenting ideologies that take shape within similar economic structures. However, this descriptor excludes countries that do not necessarily diverge meaningfully on the basis of language, such as some parts of continental Europe. 'Neoliberal societies' is used to capture the world's most advanced economies. To varying degrees, governments in these nations take a laissez-faire stance to social welfare policies that affect pregnancy and early parenthood, with obvious consequences for the lived experiences of mothers, fathers, and their children.

Scholarly Context for *Paths to Parenthood*

In 1976, Adrianne Rich published *Of Woman Born*, launching feminist scholarship in what has evolved into the field of Motherhood Studies (Rich 1976). Rich distinguishes between the experience of mothering and the patriarchal institution of motherhood. A scholarly consensus has emerged 'that motherhood is primarily *not* a natural or biological function; rather it is specifically and fundamentally a cultural practice that is continually redesigned in response to changing economic and societal factors' (O'Reilly 2004, p. 5). In other words, it is not the biological reality of bearing children that leads to women's oppression, but the cultural norms, social practices, and economic policies that evolve around it to undermine women's power and authority. For middle-class women in the Anglophone countries of the Global North at this particular moment in time, the dominant ideology of motherhood is 'intensive mothering' (Hays 1996; see also Ennis 2014). Popular media

and advice literature create a cultural climate that valorises mothering practised as hands-on, round-the-clock, complete devotion, often up to, and including the erasure of mothers' own needs. So-called attachment parenting and similar ideologies are labour-intensive modes of childrearing that come at a high physical, psychological, and interpersonal cost to both parents, but especially to mothers (Badinter 2012). The idealised Australian 'good mother' is today, as in the 1970s, a selfless carer and nurturer with an all-encompassing commitment to motherhood (Lupton 2000; Harman 2008; Goodwin and Huppatz 2010). Tensions arise from the disjuncture between social expectations for and the lived experiences of new parents, especially mothers. Often without having faced comparable experiences in their lives prior to motherhood, women in the postnatal period confront pressures to conform to conventional gender roles and can experience the gradual emergence of unprecedented power disparities with their partners (Beck 2002a; Choi et al. 2005; Lupton 2000; Sévon 2012). One objective of this volume is to contribute to the scrutiny of this ideology of the 'good mother,' its internalisation, and the affective consequences for women.

By rendering visible norms of the past, historians enhance our ability to see how earlier practices inform today's institutions of motherhood. Of this voluminous historical literature, works by Stephanie Coontz and Rebecca Jo Plant serve as representative examples of particular relevance to the present volume (Coontz 1992; Plant 2012). Coontz surveys 200 years of American history in an effort to debunk the myth of a simpler, happier domestic life in the past. She demonstrates that earlier eras, too, had their share of social ills and that nostalgia for a simpler time that, in fact, never existed creates a false narrative about the present. The 1950s is a particular focal point for Coontz. A desire to return to a gender order in which women's place was in the home and white, male prerogatives went unchallenged underpins contemporary longing for that era, and are implicated in the intensive mothering ideologies that Hays critiques. Coontz undermines that nostalgia by unmasking the historical reality as far more complex and distressing than a typical episode of *Leave It to Beaver*. Plant adds fuel to Coontz's argument by unpacking the contradictory, often transparently misogynistic threads in the mid-century national conversation about motherhood in medical

and social discourse. An idealisation of mother love in the early part of the century gave way in the 1940s to the image of the overbearing, neurotic mother, a type of 'bad' mother who continues to figure in today's popular culture and public policy (see Miller et al. 2017).

Social science scholarship has added considerably to our understanding of the challenges of new parenthood in the contemporary world. For some women (and men), the birth of a child does not bring the happiness that they expect but, rather, varying degrees of emotional distress. Mostly employing the biomedical term postnatal (or perinatal) depression, a number of theoretical perspectives have been taken to understand emotional distress in the midst of this life-cycle event. The biomedical model emphasises individual pathology and encourages treatment with psychotropic drugs. Feminist perspectives take issue with the biomedical approach, giving greater weight to the wider sociopolitical contexts of women's experiences (Beck 2002b). Focusing on women's own accounts of perinatal emotional distress, feminist approaches emphasise that the gender-specific conditions faced by new mothers contribute significantly to their distress (Mauthner 1998). From this perspective, perinatal depression is a social construct, rather than a medical condition requiring biomedical remediation (Oakley 1981; Nicholson 1986).

While the scholarly literature on parenthood has centred largely on mothers, fathers, too, garner attention. The historical literature on the twentieth-century Anglosphere underscores shifting norms of masculinity in the domestic sphere, as ideals of companionate marriage and hands-on fatherhood have become normalised across class boundaries (Kimmel 2012; Davis 2008; Leavitt 2009; Bell 2017). Recent decades have witnessed a gradual shift towards a more involved model of fathering in Australia that has unsettled gender norms (Miller 2011; Miller and Nash 2017). Hands-on fathering sits in tension with a continued expectation of men serving as the primary breadwinners in heterosexual relationships (Stevens 2015; Barclay and Lupton 1999). Childcare and domestic labour remain largely constructed as feminine, at odds with the growing emphasis on deeply engaged fathering (Miller and Nash 2017). Introduced in many countries around the world, including in Australia in 2013, paid paternity leave schemes are reworking the

landscape of fatherhood. Yet, in spite of fathers' increased participation, mothers typically continue to bear responsibility for the majority of childcare and housework, even where welfare regimes seek explicitly to de-gender parental roles or when women's earnings equal or exceed that of male partners. Parallel to mothers' uniquely embodied experience of pregnancy, birth, and breastfeeding, fathers arguably face a distinctive struggle with the stress and anxiety associated with reconciling bread-winning responsibilities with engaged fatherhood. Many fathers who wish to take on a greater caring role report resistance from unsupportive employers, judgmental peers, and female partners who depend on them to keep the family afloat financially (Miller and Maiter 2008).

Organisation and Themes

Paths to Parenthood is broadly divided into two sections, split between the period before and after childbirth. Following this introduction, the next three chapters explore pregnancy and childbirth. As already noted, Chapter 2 examines the experience of ART, which can be alternately disappointing and elating. By interrogating the intersection of biology and culture in the making of parenthood, this chapter examines how the impersonal technoscapes of IVF and international surrogacy configure the emotional lives of their participants. Chapter 3 focuses on women's policing of their own bodies through the internalisation of medical and social expectations. Attentive to the stories women tell about their lived experience, this chapter reveals how surveillance and vigilance work to reproduce an ephemeral notion of the 'perfect mother' of the future child and the ways that women respond to this ideal. Chapter 4 analyses the complex and at times unexpected, even counterintuitive relationship between physical pain and emotional suffering in labour and birth. Expectant mothers are typically regaled with tales from female relatives, friends, and strangers alike about their experiences of labour pain. But, despite expectations of pain in labour, the searing nature of that pain can often take women by surprise. This chapter hones in on how women narrate pain and suffering as part of a process of making meaning of their birth experiences.

The book's second section, comprised of Chapters 5–10, centres on the first days, weeks, and months of parenthood, though at times it overlaps with the first section, as pregnancy and birth loom large in the experience of new parenthood. Mothers and fathers continue to process psychologically what they have just been through. Medical, social, and economic challenges before childbirth can play a powerful, even determinative role in early parenthood. Exploring the challenges from conception through early parenthood for same-sex attracted women and men, Chapter 5 bridges sections one and two. Among other considerations, identity as a lesbian, gay, or transgendered person can initially conflict with identity as a parent, potentially impacting on the relationship with children or couple relationships. Chapters 6 and 7 both excavate the ambivalent feelings of early parenthood, but from distinctly different methodological approaches. Given the prominence of ambivalence in the testimonials, it merits this sustained attention. Drawing on concepts of intensive mothering, emotion work, and maternal ambivalence, Chapter 6 explores the turbulent emotions of the transition to parenthood. Chapter 7 explores the disunity between pre-birth expectations and the lived bodily experience of new parenthood. Chapter 8 carefully unpicks women's narratives of PND, laying bare not only the affective experience of it, but also the moments of resistance to dominant narratives of good mothering. The women's narratives offer a range of themes, such as those of the difficult baby and the traumatic birth, to 'justify the depression.' Equally, redemptive narratives allow the women to position themselves in opposition to their 'defective' early maternal selves. The final two chapters explore different challenges faced by new parents. Chapter 9 takes up the question of how parents in Australia think and feel about social support in the early postnatal period, arguing that a nuanced understanding of emotional experiences of social support requires attention not only to circumstances, but also to expectations. Setting the Australian experience in a deeply and explicitly comparative context, Chapter 10 analyses narratives about new parents' relationship to paid labour. It concludes that an individualised ethos of parenting exacts high costs in terms of the mental health and the relationships of parents in contemporary Australia.

The content of this book may strike the reader as inordinately grim. Women and men feel deep love for their children. Sometimes, though not always, they feel love, affection, or empathy for a partner. These warm, positive emotions are unquestionably present in the 48 interviews on which these chapters are based, but they sit side-by-side with a deafening cacophony of unpleasant feelings that could not be ignored. Stress, fear, pain, anxiety, shame, guilt, and self-doubt are prominent themes. The journey into parenthood appears fraught with feelings of abandonment, isolation, loneliness, and alienation. Regret, loss, grief, and trauma are all evident in the interviews. But the single most audible emotion across these narratives is perhaps ambivalence. An uneasy sense of conflict comes through loud and clear. Parents feel joy and love, but, as anyone who has embarked on parenthood knows, those affective experiences are only part of the story. Those sentiments coexist with emotions that are all too often rejected as unsavoury or undesirable, however real, powerful, and pervasive they may be.

One of the most salient and poignant features of these narratives is denial. Also present in men's narratives, in women's stories the rejection of the validity of their own needs and feelings comes through loud and clear. Women and men open up about a range of traumatic experiences. They attest to abusive childhoods, domestic violence, and poverty. Struggles with infertility, miscarriage, and stillbirth prove wrenching. Medical complications and physical discomfort in pregnancy and childbirth defy ideals of the fit, glowing expectant mother, while the exhaustion and emotional upheaval of new parenthood are far from the domestic bliss often portrayed in popular culture. Our interviewees courageously open up about these challenges, speaking frankly about feelings that are seen as undesirable, however wholly understandable they may be. At the same time, however, they are often quick to turn away from their own unpleasant truths.

Laura's words illustrate well the narrative strategies that give voice to real struggles, while in the very next breath erasing, denying, and delegitimising them. She describes the collapse of her relationship with the father of her two children. One week after their second child was born, her husband invited his boss over to dinner with his family. Presenting a tidy home and offering a homemade meal, Laura was expected to

play the hostess but, 'by the third hour of [the boss's] kids screaming around, jumping up and down off the couches, throwing things, I can't even describe, I just remembered thinking I know I'm being hormonal but I am so fragile right now. I have just had my vagina ripped from front to back and I am in pain and I am trying to work this all out and I'm exhausted. And just there was no regard [from my husband].' It is easy to conceive how trying this situation would be for anyone—feeling the need to mask exhaustion and physical pain even in the privacy of one's own home. But we can hear in Laura's words conflict about her feelings. 'I know I'm being hormonal,' she attests, suggesting that her feelings are not her own and do not reflect her authentic self. It is a rhetorical manoeuvre that allows her to distance herself from her feelings, presenting them as transient by-products of the storm of childbearing and eclipsing the legitimacy of her fragility and vulnerability.

Philosopher Susan J. Brison observes that 'to construct self-narratives we need not only the words with which to tell our stories, but also an audience able and willing to hear us and to understand' (Brison 2003, p. 51). Laura's brave act of telling her story deserves careful listening, perhaps especially for the very things that Laura herself struggles to say. For Laura, the other interviewees, and those readers who identify with their stories, there is solace to be had in the recognition of their feelings through deep listening. Becoming a parent is at once a common and an extraordinary experience. It happens to many people every day the world over, but individually we live our own, private emotional upheavals. *Paths to Parenthood* adds to an ongoing scholarly and popular conversation that seeks to destabilise expectations for intensive mothering and to legitimise the full range of emotions that accompany pregnancy, childbirth, and early parenthood. Exposing parenthood's historic, social, and economic construction unseats the ways that unattainable standards are naturalised and internalised. Recognition that many people feel complex and contradictory emotions as they move through the journey to parenthood normalises that affective experience and perhaps fosters a greater sense of resilience in the face of life's many challenges. Surely, the ability to face those ups and downs with equanimity can ease the burden faced by many on this often-rocky road.

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Part I

Journeys into Pregnancy and Childbirth

2

Postnatural Families: Refiguring Intimacy Through Assisted Reproduction

Camille Nurka

I felt really medicalised.
Kathleen

I was uncomfortable with how weird it was to be doing these things.
Marie

Since the earliest attempts to fertilise a human ovum outside the womb, assisted reproductive technology (ART) has shifted the biological and social boundaries of infertility. The technique known as in vitro fertilisation (IVF) was initially developed to assist infertile married couples to conceive by cultivating an embryo from their own egg and sperm (gametes), artificially, in a container outside the body, and then introducing the embryo to the woman's uterus. American fertility scientists John Rock and Miriam Menkin achieved the first successful incubation of an embryo outside the body. John Rock started conducting fertility research in the 1920s, developing the 'rhythm method' to

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help his infertile married patients conceive. As a Catholic gynaecologist, Rock used science to serve womanhood; in 1936, he asserted that 'nature intended motherhood to be woman's career' and that 'anything which diverts from her prime purpose is socially wrong' (Margaret Sanger Papers 2010, n.p.), though he would eventually amend this view as a proponent of contraception and co-inventor of the birth control pill with Gregory Pincus. He and biologist Menkin later experimented with IVF throughout the 1940s (Rengel 2000, p. 198). In 1944, Rock and Menkin published a paper in *Science* providing empirical evidence that a human egg could be fertilised outside the womb. These were the first human tests in the history of IVF, though the researchers never got as far as transferring an in vitro embryo into a human uterus (Rock and Menkin 1944; Rodriguez 2015).

Rock and Menkin's research paved the way for the birth of the first 'test-tube baby' in 1978 at Oldham General Hospital in England. The birth of Louise Brown took place under the guidance of fertility specialists Patrick Steptoe and Robert Edwards at the hospital's Centre for Human Reproduction. This watershed moment revealed the ambivalent positioning of IVF technology between nature and culture, bringing into sharp relief the conflict between the apparently natural desire of heterosexual married women for children and the unnatural means of achieving it. IVF technology had come up against deeply rooted cultural beliefs that interference with the natural process of conception violated nature. The Roman Catholic Church saw IVF as an immoral and 'illicit intervention in the natural procreative process' in defiance of God's will (Banchoff 2007, p. 306). Scientists worried about the potential for unforeseen health complications or abnormalities, which might be passed on genetically, emerging from the administering of hormones and 'chemical manipulation' of gametes (Cohn 1978, p. A19). As in Rock's experiments, the scientific motivation for Steptoe and Edwards's IVF program was to provide married women with the seemingly natural, biological foundation for their sexual identities. To these men, it was not the scientific methods used to re-establish women within the natural order, but infertility that was an aberration of nature.

On the one hand, ART helps to reinforce or restore the assumed natural link between heterosexual marriage, authentic womanhood, and

procreation. But on the other hand, its capacity to distance conception from the body produces human gametes as independent, free-floating organic singularities detached from the biological imperatives of heterosexual sex and, as a flow-on effect, the social imperatives of heterosexual marriage. In decoupling the organic process of conception from heterosexuality, ART also detaches biological kinship from the heterosexual nuclear family. Steptoe himself provided the reassurance that 'it would be unthinkable to willingly create a child to be born into an unnatural situation such as a gay or lesbian relationship' (cited in Franklin 1993, p. 31).

In the progression of IVF experimentation, from John Rock to Patrick Steptoe, the creation of queer families through ART was to be a spectral possibility—an 'unthinkable' kinship. Reproductive queer bodies occupy the limits of what we may call, taking from feminist philosopher Judith Butler (2004), 'intelligible' kinships. In 1982, two years after Australia's first successful IVF birth in Melbourne, Australia, the Victorian State Government formed a committee to recommend ethical oversight of the state's new IVF program. The committee's report recommended that IVF be a fertility treatment of last resort and that 'the IVF program be limited to cases in which the gametes are obtained from husband and wife and the embryos are transferred into the uterus of the wife.' It ruled out heterosexual people in de facto relationships and the use of donor eggs (Sarma 1982, p. 9). The use of IVF in same-sex relationships was not even entertained as a possibility, as the heterosexual institution of marriage and the begetting of children were culturally and legally mutually reinforcing.

Since the late 1970s, the global expansion of a market in reproductive materials and bodies, and changes in domestic regulation have gradually extended the boundaries of the traditional heterosexual family structure to include socially infertile same-sex couples and single people, who can become biological parents through donor gametes and surrogacy arrangements. ART has extended the nuclear familial model to give single women the option of having a baby without a male partner, while lesbian and gay parents can choose to use gametes from registered donors they have never met. In this way, ART 'denaturalizes the nuclear family by artificially proliferating biological relationships'

(Valerius 1999, p. 179). ART dislodges reproduction from the requirement of heterosexuality, coaxing state recognition of new kinship formations outside the traditional heterosexual nuclear family structure.

In twenty-first-century Australia, gay men are increasingly turning to commercial surrogacy agencies overseas to have children (Everingham 2015), typically in developing Asian countries such as India, Thailand, and Cambodia. For gay men using commercial surrogacy services overseas, the achievement of biological kin takes place in a marketised context outside the private familial sphere, in which donors, surrogates, and agencies mediate the process of conception, gestation, and birth. The commodified womb put to the service of the queer family disrupts the typical narrative of love and marriage, taking reproductive sexuality out of the private sphere of heterosexual intimacy to connect the multiple people involved in the infant's production as so many nodes in a radically revised family unit. Marketised surrogacy has rearranged the heterosexual family unit to include queer parents, but it also creates new racially and economically marginalised subjects of reproduction in its positioning of women of colour as 'container technologies' (Sofia 2000). White clients from wealthy developed nations may choose to have donor eggs flown in from countries such as the USA to create a genetically related child that matches their own racial colouring. These relationships have radically transformed the traditional heterosexual organisation of kinship, but they are also distributed within globalised relations of power, reinforcing and reproducing existing class, race, and gender inequalities.

Surrogacy and donor markets—where lesbians can choose sperm from a donor register and gay men have access to surrogate wombs and donor eggs—have contributed to the production of state-recognised queer families that would otherwise have been culturally unintelligible. These queer kinships become legible when they are assimilated into the nuclear family model; what makes them legitimate from the state's point of view is that they are genetic kinships. Asking 'is kinship always already heterosexual?' Butler (2004) suggests that the concept of kinship itself is inextricable from marital relations that produce genetically related offspring. Heterosexual sex, marriage, and genetically related offspring are so entwined that other forms of kinship that are not

reducible to the traditional family form pose a radical challenge to heterosexually defined kinship (Butler 2004). What binds the various family formations created through ART, and what makes them legible and legitimate, is the assumption of a natural desire for children that reproductive technologies were developed to fulfil. Although kinship relations are in fact socially regulated formations of care and dependency, the cultural primacy of the heterosexual nuclear family unit is justified on the grounds that it is natural, in that it is thought to be the result of 'a primal need to propagate the species' (Freeman 2007, p. 298).

I suggest that rather than rejecting the desire for children as merely a cultural construction, researchers in the field are obliged to make sense of the desire for children that people who turn to ART adamantly avow. In order to articulate the emotional journeys of people who use ART to become parents, we need first to understand their ambivalent positioning between nature and culture. In their engagement with regulatory bureaucracy, fertility agencies, doctors, and hospitals, users of ART must confront their own estrangement from 'natural,' unassisted, conception. I follow anthropologist Sarah Franklin's proposition that IVF is an 'ambivalent' technology because it reproduces nature through artifice, 'delivering children who are "just like" other offspring, but through a process of mimicry that is not quite the same as the original process on which it based' (2013, p. 34). Hence, we can think of IVF as a technology of bodily estrangement that 'generates naturalness' (Stryker 2006, p. 248) as its effect. As a scientific intervention that makes the process of conception foreign or estranged from the sphere of nature in order to reinstitute 'natural' biological kinship relations, ART creates postnatural subjects of reproduction.

Bodies, Technologies, Emotions

This chapter explores the narratives of heterosexual and queer, partnered and single parents who have used IVF programs or international surrogacy services to have children who are genetically theirs. What new bodily and emotional attachments emerge when we introduce technologies that alienate the process of conception from heterosexual intimacy?

How do technologies of procreation shape the desires and feelings of the people who achieve parenthood through them? In exploring these questions, I argue that ART creates bodily and emotional intimacies between patients and doctors, donors and hosts, and surrogates and intended parents, as well as technological intimacies between bodies and cells and fertility drugs, anaesthetics, extraction needles, ultrasound scanners, specimen containers, petri dishes, freezing agents, and incubators. These assemblages of intimacy are formed through the connective apparatuses that enable the exchange of commoditised reproductive organs, gametes, and babies in local and global markets. Certainly, infertility is not the only or paradigmatic site of medical technological intervention. Fertile people who conceive through heterosexual intercourse also submit to medical technological intervention and advice. However, I contend that medical interventions in conception pave the way for experiences of parenthood that will always be in some crucial way defined by the initial process of gamete retrieval, cultivation, and transfer. Couples can feel as if they become more intimate with fertility technologies than with each other, as reflected by Eithne, who says of her relationship with her husband after six IVF cycles in two years, 'all our intimacy disappeared.' Women undergoing IVF may form complicated emotional intimacies with doctors, which may leave them feeling supported and comforted or rejected and dismissed. People who use surrogacy services are usually discouraged from befriending the surrogate, but friendships with donors are not so strictly controlled. In this respect, kinship relations with donors exceed the limits of social legibility; registered donors, for example, are partially recognised in law as contributors of genetic material and in being required to provide contact information in case the IVF child wants to meet them in the future. But they are not legal parents, though they may form intimate friendship attachments to the legal parents, as in the case of Robert, who is friends on social media with his egg donor and her sister. Similarly, IVF clinic staff may come to feel like close relations because of the frequency of contact and length of time, particularly if it takes a number of cycles to become pregnant. Marie says of her experience that 'the clinic was lovely, they were really great …. It felt like we were family almost.'

Scholarly attention to the emotional experiences of ART can reveal how social structures, institutions, and norms are lived out in the psychic lives of subjects (Cvetkovich 2012; Ahmed 2010). As cultural studies theorist Sara Ahmed writes, 'feelings might be how structures get under our skin' (2010, p. 216). Reading ART narratives through the lens of affect theory offers us a way to understand the fantasies, desires, and emotions of aspiring parents as neither entirely structural nor entirely individual, but relational. This chapter draws on narratives of experiences with IVF and surrogacy to explore how emotion lends texture to the desire for biological parenthood and its practical realisation through ART. Women and men engaging with ART emotionally work through their fantasies of reproduction in ways that are uniquely attached to the fertility technologies to which they submit themselves. In the narratives that follow, I attempt to trace the emotions and desires that connect gay and straight, coupled and single, male and female experiences of ART and also mark out the distinct differences between them.

Some limitations of this chapter must be acknowledged. The interviewees in this chapter who underwent IVF all had a successful outcome (i.e., a live birth) and are therefore statistically unusual. IVF has a notoriously low success rate of around 20–30% of live births achieved in a single cycle (Houlahan 2015; Throsby 2004). This chapter does not include the voices of surrogates. I cannot do justice to their experiences of conception, pregnancy, and birth here because I have restricted my focus to the intended parents. Hence, the concept of 'parenthood' that is explored in this chapter is culturally, geographically, and legally specific. For work that examines international surrogacy and parenthood in more depth, readers can refer to DasGupta and Das Dasgupta (2014), Harrison (2014), and Pande (2016).

Opportunity and Foreclosure

In the USA in 2008, pregnant transgender man Thomas Beatie published an open letter in the queer publication, *The Advocate*. In the letter, he affirmed his male identity and his marital status as husband

to his wife, and stressed that 'It's not a male or female desire to have a child. It's a human desire' (Beatie 2008, n.p.). Reproductive technologies made this pioneering pregnancy possible because Beatie had achieved conception through artificial insemination with frozen donated sperm. ART has provided significant opportunities for transgender and queer men and women to have biologically related children they can raise as their own and for such kinship bonds to be legally recognised, particularly when markets in gametes are regulated through the state. In stressing the need to reproduce as a 'human' desire, Beatie universalises reproduction, dislodging it from its traditionally female location to suggest that there is a multitude of other possible ways of being and desiring that exceed the narrow scope of cisgender heterosexual coupledom. For gay men, for instance, surrogacy services make available the family they thought was foreclosed to them from the start. With the advent of new surrogacy markets, gay men can envision coupled futures for themselves in which biological children are possible. As Jack and Robert both attest, 'coming to terms with' or 'accepting' their sexuality brought with it internal struggles over the foreclosure of their potential to become fathers. For them, coming out required that they give up 'the chance of having a family.' As Robert explains, while his sexual identity conflicted with his desire for a family, and while he reluctantly gave up on this possibility, 'that desire … didn't go away.'

The anxious, tortuous routes taken by people who use ART to have children point to the deep feelings that we attach to the fantasy of biological parenthood, in the sense that a fantasy is an imagined projection of a wished-for thing. One might say that biological parenthood is a culturally shared fantasy of family-making, in which the family is imagined as bringing fulfilment, meaning, and happiness to a life. Wanting can be felt as ancient and embedded deep in the core of the self, as recounted by interviewees who express the certainty of a long-held desire: 'I have always wanted to have a child' (Kathleen); 'We always wanted to have children one day. We always saw them in our future' (Sylvia); 'I always wanted to be a stay-at-home dad' (Alexander).

From a feminist perspective, however, childbearing has come to define and delimit the course and purpose of women's lives to a much greater degree than it has for men. As feminist philosopher Simone de

Beauvoir argued, the meaning of what it is to live as a woman—her existential purpose—is inextricably bound to her reproductive capacity (2009, p. 537). As expressed by Ava, motherhood was something she had always 'known' she wanted, most particularly as a woman:

> I always knew I wanted to be a mum from a very young age. It's that sort of cliché of little girls imagining their life and growing up and having children, that sort of stuff. I always knew I wanted to have a career and have a job … and I always wanted to go to uni, but I always wanted to have a family as part of that. So, for me—for women—I guess, it's just that thing of the biological clock.

This notion of the biological clock that Ava draws on to explain her desires is in fact a phrase that dates back to 1978, the same year that test-tube baby Louise Brown was born. *Washington Post* journalist Richard Cohen (1978) coined the term to describe what he saw as women's sense of urgency to bear children, asserting that the desire for children was intrinsic to the female body and was proof of a fundamental and irrefutable difference between men and women. He suggested that while women were getting educated and entering the workforce in increased numbers, they could never be equal to men because they were ultimately undone by their own biology. This ticking biological clock demonstrated, for Cohen, that 'there was something about their [women's] situation that showed, more or less, that this is where liberation ends. This is where a woman is … uncontrovertibly different' (1978, n.p.). From a feminist viewpoint, and from the perspective of women who do not want children, the 'biological clock' is a concept that tends to essentialise the female body as intrinsically and eternally maternal. It has nonetheless become lodged in the cultural consciousness as a term through which women can explain a desire that perhaps feels inexplicable, because it is experienced as a drive without an origin.

Scientific statistics generated through fertility research, then, have produced another discourse through which women read themselves as restricted by the biological clock, materialised in their ageing ovaries and eggs. Sylvia felt that the desire for a baby imbues the life course of many women with a very particular biological urgency. She explains

that her concerns about her reproductive health arose because of her awareness of the 'statistics,' which was also a motivating factor for Marie, who said that she had 'known the statistics on how hard it [having a baby] was going to be at my age.' The sense of loss and resentment identified by Cohen is echoed by Celine, who says: 'I grew up in that era where you can have your career, you can wait, but no one tells you that after 30 your ovaries don't work as well.' For Celine, as for Cohen, women can choose to cultivate areas of their lives that have nothing to do with reproduction but only at the expense of losing their reproductive agency.

By contrast, men do not describe themselves as being bound by the same biological laws or as having to choose between work and home. Robert, for example, says that 40 was his deadline to have children not because his 'clock was ticking,' but because he feared not being 'energetic enough to raise children.' Alexander says that after his first marriage had ended, he 'thought it would be good to have a partner again and have some children,' acknowledging that time was 'ticking' for him and his second wife, as they were both over 30. Neither man invoked sperm, sperm count, or male fertility statistics as part of their rationale for the timing of their having children.

The language of the biological clock that women use to explain the sense of urgency that brought them to IVF indexes important cultural differences in the lived experience of reproductive embodiment between women and men in a gender-stratified society. Culturally, women are positioned—and position themselves—as governed, more so than men, by their biology, and heterosexual women appear likely to see themselves as having more at stake in reproduction. Marie admits that she 'just about went crazy' from repressing her desire for children because her husband 'was prepared to wait … indefinitely and I wanted it more than he did.' In the light of these pressures, women may feel as though they are at the mercy of their own biology, their partner's consent, and finally, the clinical process of ART itself. As Marie explains,

> Before you start doing IVF … they start with IUI [intrauterine insemination] …. So, we did three IUIs and none of them worked. And so the day that I'd start menstruating I'd just have this meltdown … with me just

> screaming at [my husband] down the phone how cross I was that it hadn't worked and it was all his fault. Because we'd had to wait so many years to try because he wasn't ready … [and] reading on the internet about how old I was and time was just ticking away.

Uncomfortable emotions such as frustration, anger, and blame move through these interlocking relationships of dependence and need in ways that intensify existing tensions between male anxiety over 'financial security' (Sylvia) and female concerns about biological time, or as Sylvia puts it, 'I could not help but feel bitter that we waited maybe too long.' Such emotions reveal the social structures of gender that simultaneously identify women with their bodies and restrict their bodily autonomy.

Alienation and Loneliness

In this section, I approach 'alienation' as an effect of bodily distance. I want to show how ART can alienate people even while bringing them together in the making of a baby. In international surrogacy arrangements, for instance, this distance is quite literal, as surrogates, donors, and intended parents may all live on different continents. Surrogates are also alienated from their wombs under conditions in which the health of the foetus is the primary concern—and all aspects of the pregnancy will generally be mediated by a fertility agency. It is common for commercial surrogates in India to be separated from their own families and sequestered in a medical facility, so that their pregnancies can be tightly monitored and managed (see, e.g., Centre for Surrogate Parenting 1995–2017; Kusum 2017; Surrogacy India 2017).

Although intended parents have a high stake in the surrogate's well-being, much of their involvement in the pregnancy will be through updates from the fertility agency via email, text, telephone, and video calls. Through artificial means, surrogacy agencies bring into being, through artificial means, biological intimacies between the surrogate's uterus and the embryo formed from the gametes of the intended parent and the egg donor (if the egg donor is not the surrogate). But because

the surrogate's body is commodified as the property of a surrogacy agency on behalf of a paying client for the length of a pregnancy, these biological intimacies may not become social ones. Intended parents may be discouraged from seeking an emotional connection with the surrogate, while some intended parents may not wish to build any kind of emotional intimacy with surrogates (Cunha 2014). Jack confides that although he and his partner were at the hospital at the time their two surrogates gave birth, it was 'hard' because 'you're not with the surrogate mums in person.'

The subjects of IVF are likely to describe the experience as weird or unnatural. These feelings of dislocation are, I suggest, a reflection of the alienating effects of the technology itself, through which individuals are depersonalised in being treated as curious problems of nature, as suggested by Kathleen, who 'felt like a science experiment.' Through the separation, mixing, and transfer of eggs and sperm outside the womb, ART alienates reproduction from heterosexual intimacy. In relocating the process of conception from the body to the laboratory, procedures like IVF demand constant monitoring, on the part of participants, to the productions of their bodies. For women in particular, the clinical process of trying to achieve conception is experienced as a fractured temporality characterised by periods of waiting, in between procedures of egg stimulation, insemination, egg extraction, embryo cultivation, transfer and implantation, blood tests, and scans. Kathleen explains: 'It's this constant waiting game. You're constantly [thinking] have I produced enough eggs? I've got to go in for this scan, I've got to have this blood test. It's this incredibly clinical process.' People who have gone through IVF are highly sensitised to feelings of alienation from their bodies. The word 'clinical' not only refers to the hospital environment and its procedures, but also evokes an uncanny sense of displacement between natural and unnatural. Feelings of displacement arise when a person's subjective fantasy of the potential child inhering in the sperm or egg comes up against the objectifying medical language that views patients as objects of procedures such as artificial insemination, which Celine describes as a 'very weird feeling.' Similarly, Alexander describes IVF as 'a little bit inhuman' and 'very unnatural … it doesn't leave you with a warm, glowing feeling having been through IVF; it's quite

traumatic.' While the goal of IVF is to produce the natural effect of biological kinship, the means of reproduction is changed in a postnatural process that 'is both normal and not' (Franklin 2013, p. 7), which helps us to understand why people experience IVF as traumatic, inhuman, and weird.

IVF can also put incredible stress on relationships, as the privacy of sexual intimacy between partners is disrupted by the clinical process of gamete extraction. Marie notes that her husband felt extremely uncomfortable and vulnerable with the requirement to produce a sperm sample in the clinic: 'He particularly didn't like having to do that on his own.' The alienating effects of technological intervention meant that women wanted their partner to be with them physically when going through treatments or attending doctors' appointments. Sylvia speaks of her need for her partner to show support by being present with her while she injected herself with fertility drugs: 'My husband said he couldn't [inject me] … so I at least insisted that he would always be there and watch it as an emotional kind of support or mental support that he would stand next to me.' The act of witnessing was viewed as important for women to feel as though their partners were sharing their embodied experience.

However, the trauma of self-injections, blood tests, ultrasounds, and harvests of gametes compounded by persistent uncertainty of outcome was described by respondents as emotionally exhausting and constant, and a burden that created a rift in their relationship, as expressed by Sylvia: 'The memory of going through IVF was just the loneliest year … because the experience couldn't be shared.' Kathleen, a lesbian, points out that pregnancy is embodied by only one person, not the couple, which places the burden of responsibility on the pregnant woman: 'It's going to be our baby, but it's *mine*. It's all me. My partner wasn't involved at all.' As an effort primarily of the birthing body, IVF tests the limits of empathy of the non-pregnant partner and induces deep feelings of guilt over unhappiness about ongoing bodily anguish that eventually become an inexpressible part of the romantic relationship. Women undergoing IVF procedures may feel that they have greater emotional demands of their partners. Sylvia, a heterosexual woman, frames her desire for emotional support as unfillable: 'It's just

very difficult for men to understand the level of support women would expect, and probably the more they give us, the more we would want.' Behind these explanations are feelings of guilt for wanting the partner to feel one's suffering, and anger that they can't.

But the ability to share the IVF experience is not restricted to partners; it also extends to friends and family. IVF is a technology that can easily induce shame because of the implication that non-reproductive heterosexual couplings are biologically abnormal. Coupled and single people alike are required to reveal their use of IVF in order to be able to share their experience with friends, family, and colleagues—and it may well be something they might not want to share. As Sylvia says, 'It was … an emotional experience that I didn't share with anyone else. We did not share with anybody that we were going through an IVF treatment.' Sociologist Maggie Kirkman (2001) argues that some life stories are assumed to be normal and universally shared, and these can be publicly aired; others that do not fit the normative narrative model may not. The process of 'coming out,' even after babies are born, is a feature of emotional social life uniquely related to IVF technology. Narrative accounts by women in the current study indicate that in their social lives, they may be loath to reveal their experiences of IVF because pain is difficult to share. This is perhaps especially true with regard to reproduction, which is culturally indicative of relationship progression and as a happy, exciting life-cycle event deserving of congratulation. As Sylvia reflects, 'It was not that I was even willing to share it. I felt the need [but it] doesn't mean that I was willing either, and maybe we didn't want to jinx it. We just wanted to tell people the good news.' The failure to become pregnant is not a happy story. Enclosing pain in privacy and silence, Kirkman argues, 'protects a wider audience from the embarrassment of having to confront other people's pain' (2001, p. 527).

Uncertainty, Guilt, and Pain

While ART offers hopeful parents the possibility of future happiness and fulfilment, these are procured, even when the effort succeeds, at considerable emotional and physical cost. People are ever vigilant of the

recalcitrant and dangerous forces of their bodies (or those of surrogates) that threaten pregnancy, as well as the treatment itself, and persistently anxious about the small odds of conception and likelihood of miscarriage. People who use ART spend a lot of time weighing up risk against benefit. In IVF programs, women negotiate feelings of hope and disappointment through medical assessments of 'quality' and 'viability' of eggs and embryos, and their experience is heavily mediated by interactions between their bodies and technologies such as the drugs (like clomiphene citrate) that stimulate egg production to increase the chances of harvesting a 'viable' egg. To make matters more difficult, there is no guarantee that a 'viable' embryo will implant in the uterus. Doctors also do not know in advance how a particular body will respond to fertility drugs, so this interaction is subject to experimentation.

In this landscape of uncertainty, female users of IVF are made highly aware of the possibility that their bodies will not perform well enough or respond to medical intervention in the way they hope for. In her analysis of how IVF produces subjects of failure, sociologist Karen Throsby found that among her sample of women, many attributed low egg count or quality to a fault in themselves, in producing 'crap eggs' or being 'rubbish at producing eggs' (Throsby 2004, p. 143). Marie expressed such a view in her account, saying that 'old eggs just don't perform as well …. It was always down to me so it was always my body and my eggs that were going to let us down.' If, as Throsby argues, 'one of the effects of the dominant IVF discourses is the erasure, or at least suppression, of treatment failure' (2004, p. 45), then it stands to reason that women are more likely to blame themselves when treatments fail. In IVF, the fertility of female bodies is made legible within a scientific frame of statistical probability and governed by calculated assessments determining the number and type of eggs needed to increase the likelihood of embryo implantation. The effect of this statistical management of the body is that although scientific empirical modelling is designed to increase the chances of embryo implantation and a viable pregnancy, it cannot be guaranteed. If women do not reach this goal, they may be left feeling deflated, guilty, and incompetent.

When a foetus does not survive a pregnancy, some accounts suggest that women may feel their own bodies to be inhospitable or even

dangerous sites of guilt, which is confirmed in the medical language. As Ava narrates of her miscarriage, the doctors had attributed it to an incompetent cervix, using an adjective which could as easily apply to the self. After her waters broke, she began losing amniotic fluid, and she was told that the medical staff could do nothing to save the foetus. Under medical advisement, Ava then chose to carry the dying baby for four days, rather than having her daughter removed by curette:

> The doctors had said that they think it's because I had an incompetent cervix and that's why it's happened. So, you've got these feelings of guilt that my body has let me down. If [my daughter] was in someone else's body, this wouldn't have happened. She'd go to full term. It's because of me. I've let her down … so basically me killing my baby …. It's like your womb becomes the tomb and there's nothing you can do about it.

Ava both objectifies and identifies with her body as a source of distress and pain. Through this ambivalent positioning, the body is both an opponent ('my body has let me down') and the corporeal representative of the ego ('It's because of me. I've let her down'). Feelings of loss and blame are entangled in the painful position of inhabiting a body that is at once part of the self and out of control.

The IVF process itself also carries its own risks. Fertility drugs given to women to stimulate the ovaries to produce more eggs can cause hyperstimulation, a condition in which the ovaries swell. The postnatural assemblage of drugs and ovaries can produce bodily reactions that are likely to cause miscarriage if the woman is pregnant and to reinscribe the body as a site of illness, defect, and abjection, rather than fecundity. When things go wrong, doctors and patients may become locked in an aggressive interplay of blame and guilt, as illustrated by Ava's episode of ovarian hyperstimulation: 'The IVF doctor I had at that time didn't have a very good bedside manner at all …. The fact it had happened with one of his patients was probably a point where he felt he'd failed, but he took it out on me …. We had an argument in the hospital where he came in, chastising me like it somehow was my fault, and it was just awful.' As this account illustrates, women's self-blame for things that go wrong may feel like it is being reinforced

by the attending physician. One reason for bad feeling between doctors and patients is that the rational medical approach in determining how to alleviate distress is quite different to the emotional experience of being distressed. A certain amount of distance between patients and their doctors is required for specialists to make diagnoses and prognoses, and to advise patients of the potential hazards and benefits of the hard decisions with which they may be faced. However, this means that medical specialists may come across as having a poor 'bedside manner' or as emotionally distant. Vivienne, who had a traumatic twin pregnancy, feels that 'there was no support for people that go through difficult pregnancies … I was just desperate to talk to somebody else that had gone through a really difficult pregnancy, and people just don't talk about it.' In the context of the clinic, the normalisation of suffering creates a disjunction between medical routinisation of pain and the shock of it for individual patients, to whom it may feel intolerable. What women's narratives of psychological pain tell us is that partners, friends, and medical staff may not be able to comprehend the extent or depth of their suffering. When these failures of connection occur, women will silence their pain or be left to find for themselves 'reliable others' (Erskine et al. 1999, p. 6) who will validate their bad feeling, such as support groups, especially on the Internet, or psychologists.

Doctors and nurses, too, negotiate the complex emotional territory of ART in their daily working lives. Although doctors conduct their work within a largely empirical frame, they also become attuned, through experience, to a range of emotional responses to traumatic pregnancy and birth events. In this way, medical staff can be an invaluable source of support when pregnant women are at their most vulnerable, which can help them to endure emotionally painful experiences. Ava, who was faced with the choice of having her foetus removed by curette or delivering a stillbirth, said that she was grateful to the doctors for advising her to deliver the baby because, based on their experience, they suggested it would be better for her psychologically: 'They explained that even though what's going to be happening to you is going to be awful, we found that [for] most mothers, it helps with the grieving process and what's to come afterwards if you actually get to have that time with your baby.' Social workers at the hospital provided Ava with an opportunity

to have photographs taken of herself, her stillborn baby, and her family as validation of her experience, which helped her work through her grief. What comes through in such narratives of pain is that women want to be able to share their emotions with doctors and hospital staff. Empathetic responses are particularly important. The ideal clinical setting for people undergoing IVF treatments would include staff who are able to listen, interpret, and soothe the psychological suffering of patients through providing vital acknowledgement of their pain.

Satisfaction

After suffering through ovarian hyperstimulation, early miscarriages, a hostile doctor, fibroid removal, and a stillbirth, Ava tells of her overwhelming sense of relief and incredulity at the successful delivery, by emergency caesarean section, of her son.

> It was just such a surreal moment because I had dreamt and imagined this moment for so—well, certainly through the IVF treatment, but … when you're a little girl … imagining being a parent and finally here he is and he was screaming and doing all the right things and larger than life and I sort of … thank God …. It's done, he's out, he's alive, I've done it. My body's managed to do this at thirty-seven weeks and three days' gestation. It was just amazing.

In the appearance of the longed-for baby, in the satisfaction of a desire, one finally meets the source of one's feelings of deprivation, which makes that deprivation so much clearer because it now takes a real shape. When a long-held fantasy is fulfilled, in the moment that the object of the imagination is suddenly realised, it may seem almost as if it were impossible, or, as Ava described it, 'surreal.' Robert labels the surrogacy process in similar terms. After signing contracts and organising surrogates and donors, it 'all sort of happened.' He relates: 'My daughter was conceived straight away, first attempt, which was really exciting, and nearly nine months later was born … So that was a bit of strange time in between. Very surreal.' What these interviewees are

describing, in different ways, is the sense of proximity to a love object that is both real and not real: a baby in the process of being realised. When participants of IVF or surrogacy explain their relationship to the process of making fantasy a reality as surreal or uncanny, they are attempting to resolve the gap between absence and presence. Like any parent expecting a baby, they are waiting for the moment that they can believe in the realness of the object, the moment in which the fantasy can be touched. But the surreal feeling attached to procreative technologies has a slightly different texture. For Ava, a single heterosexual woman, and Robert, a single gay man, the surreal quality of their experience is, I would suggest, indebted to the technologies that have provided an opportunity they thought had been lost to them. Unlike fertile heterosexual couples, these parents started their journey to parenthood from a place of missed opportunity. Hopeful parents undergoing IVF or surrogacy are well acquainted with the feeling of having missed out, dominated by 'if only'—I had met the right person; my partner felt differently; we did this earlier; I had a fertility test when I was younger; I had the right body; he had the right sperm. ART intervenes in the lives of infertile people to make the foreclosed or disappearing object of fantasy possible and real.

The process of realising a baby through ART entails a retelling of the birth story. For instance, parents may wish to build pictorial narratives of family that include others involved in the making of the child. Gay fathers Jack and Robert explain that they made storybooks with photographs of surrogates, donors, doctors, and nurses, so that their children could know 'where they came from.' As Robert explains, 'The whole idea about the knowing, or being able to contact the egg donor, is about that kind of involvement as being part of the bigger picture of what a family is.' Ava had bought 'donor books' to help explain to her son how he came to be (a good example of such a book is *Where did I really come from?* [Wickham and Urh 2008]). She relates that her son loves being told his own story about being a frozen embryo: 'he's going through his superhero phase and so he likes to talk about being defrosted—and then I came to life …. So, he's like, "Tell me about me being defrosted, Mum."' Because the story of the origins of the baby born through IV or surrogacy diverges from the expected path of parenthood, new stories

need to be crafted, and parents have done this through photographs, books, and narrated stories. The road to the satisfaction of a desire can be narrated in IVF/surrogacy experiences through these inventive forms of shared storytelling. This identity-construction work enables parents to become the agentic subjects of their own experience.

Conclusion

By interrogating the intersection of biology and culture in the making of parenthood, this chapter has explored how the impersonal technoscapes of IVF and international surrogacy produce postnatural assemblages of intimacy that configure the emotional lives of participants in specific ways. People undergoing IVF occupy a difficult emotional space as both desiring subjects and objects of science who are involved in chaotic and experimental processes governed by risk and probability. As Franklin describes it, 'in vitro fertilisation is not a simple process of steps leading to potential success—it is a confusing and stressful world of disjointed temporalities, jangled emotions, difficult decisions, unfamiliar procedures, medical jargon, and metabolic chaos' (2013, p. 7). Time is measured by the periods in between fertility injections, gamete extractions and transfers, and IVF cycles, while participants anxiously await the results of egg harvests and implantations. Although the medicalisation of pregnancy is not restricted to people using ART, their bodily intimacies with others, and their feelings of hope, regret, resentment, anger, loneliness, fear, guilt, pain, and joy are threaded through the technologies they are using to assist them, or their surrogates, to conceive.

The narratives presented in this chapter illustrate the ambivalent positioning of the subjects of ART in between nature and culture, normal and abnormal. This helps to explain the extreme ambivalence in the emotional lives of IVF participants. Psychically, there is no norm for which they can strive because they are at the mercy of stochastic forces, even though it is the task of medicine to manage those forces. Their estrangement from the assumed normal process of reproduction helps to shape the feelings that pass between hopeful parents and their

fantasies, doctors, partners, bodies, gametes, donors, and surrogates. IVF, for example, is a stigmatising technology that produces feelings of embarrassment and anxiety about difference by marking its users as socially abnormal, while the technology itself introduces its own gruelling and painful physical and psychological risks—to both mothers and babies—and imposes upon hopeful parents difficult decisions about how to manage that risk. But ART also establishes close relationships between the multiple people involved in making, monitoring, and delivering the wanted baby. In alienating the process of conception from heterosexual intimacy, the depersonalised technoscapes of IVF and global surrogacy produce technologised intimacies within a multiplicity of social relationships. It is only through examining how fantasies and hopes are attached to assisted reproductive technologies that we can understand the flows of emotion that animate these postnatural assemblages of intimacy.

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3

Embodying Pregnancy and Self-Surveillance

Kate Cregan

Historian Barbara Duden (1993) has argued that the personal, embodied experience of pregnant women has become increasingly subordinated within medicine, and the gestational female body primarily constructed as a vessel for a child-to-be. Yet, every day women have a lived experience of pregnancy and birth as personal, embodied changes. Since the 1990s, there has been a concerted effort by feminists, sociologists, and medical anthropologists at theorising and researching the lived experiences of women in relation to reproduction (e.g., Martin 1992; Franklin 1997; Strathern 1992; Rapp 2001, 2011). Their work demonstrates that, within a wider complex of medical and social mediations, pregnancy remains an embodied experience that is actively negotiated. Women are constantly challenged by expectations of what they should be feeling, how they should be monitoring themselves, and the importance of their actions on the health and welfare of the gestating foetus.

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Within the Western medical tradition, constructions of the human body—at least since Italian anatomist Andreas Vesalius began producing atlases of the human body in the mid-sixteenth century—have presented the male body as normative; the female body has been represented almost exclusively in terms of its reproductive organs (Cregan 2009). This early modern peering into the fecund womb of Venus or Eve in the anatomical manuals of Vesalius and his many copyists, or in Frederik Ruysch's rough woodcuts displaying excised wombs inhabited by capering infants who demonstrate the complicated foetal presentations that might arise in childbirth, may now seem quaint or ludicrous. Yet, those first steps in the visualisation of the intimate interconnection between the female and foetal forms during pregnancy began a chain that remains unbroken: that is, the female body's capacity to form and nourish a foetus has a long history of medical surveillance.

It was not until the twentieth century and the use of the X-ray that it became possible to access visually the interior of a living body without cutting into it. Not until the refinement of ultrasonography did it become ubiquitous to visualise the living, gestating foetus. As Duden has noted, the 'formation of the foetus is to a large extent the history of its visualization' (Duden 1993, p. 92). Foetal ultrasonography only became widely available, even to diagnose suspected serious complications in the second and third trimester, in the 1980s. In developed countries, scans are now performed as a matter of course at 10–12 weeks to assess the progress of foetal growth and at 18–20 weeks to screen for foetal abnormalities. Such images of the foetus make 'real' the child-to-be even before its movements can be felt, beginning a medically mediated process of monitoring and surveillance of the embodied connection between mother and infant.

Medical monitoring of the pregnant body not only overtly manages the progress of pregnancy, with the aim of ensuring the health of mother and foetus, but also openly encourages self-surveillance to achieve an ideal pregnancy. The parameters of an ideal pregnancy are malleable, while the main points found in any maternal health advice literature include as basic: not putting on too much weight; eating 'well'; staying fit; regular medical check-ups; meeting foetal growth

targets; and delivering at full term (neither too early or too late). Thus, an ideal pregnancy entails compliance with the model of a good patient and taking personal responsibility to be a good mother, who acts in the best interests of the foetus/child. These expectations are largely accepted in developed societies and permeate social expectations of how pregnant women should behave, along with expectations of dealing with the 'normal' inconveniences of gestation. Women are surrounded by broader expectations that they will embody the medical construction of what an ideal pregnancy should be. And yet, women struggle to attain an ideal that for many is difficult and for some is unattainable, leading to emotional strain. Among the diverse emotions elicited from our interviewees, self-doubt and guilt at failing to meet the ideals of being a good mother and/or a good patient are a common thread.

Before, during, and after pregnancy, women negotiate a range of medically informed and socially upheld expectations of what it is to be pregnant, to give birth, and to become a mother. French sociologist Pierre Bourdieu claims that values and associations are '*made* body by the transubstantiation achieved by the hidden persuasion of an implicit pedagogy, capable of instilling a whole cosmology, an ethic, a metaphysical, a political philosophy, through injunctions as insignificant as "stand up straight" or "don't hold your knife in your left hand"' (Bourdieu 1977, p. 94, emphasis in original). In other words, we learn multiple aspects of everyday social life—what Bourdieu calls 'fields of play'—from infancy and become more (or less) expert at them, in much the same way that we can learn the rules of a schoolyard game. The degree of expertise we acquire will depend on how well we have absorbed and embodied the largely unspoken rules.

When we look at the ways that women describe their experiences of pregnancy and the perceptions of their unborn children, we gain insight into their embodiment of the medical construction of gestation and how well they are able to negotiate the explicit and implied expectations of being a good patient and a good mother. Those might be directly stated, such as not to put on what physicians define as too much weight, or more subtly conveyed in an expectation that women will put up with the discomforts of pregnancy, even when severe.

Our subjective lived experiences lead to the absorption of social behaviours into our bodies. All the advice and admonition related to women's reproductive lives become ingrained, so that when they differ from the ideal that, too, is embodied.

This chapter explores the moments when the embodying of an implicit medical pedagogy arise in women's descriptions of their physical experiences of pregnancy, that is, when the professional and cultural medical messages that women have internalised reveal themselves. In this chapter, the primary area of investigation is the experience of being pregnant, the social construction of pregnancy as a stage in becoming a mother, and the medical construction of gestation as a period of surveillance and vigilance. Specifically, the analysis in this chapter draws on 29 interviews with women and one interview with the male partner of a woman as they reflect on past and recent (28) or current (two) pregnancies. The interviews reveal six intimately interconnected areas of concentration and two overarching themes. The six broad categories that arise in these interviews are: physical experiences; emotional experiences; self-surveillance; other-surveillance; perceptions of the foetus; and self-perception. The two main themes under discussion are embodying medicine and embodying the child.

Embodying Medicine

In medically managed pregnancy, regular intimate contact with health professionals frames the pregnant body as under observation. Women's general health is monitored through measurement of blood pressure, blood sugar, and body weight. They also undergo diagnostic screenings. At the same time, even the most routine pregnancy involves a shift in a woman's embodied experience and her cognitive perception of her own physicality. Women undergo shifts and accommodations in their bodies that have to be made in order to successfully gestate and deliver a child, all of which may prove challenging for the individual.

Certain changes in maternal embodiment are taken for granted when within medically acceptable parameters. Nausea, weight gain, and back pain can all be part of what is considered normal pregnant

embodiment. These three common physical effects of embodied pregnancy are prevalent in the interviews and provide a normative point with which to begin the analysis of the process of monitoring and surveillance that is contemporary pregnancy. Even within these experiences, we can see how women embody medical advice and social pressures that implicitly guide them on what it is to be a 'good patient' and thus a 'good mother.' Experiences of nausea, weight gain, and back pain challenge the pervasive verity of the supposed glowing mother. Sylvia, Kathleen, Elsa, and Isobelle each explicitly referred to their failure to glow during their pregnancies. And, as Isobelle relates, the social depiction of morning sickness is far removed from what many women find themselves living through. 'I remember in the movie *Look who's talking* Kirstie Alley is pregnant, and this is where all my perceptions come from, from what I see in movies, and she has nausea. And she goes to the bathroom and she throws up and then she comes back to her desk and she sits and she goes back to work and, and that's what I thought it would be like.'

Popular depictions of a woman running to find somewhere to retch in private or fainting, in film or on television, are readily decoded as evidence of pregnancy and were so for decades before discussing it was acceptable in polite company or on the screen. Although not every woman experiences morning sickness, it is a powerful physical expression of the unsettling of the female body during gestation that, as Isobelle points out, is popularly represented as innocuous and manageable. Among the interviewees, several do not mention morning sickness or do so only to clarify that they were minimally affected. As Lola says, 'I had sort of fairly mild morning sickness, you know, I was pretty fit and healthy [in my first pregnancy]. I didn't have any, it just wasn't a difficult pregnancy, throughout.'

Most of the women who openly talk about being adversely affected by morning sickness experienced it in the first and/or early in second trimester. For Meaghan, 'during my pregnancy, physically I didn't feel great, I was really sick for the first 15 weeks as lots of people are. And that was really hard, those first weeks.' It is also not uncommon for women to have it in one pregnancy but not another, as Lola found: 'my pregnancy with [my son] was—was really different [from that with my

daughter]. I had quite intense morning sickness.' But no matter when it occurs, it can be both physically and emotionally challenging. Eleanor puts it succinctly, saying that you feel 'really crap.' Furthermore, it can be pervasive. Esther describes finding that 'it was getting worse and worse day by day and I couldn't cook, I couldn't smell, I couldn't talk, I was just lying down.'

Morning sickness is ubiquitously understood as a likely part of early pregnancy and, therefore, it tends to be normalised, with the expectation from family, friends, and health practitioners that it is simply a part of the process of having a child. Daphne observes the lack of empathy, saying, 'yeah the girls at work were a bit, "Oh what—what are you complaining about? At least you're pregnant, you know."' Or, as Meaghan says, 'lots of people are' morning-sick, implying that she had no right to complain about feeling ill. This normalisation extends to medical advice, in Isobelle's case concerning how to deal with nausea on public transport: 'my GP [general practitioner] gave me this recommendation to carry a plastic bag in my handbag so I that I always had something to throw up into if I needed to.' Women thus embody the expectation that they will minimise the shared experience of it being 'really hard' (Meaghan) and of feeling 'so awful' (Marie) .

These narratives of morning sickness are far removed from the popular representations of it as amusing or innocuous, but even more from its most serious manifestation, Hyperemesis Gravidarum (HG). Eithne, Isobelle, and the pregnant partner of Alexander experienced morning sickness throughout gestation, to the point where they were living with what Isobelle described as 'completely rotten … 24 hour-a-day nausea.' As Eithne relates, 'I got quite bad morning sickness, hyperemesis, so I was in hospital for a good four months and, yeah, on a drip. It wasn't fun.' Even Eithne's characterisation of hospitalisation and treatment with intravenous fluids for months as merely 'quite bad' understates the seriousness of her condition. Implicit in these women's experiences is the wider pressure to accept that pregnancy brings unpleasant side effects, an undercurrent of guilt among those who felt ill, and a sense of being judged when they voiced their discomfort. For Isobelle, 'the over-arching message is this is just what it is and—and you just have to deal with it.'

Herein lies one point of resistance to medical advice. Anti-nausea medication for hyperemesis raises fears and feelings of unease, as Alexander reveals in his comments about he and his partner being 'concerned … you know, the thalidomide and stuff' while his partner was taking medication. The medically culpable damage to infants due to the use of thalidomide remains a strong cultural memory more than half a century after it led to birth defects in babies whose mothers took it during pregnancy for nausea and hyperemesis (Brynner and Stephens 2001). Alexander counters the fact that they acquiesced to medication by stating they had otherwise attempted to 'keep it as natural as possible.' Yet, unmedicated hyperemesis can lead to weight loss, dehydration, and nutritional imbalances, endangering the lives of both mother and foetus. To let such symptoms go unchecked implies a pregnant woman is being a bad patient and a bad mother, while taking medication linked to the collective memory, if no longer in fact, with birth defects also seems to require a defence.

Unlike nausea, which is an anticipated but not a universal experience, weight gain is a necessary part of gestation, with the combined addition to the woman's body of the placenta, amniotic fluid, and the growing foetus that they protect. It is also one of the most closely monitored aspects of maternal embodiment, even before conception. Health practitioners, maternal health and well-being advice manuals, and support networks all encourage women to 'get healthy'; to monitor their weight and improve their food habits (especially increasing folic acid intake to avoid neural tube defects); and to keep fit, in preparation for a pregnancy.

Pregnant women are also admonished not to listen to the once popular belief in the idea of eating for two, lest they develop diabetes or other gestational complications. As of 2017, the Victorian government advice on healthy weight gain varies between 5 and 18 kilograms depending on Body Mass Index (BMI) (Department of Health & Human Services 2017), but the pervasive message is not to gain what is considered too much (or too little). This stricture is reinforced by women being asked about any weight gains or losses and having fundal measurements plotted at regular prenatal check-ups. The women interviewed had thoroughly embodied this message and explicitly used their

weight during pregnancy as a marker of pride and of self-admonition. Elsa captures this vividly when she reflects on the difference between her pregnancies: 'the first one, emotionally felt good, you know and sort of physically, wasn't sort of really putting on too much weight, which I sort of found good. … Second one I thought "Yeah, I'm carrying a bit more weight still from the first one." [laughs] So, I didn't feel quite so good about it.' Elsa's observations demonstrate a clear acceptance of the concept of 'too much' weight, a desire to avoid acquiring the latter leaves one feeling 'good' and 'fit,' and concern that failing to do so has negative connotations, not only physically, but emotionally.

Among those who remark that they had put on more than a medically advisable amount of weight, guilt and shame are evident, but there is also a level of defiance in some cases. Weight gain was particularly fraught for Lola, who experienced an eating disorder when young and feared a recurrence.

> I think that was probably why I was focusing a lot on being fit and healthy in pregnancy … because becoming big again, I just didn't know how I'd feel about that. I wasn't very confident that I'd feel very good, so … my strategy was just to be as conscientious about, you know, body and health and eating as I could for—not only for the baby's sake but for mine. So—so that I wouldn't be an unhappy pregnant woman.

Lola explicitly prioritises the effect that being overweight might have on her baby, showing that being 'conscientious' about her weight and maintaining her level of exercise fit within a medically and socially approved model of maternal health. She also acknowledges the connection in her experience of being overweight and being unhappy, emphasising the desire to do the best for her future child through taking care of herself.

Exactly what constitutes gaining 'too much' can also be subjective, as the comments of Kathleen's experience of singleton pregnancy and of Marie's pregnancy with twins demonstrate. Kathleen relates that she 'put on 10 kilos within about 30 seconds of being pregnant. I now know that it's because I developed a form of arthritis which messes with your metabolism, … So, I put on 40 kilos, and that's not an

exaggeration, I literally put on 40 kilos from the beginning of IVF to my baby … being born.' In Marie's case, 'by the time they were born I weighed over 100 kilos and I put on like 23 kilos or—a huge amount of weight.' While Kathleen takes a humorous tone, her comments reveal self-criticism, despite the fact that she now knows that, apart from the weight gain often associated with IVF, there was also a medical reason for her weight gain. Marie feels equally horrified at the 'huge amount' she put on, despite carrying twins.

It is undeniable that, for anyone, the more weight one carries, the more stress is placed on ones' skeletal structure and joints. The added factor in pregnancy is that three or four kilos of that weight can shift, independently and unpredictably, as a pregnancy reaches its latter stages. The associated back pain need not involve untoward weight gain. Several interviewees experienced non-specific back pain or sciatica, and two experienced pelvic separation. Caused by hormonally induced over-relaxation of the ligaments around the symphysis pubis, pelvic separation is less common than back pain but equally painful and is similarly exacerbated by movement.

The effects of each of these conditions can range from positional discomfort to constant pain. Olivia elaborates: 'I did something to my back. And while I had felt I was very fit with my first baby and did all that walking around the horse paddock, I think I'd been, my body had not been in proper alignment the whole time. So when I started to really have some proper weight on with my second baby, my back just went. And, I couldn't walk. And I was just in horrible pain.' There is a level of self-remonstration implicit in Olivia's 'I did something to my back' and also in the suggestion that, had she been properly aligned in her first pregnancy, she may not have experienced this unpleasant outcome of her body's adjustment to a second pregnancy. This kind of acceptance of responsibility or fault for a non-conscious action is also present in other women's comments, such as Sylvia's comment that, 'I slipped or something stretched and then I just was not happy being in pain.'

This expectation or acceptance of the likelihood of back pain in pregnancy stems also from health practitioners' responses, as emphasised by Hannah's feeling that the midwife trivialised her constant pain:

> third trimester I got sciatica really badly and I couldn't walk very well, I had to have a special chair at work. … I couldn't even walk to the toilet up the stairs. When I talked to the midwife she basically just said, 'Get crutches,' and I said [laughs], 'This is hell on earth, I can't walk to the toilet in my own house, I can't even, I can't walk without stabbing pains and I've got this continuous sciatica.' And they just seemed to brush it aside, 'Oh it's nothing.' So, I felt a little bit let down.

The understated criticism in feeling 'a little bit let down' with a member of the caring professions who seemingly dismissed her serious pain as something to be put up with suggests that Hannah's sense that the midwife's attitude is unexceptional and perhaps even warranted. She is disappointed, but accepts her situation as within the parameters of a normal pregnancy, not a medical complication necessitating intervention. This is despite, or perhaps amplified by, the fact that Hannah experienced not only sciatica but also pelvic separation during her second pregnancy, which required her to wear 'a brace to work. … The first one [baby] had stretched it but this one, being so big, had fully separated it down here.'

Much like the subjective responses to gaining weight, not everyone responds in the same way to pain. For Lola, physical pain and emotional pain were allied: 'I had mild pelvic instability which … was very uncomfortable to do any exercise. … I had to put on a lot more weight than I did with [daughter's name] and, I wasn't then as mobile.' As seen earlier, Lola was particularly conscious of gaining weight and fearful of a return to obesity. She strove to be compliant with weight monitoring both for the baby's sake and for her own. She downplays her pelvic instability as 'mild,' yet at the same time makes explicit that the ability to be a good mother/patient by exercising to maintain an acceptable weight is taken out of her hands because this condition, caused by pregnancy, limited her mobility to the point where she was unable to do so without significant discomfort.

Clinical complications in pregnancy are, by their nature, less common and attract more medical attention and consequently more intervention, but not necessarily more empathy. Standard maternal health monitoring is intended to allay and/or detect specific complications.

A number of complications were reported by the interviewees, some of which were slow to manifest and others that required urgent interventions.

Participants briefly mentioned a number of aspects of their pregnancies that resulted in increased medical attention. Eleanor had an iron deficiency and regular blood tests as a result, to ensure maternal and foetal health was maintained. Daphne, who had also experienced morning sickness, reports that her 'blood pressure just rose a little bit … but it was fairly non-eventful. Like, the pregnancy just was your standard pregnancy.' Other potentially serious conditions were mentioned as having been medically investigated but without confirmation, Mary 'had to have all sorts of checks' for suspected deep vein thrombosis. And, as we saw when Kathleen was discussing her weight gain, she had developed a form of arthritis, related to her pre-existing psoriasis, that persisted postnatally: '[it is] triggered by a sort of a, an immune system overloaded stress on your body which is exactly what pregnancy is [laughing]. … [T]hat started pretty much straightaway, that achiness and, yeah, that beached whale thing.'

For other women, further medical investigation led to urgent intervention. Bethany describes how her compliance with regular medical monitoring revealed a problem of which she had been unaware. She recounts how she 'had a check-up at 24 weeks and, I went up for a scan and it showed that my cervix was shortening,' requiring admission to hospital. Bethany faced a condition that threatened to bring on a dangerously premature delivery and medical options that might induce miscarriage. Bethany's narrative of fear and uncertainty reveals the disquieting effect of the conflicting medical opinions given to her, particularly given the painfully present possibility of a late miscarriage or potential stillbirth. Further, the attribution of ownership that appears here and in the medical discussions of 'my/your cervix' or 'my/your uterus' implies some kind of responsibility for her situation. Women (and men) absorb these basic invocations of responsibility, and it contributes to the guilt they feel when complications occur.

A number of accounts involve serious complications, most of which led to hospitalisation or early delivery. All were related to the threat or the sudden onset of bleeding. Even in well-equipped and expertly

staffed hospitals, maternal haemorrhage remains a dangerous possibility in pregnancy. The ways that women responded to sudden or prolonged bleeding varied, much as the women who gained weight or dealt with pain brought their own identity to the situation. Stress was the overwhelming emotion behind the experiences of the four women whose reflections form the basis of the following section, but their comments also suggest that suppression, irony, and a surface downplaying of the situation can provide defence mechanisms against frightening or life-threatening situations.

Georgina faced the possibility of haemorrhage and hospitalisation as her pregnancy progressed: 'I had a low-lying placenta as well … which was a bit stressful. … [T]o be honest I don't—a lot of the stuff I don't really remember. I guess you just either bury it or just forget and move on and you know.' Georgina dismisses her stress as in the past, but her reference to suppressing the memories suggests the strength of their unpleasantness. Ava experienced placenta praevia, in which the placenta partly or entirely obstructs the baby's exit via the cervix. This condition poses a serious danger of placental rupture during vaginal delivery, risking maternal and foetal mortality. Caesarean delivery is thus recommended. As Ava elaborates,

> I was gonna have to have a caesarean and that was all booked in and I went to have my appointment with my doctor at 37 weeks and he said, 'Oh, look, by the way, I'm not gonna be here on the weekend but that's fine. You know, we're gonna be doing the operation next Thursday. There's only a small chance that you might start bleeding from your placenta praevia and, in which case, it's fine. Just ring the hospital and come straight in, we'll do an emergency caesar[ean section] but I'm sure it will—that won't happen and I'll see you next Thursday.' … So, of course, that weekend, it happened.

Ava recounts her experience using irony, downplaying the severity of the risk to her life and the seriousness of her condition by contrasting it with the relaxed attitude of her doctor. But, like Georgina, Ava's downplaying of the memory of what must have been a stress-filled event

heightens the sense of what is not stated—the fear and anxiety experienced in the moment.

Several women experienced significant bleeding for less clear reasons. Sophie had an unexplained haemorrhage at 28 weeks which led to hospitalisation and ongoing bleeding for 10 days, until the premature birth of her son at 30 weeks. Eithne had an unexplained haemorrhage at 26 weeks with her fourth pregnancy for which she was temporarily hospitalised and experienced regular bleeding every two weeks until the baby was delivered at 34 weeks. With her sixth pregnancy, Eithne was diagnosed with a sub-chorionic haematoma that bled continuously and threatened miscarriage of the foetus from confirmation of the pregnancy until more than half way through the pregnancy. Beginning at five weeks, 'I got scanned quite regularly and … this haematoma was—it was big and it just needed to just bleed out. And that's what it did and it was either going to take the baby with it, or it wasn't. As it was, it didn't, which was fantastic, but it was—it was—yeah, horrible. That lasted for 22 weeks, where I just bled all the time, and then all of a sudden it just stopped.' Irrespective of the causes, which sometimes go undiagnosed, as Eithne remarks pithily, 'being pregnant and bleeding does your head [in].'

These women's responses to the constant advice and admonition related to their reproductive lives, their explanations of how they dealt with discomfort and life-threatening complications, are full of examples of when they felt they fell short of those expectations, which are reported and maintained in their narratives through self-criticism and self-surveillance. Women's retellings of their experiences provide insights into how their subjective experiences of pregnancy are guided by deeply ingrained social and medical expectations of their behaviour, with an implicit pedagogy on what it is to be a good mother and a good patient, or how to embody pregnancy. The remainder of this chapter explores a corollary: how through embodying medicine during pregnancy they also experienced embodying their child-to-be.

Embodying the Child

The first weeks of pregnancy are the most precarious for the embryo. If one has an irregular menstrual cycle, or if one is not actively trying to become pregnant, miscarriages in the first two or three weeks after conception can go unnoticed. However, if one is trying to conceive, miscarriage within the first twelve weeks of pregnancy is a ubiquitous concern. Since the 1980s, many, if not most women, have used a home pregnancy kit in the first weeks after conception, before attending a GP for confirmation and embarking on regular check-ups and booking into a hospital. As a result, early miscarriage is more visible.

The first trimester is the period when it is medically and socially understood that miscarriage is most likely to occur. Many women choose not to disclose their pregnancies until that marker has been passed. The stage of gestation and the degree of difficulty in achieving pregnancy can affect how women interpret and feel about a miscarriage. Elsa, for example, experienced a number of miscarriages: 'And again, you know, the odd miscarriage here or there. Had one that was a little bit further along, might have been 12 or 14 weeks, which you know, it sort of played on me a little bit. But not, not really a lot. You know, I was disappointed, because I thought "Oh, you know, we really wanted to have one."' Elsa's response to multiple early miscarriages throughout her childbearing period does not immediately reflect the emotionally charged grief that other women may feel, particularly those who have taken the path to assisted reproduction. Her understated response to repeated miscarriages, 'here or there' because she knew it was 'fairly ordinary,' and the way she characterises how she felt as 'disappointed' when she lost the foetus that had almost reached the second trimester present as accepting, even detached. Yet, as with the use of irony in earlier examples of emotional responses, Elsa's seemingly uncomplaining attitude may also be a way of suppressing much greater disappointment than she chooses to convey openly.

For others, multiple miscarriages evoke a range of sentiments, from anxiety to a sense of empowerment and agency. Kelly does not mention directly how she felt when her repeated miscarriages happened, but the

experience of having them led to anxiety when she was carrying her second child: 'I had three miscarriages and only one, you know, successful pregnancy that led to a baby. And so my pregnancy was quite difficult in that it was constantly worrying that something was going to happen, which was completely not my experience first time round.' Ava's experience of miscarriage was more complex, as it involved both assisted reproductive technologies (ART), due to fibroid cysts, and a stillbirth. She had a miscarriage of an undiagnosed naturally achieved pregnancy as a result of the ART hyperstimulation treatment, prompting her to take a more active approach to achieving a successful pregnancy:

> all that planning that led up to getting pregnant with my son, it gave me a bit of confidence as well because I felt like I was taking some control back and doing all I could to try and ensure it wasn't gonna happen again. … [The specialist] explained to me that, you know, for a subsequent pregnancy, he would—and he was very positive, you know, I would get pregnant again and, and he would put a stitch in my cervix when I was about 12 or 13 weeks pregnant and that would give me about a 95 per cent chance of getting through to a viable stage of the pregnancy.

Like Elsa, Ava characterises her experience of miscarriage as saddening and a setback, but not as emotionally debilitating. She presents herself as adhering to notions of what constitutes a good patient and a good mother, with faith in the medical treatment she was receiving.

With increasingly sophisticated medical technologies, the demarcation between miscarriage and premature birth is a boundary that continues to be tested. Once a foetus reaches a stage of development that makes survival outside the womb viable, what in the past might have been a late miscarriage may now be a premature birth, which brings with it a different range of emotions. In the case of twins, a premature or early birth is not uncommon. As Caitlyn recounts, 'I had women around me who had had—their babies were coming out at 29 weeks and I made it to 36 weeks which is pretty good for twins.' Caitlyn expresses a sense of achievement in retaining her twins until the pregnancy was well advanced in comparison with others, despite the fact

that in the last weeks carrying them was putting significant stress on her major organs.

Even when premature babies survive and thrive, women can feel that it was in some way their fault that their baby was born early and required intensive care. Sophie, for example, felt that her mental state had physically affected her pregnancy, asking rhetorically, if her son was 'premature because I had those morbid thoughts during his pregnancy … [or] my—my body and my mind [was] preparing myself for it? I don't know, I don't know if it was a self-fulfilling prophecy or whether it was actually, you know, something instinctive in me that knew something was wrong.' For Sophie, these thoughts had begun at eight weeks, before the first scan at which she was told there was a strong possibility that the foetus had Downs Syndrome. Such a diagnosis inevitably leads to a discussion about termination, a difficult decision to be faced with in the context of a desired pregnancy, especially when framed by medical and social expectations of striving for a 'healthy,' 'normal' child-to-be. After further testing, it turned out not to be the case, but the dark thoughts haunted Sophie throughout her pregnancy.

Thus far, the analysis has related directly to the maternal body and how women's perceptions of their pregnancies display their embodiment of medical and social expectations of them, in ways that may or may not have direct consequences for the foetus. As has been demonstrated in the preceding discussion, even when dealing directly with normative aspects of pregnancy, medical discourse seems to be on the verge of discovering maternal or foetal complications. Alongside this, socially women are expected to feel attachment to the growing foetus and to think prospectively of the person-in-making: a little baby. This is increasingly intensified by the medical capacity to visualise the foetus from the earliest stages of development (in IVF, from conception). This final part of the analysis focuses on these women as they experience embodying, both physically creating and perceiving themselves in relation to, their child-to-be.

Many of the interviewees talked about the foetus in ways that suggested emotional care not only for the foetus's physical well-being but also in relation to the direct connection with a growing life. Meaghan speaks of the point of realisation that there is 'a little baby, it's part of

me, inside me' and Caitlyn expresses her amazement that in 3D ultrasounds 'you can actually see their faces and stuff.' Esther's comments are particularly intense in recounting her feelings towards her child-to-be: 'I was so proud, you know, I—I was so happy, so excited. I was so proud that I'm going to be a mum. I remember I still have my notes, I left—I—I used to write notes for my to-be-born baby and I didn't know whether she was a boy, the baby was a boy or a girl, but I used to leave my notes and to call her by very beautiful names.' There is a palpable emotional attachment to a projected baby in Meaghan and Esther's descriptions of their perceptions of their expectant babies. For Caitlyn, her excitement is emphasised and facilitated by the medical technologies that put faces to her developing twins.

The emotions as described in these comments fulfil the expectations of implicit pedagogy of what it is to be a modern mother, lovingly expectant of the relationship to come with the unborn child. Later chapters in this volume provide insights into how these women relate to the baby once no longer imagined, complicating these memories of pregnancy. It is worth remembering that the day-to-day reality of caring for an infant is likely to have affected how women remember their feelings before their baby arrived. We have seen that suppression of distressing events was Georgina's recommended response to a difficult experience, but for other women, reshaping or recasting their memories of intense emotional experiences may also be a way of dealing with a traumatic or troubling situation. All interviewees actively construct their narratives and may reshape and recast past experiences and events to make them align to their expectations or those of the interviewer, medical carers, or society more broadly (Gubrium and Holstein 2014). Thus, either superlatives, as seen above, or self-criticism and self-doubt, as in the following examples, are perhaps being used to make sense of or rationalise the discrepancies between what was imagined during pregnancy and the lived experience of parenting.

Social expectations that women will form loving attachments to the foetus also bring pressures, whether spoken or unspoken, that can engender the kind of guilt observed earlier and associated admonishments to ensure the best interests of the child-to-be. As Isobelle states of her feelings of guilt over experiencing HG, 'already you're feeling like

"Am I being a good mother? Am I doing the right thing?" And inevitably you came to the conclusion that perhaps you weren't but it was the only way that you could, could manage to cope, I think.' Eleanor's worry about the environment in the heavily polluted area where she conducted fieldwork while pregnant conveys the guilt she felt at the time that she may have adversely affected her baby. There is strong evidence that environmental pollutants can lead to foetal damage with long-term effects on the resulting children, Agent Orange being a case in point (Ngo et al. 2006). Reminiscent of Alexander's concern about his partner taking anti-nausea medication, for many pregnant women, there is an ongoing internal dialogue about whether one's actions during pregnancy meet social and medical expectations. Eleanor thus implicitly expresses what Isobelle asks explicitly: 'am I being a good mother?' While Isobelle expresses the belief that she is not being a good mother, even posing the question and reflecting on her parenting suggest that the correct answer is more likely to be 'yes.'

Other interviewees express even more profound self-surveillance and self-doubt than Eleanor and Isobelle. Esther's loving notes to her 'to-be-baby' are precisely the kind of attentive actions that Sylvia remonstrates herself for not performing. She blames herself for not being sufficiently attached to her baby during pregnancy and for thus undermining the early relationship with her baby once born. 'I could have focused more on the baby,' she chides herself. 'And I could have talked to her more, and acknowledge her more. And I wasn't the type of mother who read and sung to her unborn child. I was the mother-to-be who complained, "Ah, you're kicking me and I feel so big. And I can't turn and,"—maybe I feel the guilt because I could have established a better relationship then.' Sylvia openly states her feelings of guilt, mostly for expressing frustration with the embodied changes that envelope the pregnant body. She castigates herself for worrying 'about me not wearing high heels, me not being able to bend, me not being able to sleep at night. And all the complaints were just about my physical wellbeing.' The repetition of 'me' is a claim to self-centredness and that she should have cared more about the state of the child-to-be than her own needs and desires. On the face of it, she does not feel she lived up to the social ideal of the besotted, excited mother-to-be and as a result had neglected building

a relationship with her unborn child. But it is also possible that this heightened self-criticism is a narrative strategy. Sylvia is perhaps reflecting with some degree of irony on the way she had complained about carrying the child-to-be and rationalising her actions then against her relationship with her child since birth.

Uncertainty and self-doubt are not confined to the women discussing their perceptions of the gestation of a first child. Having been through one pregnancy prepares one to some degree for a subsequent pregnancy, but having had one child is no guarantee that subsequent pregnancies will be experienced in the same way. Indeed, already having a child is, in itself, likely to alter the experience of a subsequent pregnancy. Laura and Lucy each represent their relationship with the foetus in their second pregnancies as affected by their experiences with their first children. For Laura, how she related to her son's health issues shaped how she experienced her second pregnancy with her daughter: 'So I had the pregnancy with her not knowing what was going on with [my son] health-wise and up until the very end I remember giving birth and just thinking, you know, "Is she alright, is she alright?" Just not knowing what was going on with him.' Laura's son had undiagnosed developmental difficulties that were under investigation throughout her pregnancy with her daughter. These uncertainties deeply affected her perception of her second pregnancy, making her fearful for her unborn daughter's health. For Lucy, having first had a daughter and knowing that she was carrying a boy, she worried that the sibling dynamic between her two children would repeat the unhappy relationship she had had with her own younger brother. 'It's the second child and I was the first and my daughter was a girl and she was the first. And, oh no, what am I going to do? I hope I don't do the same thing to her that I felt and all that sort of thing.' For Nina, her first pregnancy was her partner's second child; his first child had died shortly after birth of a chromosomal abnormality. This experience had reportedly left him 'feeling really fucked up' and overshadowed Nina's pregnancy with foreboding, until prenatal testing allayed the couple's fears that this child might carry the abnormality.

For some mothers, the relationship to their unborn babies was quite tenuous. Olivia, for example, 'had no connection to what was in me. I just didn't … I didn't have this great love for what was inside me or

anything. I just, I love research, and so I just read everything.' There is no sense of a child-to-be in the abstract notion of 'what was in me.' Instead, by concentrating on what had consumed her up to that point—her work—Olivia made a connection with the child-to-be through researching pregnancy. A similarly abstract characterisation of the foetus is voiced by Leah, one of the women who was also morning-sick: 'really for the first time [I] experienced that my body was not my body. It was someone's home and I guess I just—you know, on top of feeling horrible about my career ending, I felt horrible about, you know, [laughs] having this little thing inside of me that just zapped any amount of food I put in.' Like Olivia, Leah grappled with the loss of work and a concomitant shift in identity. She characterises the foetus almost as an abstract 'little thing,' a parasite that had made its home in her. In saying that 'my body was not my body,' Leah not only suggests she has been seemingly taken over, but conveys a sense of alienation between her embodied self and the baby within her. She rejects the foetus from her own embodiment, thus rejecting the social expectation of attachment to her child.

Marie notes the dissociation she feels from her own body but expresses care and responsibility towards the infant she was bear. As she puts it,

> my pregnancy was difficult. I've never felt so vulnerable in my life because you've got this precious cargo that you're carrying and you've got to watch everything you eat and everything you do because, you know, if you fall down you're probably not going to get hurt, but you could do terrible damage to them and, you know, I was very aware [that] they were my partner's children as well and I was carrying them for both of us. So, there's a huge responsibility. … [And] it didn't feel like my body because I was gradually just sort of bloating up and my feet were swelling.

Marie presents herself as vulnerable, responsible, guilty, self-monitoring, and food-conscious. On top of it all, she conveys a sense of disassociation, expressed in her phrase that it 'didn't feel like my body.' But even within the disassociation from her body, she also reiterates the socially expected attachment to her 'precious cargo.' Carrying IVF twins added

to her feelings of responsibility for her 'partner's children,' perhaps an odd thing to say given that all pregnancies are created and embodied out of the genetic matter of more than just one being. Her testimony may also indicate the level of abstraction introduced by the hyper-medicalisation of the procedure that facilitated the pregnancy, explored in detail in the previous chapter. And yet, Marie's comment encapsulates all the medical and social concerns from these women's narratives of embodying pregnancy and embodying the foetus.

Conclusion

As Duden (1991) details in her study of eighteenth-century medical records, historically, pregnancy was not considered established until quickening, when foetal movement was felt by the woman. Miscarriages before this point were understood as heavy menstrual flows. Today, pregnancy can be determined within days of conception and early scans provide images of the foetal body that give shape to the projected child. The sex of the foetus no longer need be a mystery until birth, even though many parents still choose to wait until birth to learn that information. Connections with and expectations about the projected child for many expecting parents begin to be built very early in pregnancy, intensified by a visible form being given to the otherwise abstract notion of the foetus. All these factors affect how a woman imagines and responds to her child-to-be and in turn experiences her pregnancy. However, distinct differences remain between medical and social expectations of pregnant women in this regard.

In the narratives of pregnancy analysed in this chapter, it is possible to discern the ingrained acceptance of medical and social injunctions on what it is to be a good patient and a good mother. In embodying medicine, a good patient follows her doctor's and her society's public health messages to be healthy, fit, put on 'just enough' weight, and to accept that she will probably feel unwell and be in discomfort or even in outright pain. She internalises the idea of her pregnancy as being separated into stages, marked by regular interventions, punctuated by unnerving scans, and counted down week by week. In embodying the

child, a good mother will do all this and also bond with the foetus, and cope with every challenge that arises, all the while glowing with vitality and the anticipation of maternal bliss. In many ways, these are impossible, even unreasonable, ideals. The narratives on which this chapter draws demonstrate the degree to which those ideals are embedded and embodied in experiences of pregnancy and the guilt, self-doubt, and self-criticism felt when the interviewees felt that they fell short. And yet, the accounts also show that the lived experience of pregnancy exceeds those medical or social expectations.

The active construction of experiences of pregnancy and the characterisation of perceptions of children-to-be have provided insights into how well different women are able to negotiate the implicit pedagogy around pregnancy. While most narratives display the varying ability of each pregnant woman to follow the expected patterns and behaviours of pregnancy, we also saw instances where narratives revealed a resistance to medical authority or social expectations of loving attachment to the child-to-be. In Bourdieu's terms, some interviewees adhered to what was expected and some were more expert in the apparent 'rules of the game' and thus able to resist or turn to their own ends what was expected of them. Each of the narratives reveals how people found ways of mediating and negotiating embodied medical and social injunctions in transitioning through pregnancy to parenthood.

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4

Pain and Suffering in Labour and Birth

Paula A. Michaels

The meaning and management of pain have since time immemorial been central—arguably, defining—dimensions of childbirth. In the developed world, women must decide whether or not to avail themselves of anaesthetics and analgesics during labour and birth; how they understand the wisdom and utility of the choice they make contributes to their assessment of their birth experience as positive or negative. Advice books explore the question of pain management in childbirth, while antenatal courses present the pros and cons and the mommy blogosphere perennially buzzes about the issue. Many advocates of so-called natural childbirth insist that only by eschewing pharmacological pain relief can a woman experience a fully empowered, satisfying birth. Others argue that modern advances in pharmaceuticals in maternity care have allowed women to have a more joyful experience of childbirth by sparing them the intense physical pain that is typical for so many labouring women (e.g., Klein 2016).

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This chapter explores how mothers and their partners reflect upon and articulate their experiences of pain and suffering in childbirth. I first offer a brief history of pain and its management in childbirth. I survey modern pharmacological and psychological approaches to obstetric pain, situated in the Western cultural tradition in which they developed. Drawing on narrative interviews conducted in contemporary Australia, I then analyse how women remember and understand their experience of pain, which was often intense and overwhelming. The expectations women had about pain, its meaning, and its management affected how they remembered labour and birth. For some women, it was insignificant or an experience best forgotten, while for others it was an enduring trauma that figured prominently in their launch into parenthood. The final section explores the traits that one scholar has identified as defining a 'good birth,' that is, a satisfying, empowered experience. Women's birth narratives, including their memories of and feelings about pain, serve to illustrate these characteristics and to suggest a road map to improved quality of care and satisfaction in childbirth. What is clear from women's stories is that finding equanimity about pain in childbirth can be truly challenging; for many women, the pain of labour and birth escalates into real and perhaps unnecessary suffering. Genuine, deep, heartfelt care is perhaps the key safeguard against physical pain escalating into psychological suffering both during and after childbirth.

The History of Pain Management in Childbirth

Contemporary debates about labour pain link to a long genealogy. In the Western cultural tradition, normative ideas about pain in childbirth trace back to the Hebrew bible (Genesis 3:16), in which God curses Eve and her descendants: 'in sorrow thou shall bring forth children.' That injunction was used for millennia to inscribe meaning on women's suffering as the fulfilment of God's will. Despite this justification, of course, wise women around the globe used what comfort measures were available to ease pain in childbirth, for example: herbal remedies; massage; acupressure; aromatherapy; heat and cold; positioning. Moreover,

women found relief from their suffering in the emotional support of the lay midwives who shepherded them through labour and birth. Birthing at or close to home, women brought new life into the world surrounded by female relatives and friends.

In mid-nineteenth-century Europe and North America, childbirth practices began to change. The rise of the germ theory of disease led to attention to the sterility of the environment in which women birthed and a steady decline in maternal and infant mortality rates as a consequence. Increased safety in childbirth occurred alongside advances in anaesthesia and its obstetric application. As childbirth became less a matter of life and death, women's comfort during childbirth began to be an arena of intense interest. Among other considerations, promises of pain relief drew women to increasingly professionalised carers who began to work initially in the home and, over time, more and more in hospital settings. Queen Victoria's use of chloroform for the delivery of her eighth child in 1853 paved the way for an ever-expanding cornucopia of pharmaceuticals to combat pain in childbirth. Physicians mixed sedatives, anaesthetics, and analgesics in infinite combinations in their quest to bring physical comfort to women and order, calm, and quiet to maternity care facilities. Ether gained popularity in the USA, supplanted in the early 1900s by 'twilight sleep,' a cocktail of morphine and scopolamine first concocted in Germany. Far less potent, nitrous oxide found a broad base of devotees in Great Britain, where it remains a popular method of pain relief. The sedative pethidine, too, has enjoyed a long history of obstetric application (Wolf 2009).

Obstetric anaesthetics and analgesics grew in popularity thanks to support from both medical professionals and mothers, but they also had their detractors. There is some debate over the extent of opposition, but some critics argued against the use of obstetric anaesthesia on religious grounds, questioning whether chloroform and other medications violated God's command that women should suffer in childbirth (Farr 1983; Cohen 1996). In 1956, Pope Pius XII weighed in on the controversial question of psychological approaches to obstetric anaesthesia. Two methods of obstetric pain management through psychological conditioning and physical relaxation—alternatives to

pharmacological pain relief—had emerged after World War II. British physician Grantly Dick-Read developed what was alternately known as Natural Childbirth or the Read method. Almost concurrently and wholly independently, Soviet psychologists developed a similar method known as psychoprophylaxis and popularised in the Anglophone world as the Lamaze method, which relied on Pavlovian conditioning to explain how it achieved pain relief. Patterned breathing served to inhibit the transmission of pain signals along the cerebral cortex. Catholic obstetricians expressed concern that these approaches contradicted Genesis 3:16; moreover, developed in the atheist Soviet Union, the Lamaze method raised concerns that its use might suggest support for communism. Pius XII made explicit that neither the Read nor the Lamaze methods violated Church doctrine. Catholic women could use either method without compromising their faith. Interestingly, the pope condemned the use of hypnosis in childbirth because he believed it robbed women of their full, conscious participation in birth, thought to be an important part of the transition to motherhood ('Discours du Pape Pie XII sur l'accouchement naturel indolore' 1956; Michaels 2014, pp. 76–77).

Proponents of the Read and Lamaze methods based their case for a psychological approach to pain relief and against pharmaceutical anaesthetics and analgesics on, among other factors, safety considerations. Evidence suggested that the powerful drugs available in the mid-twentieth century led to the birth of sedated, anoxic babies. The thalidomide scandal raised awareness that drugs administered to the mother passed to the baby through the placenta and heightened fears of taking drugs during pregnancy, labour, and birth. Reluctance to take drugs to alleviate pain in labour was further strengthened by the mainstreaming in the later 1960s and 1970s of countercultural values, including a rejection of the post-war embrace of 'better living through science.' Instead, an increasingly wide swathe of the middle class began to see 'natural' as better, including in childbirth (Michaels 2014, pp. 113–118; Binkley 2007).

Building on this antipathy towards the use of drugs in pregnancy, labour, and birth, in the 1970s second-wave feminism offered a fresh challenge to the use of obstetric anaesthesia. The women's health

movement saw conventional obstetrics, including labour and birth in the hospital setting under the supervision of male physicians, as disempowering to women. Many feminists argued that mainstream medical practices, including in maternity care, wrested from women the authority to control their own bodies. When, historically, birth had taken place at home, women cared for women. A slight uptick in home births during the 1970s reflected feminist suspicion of the patriarchal medical establishment and of the dangers of what anthropologist Robbie Davis-Floyd terms the 'technocratic model of birth'—a birth characterised by medical interventions that are often driven by considerations of convenience for the medical staff and a distrust of women's bodies to function in a normal and healthy way (Davis-Floyd 2001; see also Morgen 2002; Nelson 2015; Kline 2015).

By the mid-1980s, the natural childbirth movement was in decline and the use of pharmacological pain relief was again on the rise. Greater access to and advances in epidural anaesthesia contributed mightily to the swing of the pendulum back towards technocratic birth. Epidurals allowed women to achieve the very thing that many women sought in childbirth—to be 'awake and aware,' something that the powerful pharmacological pain relief options available in earlier decades had not facilitated (Chabon 1966). Unlike twilight sleep or general anaesthesia, epidurals in most cases offered women effective pain control without diminishing their alertness. When administered successfully, epidurals allow women to be fully conscious and alert, yet pain free during labour. Ideally, the anaesthetic wears off enough during birth that the woman can push effectively. Despite a lack of clear evidence, however, detractors argue that it slows the progress of labour and leads to a range of interventions, including contributing to explosive growth in caesarean section rates (Halpern and Abdallah 2010; Zwelling 2010). Opponents assert that it carries risks for the mother and child that are not sufficiently appreciated by the women who consent to the procedure. The most zealous opponents claim that epidural anaesthesia can rob women of an opportunity to experience the euphoric, even orgasmic ecstasy of birth (Pascali-Bonaro and Liem 2008).

In the early twenty-first century, pharmaceutical options remain varied, as are the arguments for and against their use. In the Global North,

where there is ready access to drugs, one finds tremendous national variation in preferences. Approximately one-third of women in Australia and the USA rely on epidural anaesthesia for relief during labour. Around half the birthing women in Australia, Canada, and Finland and 60% in the UK avail themselves of nitrous oxide, a much less powerful drug with a long history of safe use and few side effects. By contrast, for complicated and as yet incompletely understood reasons, less than one per cent of US maternity care facilities offer this option, which enjoys so much popularity elsewhere (Plenda 2014).

Whether they have epidural anaesthesia, some other form of pain medication, or forego pharmacological relief altogether, for some women the pain of childbirth can be traumatic. For a small percentage of women, that trauma rises to a level diagnosable as post-traumatic stress disorder (PTSD). Entering the 1980 edition of the Diagnostic and Statistical Manual (DSM-III)—a compendium of psychological disorders officially recognised by the American Psychiatric Association and a standard reference work around the globe—PTSD has its immediate origins in the cluster of symptoms that psychiatrists began to notice among some veterans of the Vietnam War. These include flashbacks, hyper-arousal, and nightmares, as well as a range of frequently co-occurring conditions, including depression and substance abuse. Over time, mental health professionals came to recognise these symptoms in victims of other types of trauma, including childbirth. Like women with postnatal depression (PND), those with PTSD may be clinically depressed, but they exhibit the clear, distinct markers of trauma enumerated above. One Australian study of nearly 500 women found that at four to six weeks postpartum, 5.6% met the diagnostic criteria for PTSD. An additional 22.6% exhibited some symptoms of PTSD. Severe pain and obstetric intervention, particularly emergency caesarean sections, correlated strongly with PTSD. The overwhelming majority of these women—over 80%—expressed satisfaction with their birth experience, but that satisfaction did not preclude for some a lingering sense of trauma in the weeks and months after childbirth (Creedy et al. 2000).

As this brief survey of the historical record on obstetric pain and its management suggests, approaches to and meanings inscribed on pain

change with the times. At present a range of options are available to women that allow them choice about how to manage their pain, while the feminist health movement's legacy has been to encourage women to take control over their bodies and their care in order to maximise their chances of having the kind of birth experience they desire. But what is the relationship between expectations and experience with respect to pain? How does pain management relate to women's sense of having a positive or negative birth experience? How can we make sense of the fact that the vast majority of women express satisfaction, but a significant minority report experiences in labour and birth that leave them traumatised?

Women's Testimonies of Pain and Suffering in Childbirth

This section draws on narrative interviews with contemporary parents living in Australia to understand women's experiences of physical pain and emotional suffering in childbirth. Qualitative data offer insight into the complex relationship between pain, birth, and satisfaction. Listening carefully to their statements and their silences may point the way to improvements in outcomes, particularly with respect to women's psychological well-being.

A wide range of sources of information shape women's expectation of pain going into labour: antenatal preparation classes; books on pregnancy and childbirth; the recollections of friends and relatives of their own experiences; online resources; public discourses conveyed through visual and print media and popular culture. When her waters broke, Isobelle felt powerful, painful contractions right from the start. Their intensity took her by surprise as 'that wasn't what it said in the books and it wasn't what they said when we went to the birthing classes. The way it was supposed to go was you're at home for a really long time and you—you bounce on the bouncy ball, you know, you do all the exercises they tell you to do and your deep breathing.' Isobelle felt unprepared for divergence from that pattern with a lengthy, agonising labour

that ended with a caesarean section. The intensity of labour pain often takes first-time mothers by surprise. As Eithne puts it when describing her first child's birth: 'I'd done the antenatal classes and everything, … no one had told me how awful it is. Like it was such a shock. I didn't expect to feel such—such pain.' Extreme pain led Eithne to turn to epidural anaesthesia for relief. Offering advice to his labouring partner Sharon, who expressed a desire to avoid pharmacological pain relief, Rory recounts cautioning her that 'you don't know how painful it's gonna be so don't make your mind up until you're in there.' We do not know from Sharon's narrative if his words shaped her experience of labour, but she attests that 'I kind of had a rough birth. I tried naturally, and I just couldn't.' Despite her aspirations, Sharon received pethidine, nitrous oxide, and, eventually, epidural anaesthesia. When an episiotomy and vacuum extraction failed, Sharon and Rory's baby was delivered by emergency caesarean section.

The intensity of labour pain can be so unprecedented in a woman's life that processing and integrating the experience of it pose a significant challenge during labour. As Rosemary puts it, 'I was shocked by … my lack of capacity to deal with that pain, whereas I thought it was going to be awesome.' Women struggle for words that convey how utterly overwhelming the pain can be. In a typical comment, Kathleen grapples with putting the feeling into words when she says that the contractions 'just keep coming, and I was just, it's excruciatingly painful. More than I had ever even, different pain that [sic] I had ever imagined.' Precipitous labours, in particular, can present to women a cognitive challenge to grasping and coping with the pain. For Lola, 'it was five hours—intensely painful and I think I was just in a—the fight response the whole time. … [I]t was … intense.' Lola's invocation of the fight-or-flight response suggests that she experienced the intensity of her rapidly progressing labour as akin to an existential threat, her body assaulted by overwhelming sensations. Psychologist Peter Levine has argued that a lack of resolution to or a 'freezing' of the fight-or-flight response lies at the heart of persistent symptoms of trauma (Levine 1997). This is not to suggest that Lola suffers from PTSD, but that how she (and the medical professionals who cared for her) managed her impulses could contribute significantly to her memory of and feelings about childbirth.

There is no question that for some women, access to pharmacological pain relief proved critical in coping physically and psychologically with the sensations of labour. However, when drugs are ineffective, women find themselves disappointed that relief proves elusive. Women in the study availed themselves of a range of drugs—from paracetamol to nitrous oxide to epidural anaesthesia. Eleanor, for example, found that epidural anaesthesia enabled her to be more fully present and companionable. The epidural was 'magic bliss. You just go from like full-on pain to like nothing [laughs]; like, hi everyone.' Others had less positive experiences, irrespective of whether they went into labour intending to make use of pain relieving medication or not. Kathleen 'had no issue with having pain relief,' but her epidural anaesthesia failed to work and she experienced 'horrendous pain' that the medical professionals attending her initially dismissed. Daphne endured multiple, failed attempts to administer an epidural; the effort led her to 'freaking out' that the anaesthetist might leave her paralysed. Hannah experienced overwhelming pain when her labour was induced, which led her to request epidural anaesthesia. Like Kathleen, she found the epidural ineffective, a disappointment made all the more distressing by the fact that, as Daphne experienced, it took multiple attempts to insert the needle properly. Hannah also had a negative experience with nitrous oxide, which caused her to slip in and out of consciousness. She found that upsetting, as did her husband, despite reassurances from the midwife that it was not atypical.

When the course of labour departs from the imagined best-case scenario, women feel ill-equipped to handle the turn of events and physical pain can escalate to psychological suffering. Sharon notes that nothing she learned in sex education class in school or in her antenatal classes had readied her for how frightening childbirth was. With her son stuck in the birth canal, neither an episiotomy nor forceps proved effective in aiding delivery. These efforts, followed by an emergency caesarean section, terrified Sharon, who felt absolutely unprepared for this course of events. As she comments, in school 'they don't say that you know you can actually die while you're in labour. You can—like there's multiple ways that you can die or the baby can die, it's really risky, but they don't say that and I think that [sex education

classes] should…. Like even the birthing classes, they didn't even mention anything like that.' Sharon felt that she 'went into [pregnancy, labour and birth] blind.' She believes that more direct, explicit information could have prepared her for what she experienced.

However, emphasising the ways that things could go awry could exacerbate the fear and lack of confidence many women already feel going into labour. Concern that underscoring the potential for negative outcomes might lead to increased physical and psychological suffering led childbirth educators beginning in the mid-twentieth century to try to avoid using words like 'labour pain' and 'contractions.' They feared that by suggesting pain they were, in fact, leading women to expect it, and thus create or intensify their own suffering. American midwife Ina May Gaskin tried to popularise the term 'rushes' as an alternative to 'contractions' so as to convey a sense of powerful, even pleasurable feelings without the connotation of pain or constriction. Similarly, proponents of the Lamaze method wrote about 'sensations' rather than 'contractions' (Gaskin 1978; Chertok 1963). Of course, what women are told and what they take away are not necessarily one and the same. From her testimony, it appears that Sylvia attended an antenatal class that dealt quite directly with the question of pain and the potential for suffering in childbirth. Rather than leading her to embrace the range of pharmaceuticals that her childbirth educator recommended with enthusiasm, she came away with an aspiration to avoid them entirely. 'Having gone through the prenatal classes at the hospital and learning about a [sic] different pain relief drugs … I'm only motivated to stay away.' Firm in her faith that her body had the capacity to labour as women always had, she made her own meaning from the information she received. Like all women in antenatal classes, Sylvia was not a blank slate. She filtered the information offered through the myriad lenses that defined her worldview.

Of the factors that shape women's expectations, perceptions, and desires, previous experience of childbirth prepares mothers who have more than one child in a way that readings, educational films, lectures, and other sources of information cannot. The intensity of pain and how it was managed, whether successfully or unsuccessfully, serve as a filter through which women make their decisions about subsequent

labours. Eithne chose epidural anaesthesia during her first, excruciating labour, but later had misgivings about that decision. Pethidine had made her vomit, while the nitrous oxide left her high. 'I felt out of control. It was just a horrid feeling.' Epidural anaesthesia was less than fully effective and, by the time the decision was made to deliver her daughter via caesarean section, it had largely worn off, a fact discovered only when the first incision precipitated her shrieks of agony; the C-section proceeded under general anaesthesia. For her second child, Eithne chose initially to forgo pharmacological pain relief while she attempted a vaginal birth after caesarean (VBAC). 'I wasn't high on drugs…. Everything that was going on was on my terms. …So, yeah, next time around I did nothing. You know, it was just—and it was so much easier. …Mentally I knew it was going to be rough, but I was prepared for it.' Of course, not everyone finds subsequent labours easier. With the passage of time, the memory of labour fades for some women and then, as Eithne said, 'what a shock, having to do that again. It was like, oh my God, the pain.'

With whom women give birth and how the interpersonal dynamics unfold feature centrally in women's experience of pain, which can be exacerbated by feeling unsupported, dismissed, invalidated, or disrespected by medical professionals. At times, medical carers fail to take seriously the testimony women offer about their somatic experience during labour and birth. For some, the minimisation of their pain begins during pregnancy when, for example, severe sciatica goes untreated and dismissed by Hannah's midwife as 'nothing.' Later, her suspicion that her waters had broken was met with disbelief, leading Hannah to spend a week leaking amniotic fluid and running the risk of infecting her baby with strep B. Third-time mother Sophie told a medical student that she was in hard labour, only to be rebuked as misunderstanding her body's signals. 'I know how it feels and I'm definitely going to push this baby out tonight,' she reports insisting, as she pressed the student to get the obstetrician. Eithne felt a powerful, instinctual urge to push, but was told 'it's not the time, you can't push,' irrespective of what her body was telling her.

It is, of course, very difficult for women in the throes of labour to resist medical authority. Rosemary captures the power imbalance in the obstetric encounter:

> You're in this incredibly vulnerable and pained situation, people are coming in, making decisions about your wellbeing, which of course they have to, they're doctors, but there's a massive tension between what you want and what they're saying is best for you and the life of the child, how dare you even say anything against it because are you a bad—are you an evil mother, you know?

Rosemary's words echo the sentiment in Ricki Lake's widely viewed documentary *The business of being born* (Epstein and Lake 2008), which similarly emphasises women's powerlessness when confronted by physicians and midwives with threats of life and death, some of which may be overstated. In pain and psychologically turned inward, women in labour are challenged to make decisions about their own care. Birth plans drawn up at cooler moments are meant to make their wishes clear, but are often cast aside unceremoniously at any sign of risk to mother or child. Women have little choice but to trust their medical carer's judgement about assessing risk. As Rosemary attests, 'All your power is taken off you. They make the choices of what happens to you and your body and your child. Not allowed to say anything against it, and you kind of don't because they're saying that your child's life is at risk so you shut your mouth, but emotionally, like, you're feeling like you're being violated.' With time of the essence, women are pressed to consent as if they are making a choice when, in reality, there really is none. Intense pain only compounds women's sense of powerlessness and vulnerability before medical authority. They consent to procedures they might otherwise question because, as Isobelle states, they are 'relieved that [the medical staff] were going to do something to make [the pain] stop.'

The absolute nature of medical authority perhaps fuels what some women experience as a lack of empathy from medical carers. Staffing pressures surely contribute to brusque care. Otherwise well-meaning maternity professionals are often short on the time necessary to support women in labour. Eleanor, for example, wanted an epidural to

alleviate the pain of labour, but the anaesthetist was unavailable because of two concurrent caesarean sections. Kathleen found that her midwife had just finished a shift when she arrived at the hospital in labour. For unknown reasons, neither of the other two midwives in the practice was summoned and Kathleen and her partner were left alone in a delivery suite. As she reached transition, the most painful stage of labour, she could not bear the pain any longer, but 'there was no-one.' Kathleen's partner went into the corridor to get help, only to be told that, as they were under the care of the midwifery practice, '"you're not our problem."' From Kathleen's perspective, of course, what mattered was that 'I needed pain relief and I needed help'; it was more than an hour before a midwife arrived. Care immediately after birth was similarly lacking for some of the women surveyed. For example, Hannah laments that during the days spent in the hospital after her child's birth she wanted to take a shower, but could not figure out how to steal a few minutes to do so. 'Nobody had come in and helped me and said we'll look after baby so you can have a shower. I thought, "What do I do?"' For women without family to turn to and unable to find the wherewithal within themselves to assert their needs, staff shortages and indifference leaves them untended and unsupported.

As Mary-Rose MacColl argues, for medical professionals, given the pressures of the job, of caring day in and day out for 'women at their most vulnerable, … a veneer of callousness' may be necessary to cope with the work (2009, p. 192). For women during labour, birth, and its immediate aftermath, this 'veneer of callousness' at times translates into the sting of harsh and impatient tones from nurses, midwives, and physicians. Sharon was subjected to a rough vaginal exam early in labour, and when she cried out in pain, the 'really rude' nurse told her that 'if you're old enough to have sex you're old enough to go through labour. And she's like "millions of people carry gallons of water on their heads and you don't hear them complaining," because I was having contractions and I was—and it was hurting.' Her experience while recuperating after birth suggests ongoing gruffness, to which Sharon had perhaps now become especially sensitive. She felt the nurses harassed her for not coming promptly when summoned to the nursery to tend to her newborn, even when she protested that she had not received the message

that she was needed. After a harrowing labour, Hannah found herself assailed by a nurse displeased with her for having stained the sheets. Rosemary yearned to talk about her experience in its immediate wake with the medical staff that had attended her during labour and birth in order to understand and come to a feeling of equanimity about the experience. No doubt rushed for time and already on to the next patient, 'anonymous medical figures … don't even come back to debrief with you or tell you why they made the choices that they did or even … just, I guess, sitting—taking 10 minutes to sit down with you and sympathise with you and acknowledge your feelings and emotions.' And, of course, as Rosemary observes, it is the new baby that friends and family want to talk about, more than the new mother.

For some women, the lack of empathy from maternity carers escalates into a feeling of abandonment, which can be exacerbated by a sense of the lack of meaningful support from a partner or friend. The premature labour and birth of Sophie's third child proceeded so rapidly that her husband did not have time to get to the hospital, where she had been admitted 30 weeks into her pregnancy due to bleeding. Without her husband there to help her cope, she was 'devastated' that she could not get an epidural because of her rapidly progressing labour. 'I felt alone …. I just didn't think I was gonna be able to mentally deal with pushing this premature baby out.' Sharon's partner Rory was 'too scared' to stay with her during her emergency C-section, to her annoyance sending in his sister instead.

Even when the support person is there and ready to help, it can be challenging for her or him to figure out how to be of use. In an effort to aid Sharon, Rory tried to rub her lower back but, as is common, she could not stand to be touched and he simply held her hand through her long labour. For Nadir, witnessing his wife's pain during labour and birth was a mixed experience. On the one hand, 'it's a wonderful experience' to share with his wife the birth of their child. On the other hand, he suffered watching her, observing that 'she had the pain physically and I had pain mentally and oh, it's terrible.' In striking contrast, Eleanor found that her doula acted as a support person for both her and her partner, aiding him to support her and to feel less helpless in non-pharmacological pain management techniques. Her experience echoes studies that document the myriad benefits of doula services, which are

credited with reducing caesarean section rates, preterm births, and low birth weight (Gruber et al. 2013; Kozhimannil et al. 2016).

At the heart of women's narratives lay entwined feelings about pain and its challenge to dignity and control. Intense pain and birth complications led Kathleen to have a full spinal block, rendering her numb, unable to move her arms or legs. She felt out of control and as if she had failed—not because she needed to rely on drugs, but because she had comported herself in a manner she felt was undignified. 'I lost my shit. I lost my decorum … . I was a screaming mess.' Enduring lengthy labours, both Sylvia and Helen spoke of 'losing it' from exhaustion. In a grim effort to find a silver lining to her subsequent, humiliating experience with IVF, Eithne thought 'once you've been through a labour and delivery, you sort of—there's no dignity left, is there?' Before migrating to Australia, Delia, a native of South Sudan, had resettled in another African country. Pregnant there with her third child, she felt uneasy about the quality of care she would receive. 'I was scared for myself for my health and I don't want to give myself to a doctor like, you know, when having a baby, it's like you're giving yourself to that person. … I didn't feel safe. … I didn't want to feel pain, I didn't want to scream in front of' the medical staff, in whom she lacked confidence and trust. For her, a caesarean section appealed because it meant that anaesthesia would allow her to maintain, in her view, dignity and composure.

Women describe their experience of fear and loss of control as trauma in no uncertain terms. Described in detail above, Kathleen experienced indifference from the medical staff as 'hugely traumatic.' For Rosemary, the attention focused on the new baby and a dismissal of what she'd been through inhibited her ability to process the trauma of birth. The gulf between her expectations for the birth and the experience she had angered her and it 'really magnified the trauma because you just feel so completely unacknowledged, there's no space to talk about what you experienced.' The arrival of a healthy baby girl eclipsed the desire of family, friends, and carers to talk with her about her feelings, leaving her struggling to process the event.

For others, including Delia, the trauma of the experience proved so searing that the memory of it did not fade, but continued to intrude, 'always in my mind.' Though she could not, Delia wanted desperately

to forget the fear and physical discomfort of a pregnancy spent in a foreign country where she felt unsafe and isolated. She never labelled it PTSD, but Sophie identifies a hallmark symptom of it. Her painful labour without adequate professional medical support left her 'having flashbacks to those—to—to that night on the ward … . It felt traumatic at the time, yeah, it did, it really did.' For Eithne, the symptoms were clearer and more pronounced following a near-death experience during the birth of her sixth child: 'I've never dealt with PTSD before, but I knew that there was something not quite right with how I was feeling. You know, I'd be listening to things in the—in the hospital and all of a sudden I could feel a panic attack, you know, coming on, because I could hear, like, machines, buzzers, and it would be like, you know, it was just an awful feeling.'

Women consciously and unconsciously use a range of strategies to cope with the trauma of birth. Rosemary experienced memory loss around the events of her child's birth. For her, it is not just that her memory of the pain's intensity faded over time, but parts of the event were erased from her mind in order, she believes, to allow her to move on from it. Georgina, too, experienced loss of memory, which she argues was part of the physical, as well as emotional healing process. 'I guess you just either bury it or just forget and move on. … Like the pain of childbirth, when it's happened and the weeks after it's so raw and so present… . I can't sort of think back to that time and actually feel the way I did then.' Others, like Sharon, focus on the arrival of a healthy baby, which is, of course, a happy outcome, but need not erase or invalidate the mother's experience of trauma. Positive thinking is surely an important tool, though it is no reason to avoid critical examination of the medical, cultural, and economic catalysts to women's physical and psychological trauma.

Women frequently drive blame inwards, engaging in self-criticism over births gone awry. Resorting to pain medication when they had hoped to have a 'natural' birth, comporting themselves in a way they viewed as poor, or having their baby by caesarean section in a situation in which its necessity was unclear can contribute to women seeing themselves as having failed. Sophie took pride in her two drug-free births. Even as she understood intellectually why she felt she needed

it, pethidine for her third birth left her feeling 'disappointed…with myself' for turning to it for relief. Some judge themselves and others with equal harshness. Sylvia, for example, felt strongly that historically women had 'laboured without [drugs]. How is it possible they could cope and what makes us weak that we wouldn't cope?' The clear suggestion is that weakness leads to the choice of pain medication. Sylvia did, in fact, resist the use of anaesthetics and analgesics. She credited her doula, under whose guidance 'my focus shifted from my, selfish discomfort and complaints to thinking about a baby.' In one swift rhetorical move Sylvia passes judgement on herself for the expression of discomfort and, by inference, on all those mothers who complain about the intense pain of childbirth, from which they seek escape through drugs.

A traumatic birth is a difficult entry into parenthood. Kathleen felt that she 'had done a bad job of labour and a bad job of birthing and a bad job of pregnancy. … So, it just followed that I thought that I'd do a bad job of mothering.' Similarly, Kelly described her pregnancy and birth as 'hard' and felt early motherhood had to be established on a shaky emotional foundation. 'You've run a marathon and then your next marathon starts that day. You know, there's no break. There's no leeway of, of processing.' Vivienne experienced a pregnancy with complications that culminated with the delivery of premature twins by caesarean section. It was, needless to say, a challenging start to motherhood and her tears, shed as she recounted those events some nine years later, attest to the lingering trauma of that experience.

Pain and a Good Birth

What leads women to feeling empowered, strong, and more resilient to trauma during their journey to motherhood? Medical anthropologist, bioethicist, obstetrician, and mother of five, Anne Drapkin Lyerly (2013) identifies six qualities to a positive birth experience: control; agency; personal security; connectedness; respect; knowledge. Over one-third of women interviewed for this research reflected on their experiences negatively, but their birth stories also richly illustrate Lyerly's key characteristics of a good birth and point the way towards improved

satisfaction with maternity care. Here I briefly explore in turn each of the qualities that Lyerly identifies and I put them into dialogue with women's testimonies.

Control means neither clinging to nor relinquishing control over the birth process, but sustaining the feeling 'that we can in some way *preside* over birth' (Lyerly 2013, p. 33, emphasis in original). It is a sense of riding the unpredictable and intense emotional and physical sensations of labour, rather than being swept away or drowned by them. Agency, for Lyerly, means acting on one's own behalf, even when in the hands of others. A key component of agency is a sense of being fully present for the experience. For some women, pain may be so overwhelming that pharmacological intervention is the thing they need to achieve a sense of presence. For others, fully experiencing the physical sensations of labour and birth may facilitate the sense of being wholly in the moment (Lyerly 2013, pp. 66–74). Eithne's testimony conveys how a sense of agency can be experienced even as a woman's wants and needs change over the course of labour and birth. She went into her second labour hoping to avoid the drugs that she felt undid her during her first child's birth, which ended in a caesarean section. Eithne spent hours labouring in an attempt to have a VBAC. Her efforts ended in another C-section, but without disappointment.

> I wanted to get into the hot tub and labour in the tub. I did that. … I had a shower. I did that. I didn't do anything that they were saying, you know, 'Oh, you should do this, you should have this. You know, have this drug, have that.' You know, I—no. I did it how I wanted to do it and it was so much better, I mean, even though it had a similar outcome, I still came … out of that feeling like 'Woo hoo!', you know, I gave it my best shot and it was on my terms.

It was not the birth Eithne hoped it would be, but it was a birth she felt in charge of. She could not control its course and she remained flexible. Significantly, she had faith in what her inner voice told her she needed. Eithne listened to the wisdom of her own body and mind and found in that an ability to take in what medical carers advised, but still retain a sense of decision-making.

Personal security encompasses more than physical safety. It means the creation of an atmosphere in which the labouring woman feels care and protection. Lyerly identifies a constellation of components: comfort, privacy, calmness, and trust (2013, p. 79). And, as with agency, safety means different things to different women. The home might be where some women feel safe, while others may feel safer in hospital. Sylvia said she 'wanted to have a positive birthing experience and *naturally* that meant that … we wanted to stay away from medical interventions. We wanted to stay away from any painkillers, if possible' (emphasis in original). For Sylvia, there was only one path to a positive birth experience. For other women, however, pharmacological pain relief was the key to feeling a sense of agency. Those seeking to avail themselves of epidural anaesthesia must birth in hospital, but the kind of calmness Lyerly identifies as important can often be hard to attain in that setting, even in the case of birth without complications. Multiple women interviewed for this research describe how the frenzy of activity, the hustle and bustle of carers, and confusion over precisely whose hands they are in undermined their sense of being cared for and secure.

Connectedness and respect both feed into a woman's ability to reflect positively on her experience of becoming a mother and cannot easily be disentangled. Bonding with the baby is one form of connectedness, but so, too, is feeling a connection to loved ones, especially one's partner. A partner's deep, full presence in a shared experience profoundly affects a woman's experience of labour and birth. Continuous labour support—from family, friends, or medical professionals or paraprofessionals—has been shown to be critical to managing the pain of labour without resort to pharmacological relief and to decreasing the chance of delivery by caesarean section. Companionship and aid from doulas, in particular, have proven effective at pain management, and surely, a sense of connectedness to a knowledgeable and caring doula gives women a sense of empowerment (Hodnett et al. 2013; Amorim and Katz 2012). Sylvia cited her doula as significant to her ability to cope physically and psychologically during birth, but also felt a connection to her obstetrician; she thought that she 'got to know him through the process of how my baby was born' and that connection enriched her birth experience. When a midwife who had been rude to Sharon tried to enter her

labour room, she felt connection with and gratitude towards the nurse who barred her. Unable to advocate for herself in the painful throes of labour, she relied on the advocacy of her carer, who sided with Sharon over her colleague.

As Sharon's experience illustrates, it is hard to imagine connectedness being achieved without respect. Many of the women in this study felt their pain went untreated, dismissed, underestimated, and disregarded. Their judgement about their pain and what they did or did not need was too often trumped by the authority of medical professionals. But respect in a good birth is also, in Lyerly's estimate, about honouring the sacred quality of birth as a rite and taking women's desires in this realm seriously. A healthy baby and healthy mother are certainly of paramount importance, but only in rare instances need the achievement of that outcome eclipse all other considerations (Lyerly 2013, pp. 159–173). Several interviewees conveyed in their testimony that their suffering was exacerbated by not having their attestations about their own pain taken at face value.

Valuing what women communicate goes hand-in-glove with offering women the information they crave before, during, and after childbirth concerning what is happening to their bodies and their babies. They seek clear, precise, and real-time information about the course of labour and birth (Lyerly 2013, pp. 191–220). Knowledge links back to the sense of calm needed to insure women's feelings of personal security. This need is evidenced in the testimony of Eleanor. Her request for epidural anaesthesia unmet, Eleanor's partner lost all patience, stormed to the nurses' station, and insisted that 'you need to tell us clearly what's going on and when we can expect to see someone.' Eleanor's partner sensed that her suffering (and his own) was compounded by not knowing when or even if she could expect relief. No doubt his zealous advocacy helped to enhance her sense of security and connectedness in this trying situation. As her experience makes clear, how maternity carers respond to and treat women's pain in labour lies at the very centre of the interconnected qualities that can lead to experiencing a good birth.

Conclusion

Women's narratives about pain in labour and birth point the way to more effective care. It is not simply a question of treating physical pain. In terms of both their positive and negative reflections, women's words tell us what is working for them and what is not. Overall satisfaction in birth is high, but persistent disquiet hums among mothers gathering around playgrounds, office water coolers, and social media. The interviews analysed here suggest that the obstacles to equanimity with regard to women's birth experience stem as much from interpersonal, as medical questions. Certainly, unexpected and disquieting turns, including in pain, present challenges to women in labour and can be difficult to come to terms with afterwards. Equally important is feeling heard, supported, and respected—feeling genuinely cared for by one's partner and by one's medical carers.

Anthropologist and bioethicist Annemarie Mol (2008) discerns in contemporary medicine an inclination for choice in medical care to trump care. Medicine is marketed as a commodity, and women's choices in childbirth, as in other realms, are lauded. Just as they can pick from 40 types of cereal in the supermarket, women are told they can choose where, how, and with whom to give birth. Their birth plans reinforce the belief that they have a say in the kind of birth experience they can have. But many attested to not having the experience of their choosing. They found it difficult to get what they wanted in the course of labour and birth—at times for medical reasons, but often for reasons that were unclear and left them with questions afterwards about whether their pain and suffering had been necessary or needless. Mol argues persuasively for the need to reorient medical services in a way that emphasises real care over choice—that genuine listening and presence, weighing in empathetically rather than seemingly offering up options, will infuse medical practice with the human touch that patients need in order to feel deeply supported irrespective of the particular course of treatment. The testimony of women in this study surely suggests that such care was outside the experience of many of them and would likely have led them to reflect in very different ways on their pain.

Historians have for a century written about the creation of a 'usable past'—finding meaning in history in order to make sense of the present (Brooks 1915). As Alan Kimball describes it, the usable past 'is the key to self-justification and self-identity. It is at the same time the key to purposeful action toward the future' (1985). Just as historians craft narratives that shape the collective meaning we make from our past, individuals do similar work with their life stories, which they piece together and analyse in a way that imbues their journey with significance. Women and their partners excavate their memories of the often confronting, tumultuous, and challenging experience of childbirth to find in it a usable past that makes meaning out of this life-cycle event. For many of the women in this study, pain in labour and birth challenged their efforts to attain dignity and profundity. In the days, months, and even years following childbirth, they struggled with painful memories that could on occasion only be dealt with by setting them aside. For a couple of these women, those memories continued to intrude on their lives in painful and unmanageable ways. Infusing genuine care into birth may hold the key for more women to craft a useable past marked, at a minimum, by greater equanimity towards their experience of childbirth.

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Part II

Journeys into Early Parenthood

5

Same-Sex Attracted Parents' Emotional Transitions to Parenthood

Ruth McNair and Deborah Dempsey

> It takes a while when you have a baby … probably for most parents, to feel comfortable with that. The first six months are just so anxiety-producing. There's so much change. … There's a whole lot of stuff where you can't escape, you can't run away. And it's a lifetime commitment. It takes a while to get used to it, I think, and be comfortable with it.
>
> Robert

The emotional journey to parenthood for same-sex attracted parents is, as Robert alludes, to some extent similar to that of any new parent.

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Alongside the joy of welcoming a new family member, the transition to parenthood may also impact on relationship satisfaction, on parents' emotional health and well-being, and contribute to a sense of isolation. New parents often have high expectations of themselves at the same time as they are coping with unfamiliar and non-negotiable responsibilities to a baby, and considerable changes to work and leisure routines.

There are, however, important differences for Lesbian, Gay, Bisexual, and Transgender (LGBT) parents. Despite advances in recent years of better legal and social support for same-sex parented families, LGBT parents, no matter what their family configuration, still have fewer road maps or cultural conventions to guide them. Children are usually conceived through donor insemination, in vitro fertilisation (IVF) or surrogacy, and these pathways to parenthood are often costly and require a great deal of negotiation, preparation, and resilience in the face of medical setbacks, should these arise. Successful conception and birth may involve invasive medical procedures above and beyond the usual experiences. More diverse family structures including single-parent-by-choice and multiple parent families can give rise to complex and sometimes difficult negotiations about the status of family relationships (see Dempsey 2010; Riggs 2008).

In this chapter, we draw on our many years of practice and research experience in the LGBT parenting and allied communities to discuss the distinctive emotional challenges that are still faced by LGBT prospective and new parents in Australia. We illustrate our discussion with excerpts from narrative interviews with the four lesbian and gay parents in the broader study: Helen, Jack, Kathleen, and Robert. We have organised our discussion into three main themes: mental and emotional health, including experiences of social support; trauma during pregnancy or birth; and difficulties negotiating familial identities and relationships. In the context of shifting and, at times, unpredictable social attitudes towards same-sex parenting, we conclude with suggestions for health and social care practitioners seeking to provide more appropriate support to same-sex attracted and transgender prospective or new parents.

Mental and Emotional Health of LGBT Parents

Statistically, more LGBT adults have poorer mental health than heterosexual adults (Australian Bureau of Statistics 2008). This difference is largely attributed to experiences of discrimination, abuse, and violence related to sexual orientation or gender identity (Bostwick et al. 2014). In the Australian National Survey of Mental Health and Well-being (Commonwealth of Australia 2008), the most commonly reported mental health problems experienced in the past twelve months by LGB respondents were anxiety (31.5%), affective disorders (19.2%), and substance use (8.6%), compared with heterosexual people (14.1, 6.0, and 5.0%, respectively) (Australian Bureau of Statistics 2008).

The mental and emotional health of same-sex attracted parents is not well studied, particularly for gay men and transgender/gender diverse parents, although some studies on the transition to parenthood for lesbians have implications for other subgroups. Goldberg and Sayer (2006) found that the transition to parenthood for lesbian couples resulted in some loss of feelings of love and an increase in conflict. Individual personality factors and levels of social support available to the couple were factors in this. For non-biological mothers, lack of support for their parental status by the biological mother's family was believed to contribute to the higher levels of reported conflict and decreased relationship satisfaction. Ross et al. (2007) found high levels of perinatal depression among lesbian mothers. Risk factors for depression in this group included a past history of experiences of depression or anxiety related to discrimination or homophobic abuse, a lack of social support particularly from families of origin, internalised homophobia, and fears that the children would be stigmatised. Lack of socio-legal support for lesbian-parented families is also known to be a factor in lesbian mothers' poorer mental health. Shapiro et al. (2009) found that lesbian mothers in the USA, where their legal status was uncertain, were more likely to experience depression than Canadian lesbian mothers. In the context of the continued presence of negative attitudes towards LGBT parenting, both within LGBT communities and in the larger Australian population, there can be a huge burden placed on individuals

to prove their competence and legitimacy as parents. This can lead to greater reluctance to look for support in times of difficulty, particularly if the attitudes of health or social care providers towards LGBT parenting are unknown.

Characteristics that improve mental health (protective factors) for LGBT parents include relationship satisfaction and shared household tasks, high levels of planning for pregnancy and parenting, and social support from family members and friends (Ross 2005). Another protective factor is the ability to disclose sexual orientation within social networks and services. A study of mental health service use by lesbian and bisexual mothers found that the more they disclosed their sexuality, the less likely they were to need and use mental health services (Steele et al. 2008). Similarly, among gay adoptive fathers, those with 'a less positive gay identity,' and presumably lower levels of disclosure, had higher levels of parenting stress (Tornello et al. 2011). It is possible that the specific risk and protective factors for mental health for LGBT parents cancel each other out and result in similar levels of mental health regardless of sexual orientation. However, the additional stress arising from pervasive levels of discrimination should not be underestimated (Trettin et al. 2006). For instance, Helen reports that she struggled with her mental health in the early years of her young son's life due to experiences of discrimination. This was alleviated to some degree by the support she received from friends: 'I think that the lack of family support was a big issue and that was to do with discrimination against same-sex couples … but you know, all our friends have more than made up for that with their support and their totally non-judgemental stance towards our family form.'

Getting more or less social support than expected from one's family of origin and friends may accompany the transition to parenthood for LGBT parents. Family members of lesbians and gay men may become more supportive once a child is born due to the increased sense of common ground (Gartrell et al. 1999; Bergman et al. 2010; Goldberg 2006; Tuazon-McCheyne 2010). For example, Goldberg (2006) found lesbians' perceptions of support from their own and their partners' families increased across the transition to parenthood. There may be a rebuilding of family relationships by estranged parents or siblings because they

want to develop a relationship with a new grandchild, niece, or nephew (Gartrell et al. 1999; Goldberg et al. 2012). In some studies, lesbian and gay parents have reported closer ties to their parents after becoming parents themselves (Gartrell et al. 1999, 2006; Goldberg et al. 2012; Bergman et al. 2010; Tuazon-McCheyne 2010). It is also true to say some LGB parents experience less support from their families upon announcing their intention to parent. Family members may express opposition to the decision to parent on moral and/or religious grounds, or because they believe that life for the children as a member of an LGB-parented family will be difficult (Goldberg and Gartrell 2014). An emerging area of literature relates to transgender parents. One US study with 50 transgender parents showed that conflict with the co-parent or partner and other family members was a particular challenge (Haines et al. 2014). This usually arose in the context of the transparent having transitioned after children had arrived, and the other parent not supporting the gender transition and threatening to remove the children from their care.

On the whole, Australian studies of lesbian parents have shown that women report relatively high levels of social support from families, friends, and health care providers. McNair et al. (2002) found that prospective and current lesbian parents reported high levels of acceptance and support from their family and friendship networks and health care providers, with prospective parents anticipating more difficulties than the current parents had actually experienced (see also Mikhailovich et al. 2001). The Work Love Play study of 324 LGB Australian and New Zealander parents found that their level of psychological well-being was similar to that of a matched sample of heterosexual Australians (Power et al. 2015). Social support was an important protective factor for this group, with the LGB parents reporting lower levels of connection with families of origin, but higher connection to friendship groups, reflecting Helen's comment above. However, social connectedness varied according to geographic location. LGB parents living in outer metropolitan and rural areas felt less connected with their local community than those living in inner metropolitan areas. They were also less open about their sexuality and had less connection with an LGBT community (Power et al. 2014).

In the current study, lesbian and gay parents described challenges related to inadequate social support for their parenting, including a lack of extended family support either in the initial stages of parenting or on an ongoing basis. A single gay father through commercial surrogacy, Robert noted that his parents struggled with his plans to become a parent, his father even telling him he was 'an idiot.' As a result, his parents initially refused to help him with the baby. Their response was fuelled in part by the fact that he used commercial surrogacy, a controversial pathway to parenthood and one that had necessitated his mother telling her friends that her son was gay. Robert believed that his parents had needed a long 'period of adaptation' which, fortunately in his case, culminated in them becoming very supportive over time. As Robert explains: 'my parents had been really struggling with the idea of surrogacy and me having a baby … they weren't happy when I broke the news to them. So that was having a bit of a negative impact on me and was quite anxiety-producing actually.'

Helen described an ongoing complete lack of support from three of her child's four grandparents due to their judgemental attitudes. Since their child was born, Helen and her partner had had little contact with their parents, including with Helen's mother, who was the only grandparent supportive of the women's relationship. Helen and her partner had not anticipated this lack of support from family or how much there was to gain from being able to take for granted some help with parenting from extended family. Helen and her partner felt considerable 'loss, anger, and grief' about this lack of support from family members. As she explains: 'Every bit of help we have had we've had to negotiate [with friends] … I guess I didn't foresee that most of the grandparents would take the stance they did. So, that's been all pretty massive. A bunch of things to come to terms with emotionally and then just deal with it practically, you know.'

Some same-sex attracted parents demonstrate considerable resilience despite a lack of social support, particularly in the face of discrimination and the threat or reality of homophobia. For instance, Robert recounted a particularly distressing incident that occurred when his child was a baby. A woman had begun shouting abuse at him in a supermarket when she realised he was a gay father and no one came to his defence.

Robert's story indicates the extent of the homophobic abuse that can be directed at gay parents out in public with their children and it is worth retelling in detail:

> Then there's homophobic stuff that happens as well…you get it sometimes. I was standing with my daughter when she was about six months of age or something. She was in a Baby Bjorn and I was doing the grocery shopping at [the supermarket] up the road. This woman in her 60s or her 70s, with a nice grey bob, she was in front of me being served and … she turned to me and said, 'Are you married?' and I said, 'Sorry? No, I'm not married.' And she started doing this, 'God is going to curse you for not being a married parent, blah, blah, blah.' I said, 'Well, in fact, I can't get married – because I'm gay.' Thinking that it would just scare her away. Oh, no. At the top of her voice, shouting and yelling that gay was a sin and I was going to rot in hell and all sorts of things … and everyone who was behind me, no-one was saying anything at all. I'm thinking … 'You could at least defend the man with the baby [laughs].' She went outside and I thought, 'Oh, I need to avoid you…,' but then she came around the back in one of the streets, started yelling across the road at me.

Although this incident had been a significant source of anxiety for Robert, it is important to point out that he was able to laugh at the incident in telling his story, along with expressing the view that same-sex attracted parents had to overcome anxiety and stand their ground, when required to do so. 'As a gay parent, you've got to be vigilant about that sort of thing,' he explains. Robert saw a need to be 'very proactive' in enabling his daughter to be 'well-armed' against such attitudes and to correct misassumptions. He chose to be honest with her about her origins and the extent of planning that went into his parenting journey. He was compiling a photo book about his daughter's early life with a view to normalising the circumstances of family formation by surrogacy.

Similar to Helen and Robert, Kathleen and her partner also described emotionally challenging experiences. As a consequence of trying to juggle parenting with work, combined with very limited family support, the women had experienced relationship conflict. However, they had come through this upheaval and Kathleen was clearly proud that their relationship and careers had prevailed despite the challenges they had

experienced. In the quotation below, it is apparent she believes that the capacity to maintain equity in the face of conflict can be a strength of same-sex parenting relationships. 'I think we actually rock that we're still here now [laughs]. And we have managed to both keep our careers going. We both haven't [suffered a demotion at work] which is often the case. Often women just let it take a dive and, typically you know, they're in a heterosexual relationship and their partner's working full-time, a lot of the women I work with, that's the situation.'

Overall, the stories from gay and lesbian parents in this study illustrate their emotional resilience in the face of adverse circumstances. When confronted with censure or homophobic abuse, they emphasise the learning experiences these incidents provide to develop the strength needed to foster resilience in their children. In the absence of family support, they seek out and negotiate help from friends with an eye to ensure that one member of the couple did not have to make undue career sacrifices.

Trauma Associated with Pregnancies

While one in six heterosexual couples experiencing infertility will turn to reproductive technologies such as donor insemination, IVF, and surrogacy (Fertility Society of Australia 2016), LGBT parents more commonly rely on assisted reproductive technologies to form their families. This means that they are far more likely to experience a highly medicalised conception, pregnancy or birth, which, for some, can result in traumatic experiences.

Studies from various countries in the Global North and in Australia find that LGB parents are mostly a highly educated group, more likely than people in heterosexual relationships to hold a bachelor degree or higher, and more likely to work in professional or highly skilled occupations (ABS 2013). They are more likely to be used to having control in their working lives. When carefully conceived plans to have children and idealised expectations of early parenthood do not live up to the difficult medical reality, they may experience a greater sense of loss of control during pregnancy and birth, contributing to distress and trauma.

Below, Kathleen highlights the painstaking decision-making that had occurred over many years regarding a dizzying array of choices: the sperm donor, who carries the child, whose egg to use, who would be the primary parent, and who would return to work.

> The whole IVF process of, 'How we're going to do this,' was nothing compared to the process of, 'Are we both going to parent this child together? Is this going to be our baby or is this going to be my baby that you are involved in because we will stay together as a couple?' By default, eventually, I'm sure it would have become her baby, but … you understand the subtle difference … and that was a huge thing for us. So, the next big decision for us was, 'How are we going to do it? Are we going to go through IVF? Are we going to do the whole turkey baster thing which women have been doing and other couples have been doing, heterosexual couples have been doing for decades, centuries probably even? How are we going to approach the donor issue? Are we going to go with a known donor, … one of our friends? Are we going to ask someone to donate? If so, how do we approach them? How do we do it in a non-threatening way? What are the implications?'

The need for perseverance throughout this long planning phase is highlighted in another Australian study of lesbian mothers (Chapman et al. 2012).

Kathleen's story exemplifies what it can be like to experience extensive medical intervention and an associated loss of control of one's body and carefully laid plans. She had needed several cycles of IVF to get pregnant, experiencing considerable pain and discomfort during the necessary hormone treatment. After becoming pregnant, she needed ongoing medical monitoring to maintain her pregnancy. Kathleen recounts that she had a difficult birth and then experienced problems trying to breastfeed the baby. In her story, years of deliberation and careful planning for pregnancy contrast with months of ill health and relinquishing power to medical professionals:

> I felt like a science experiment. … [I]t was really very difficult because I am normally really fit and I run a lot … definitely obsessive about running and exercise and diet … and the medication really affected me and

> I actually ended up having an overstimulated ovary because of my reaction to the medication. When I was 10 weeks pregnant I needed to have emergency surgery to untwist one of my ovaries which had gotten so big because of the drugs. Which is exactly the point that I miscarried when I was pregnant a thousand years ago. So, it was terrifying. So, even before getting up to that point my relationship with my body was just so conflicted because I was so uncomfortable. … I was pretty emotional. … You just, you cannot do anything about it. It's not like you can go home and shag your partner, I mean we can do that but it's not going to make any difference to us at all. It's not going to get us pregnant and I felt really powerless and really medicalised.

Kathleen here describes pregnancy as a traumatic event in which the difference between expectations and the difficult reality put significant pressure on her relationship and her mental and emotional health. Ultimately, Kathleen and her partner were able to access a wide range of medical and social services including a perinatal depression and anxiety support group, their general practitioner, and a psychologist.

Gay men can also experience trauma during planning for pregnancy and parenthood. Like many contemporary Australian gay men (see Dempsey 2013, 2015; Everingham 2014), Jack and his partner had travelled overseas to use commercial surrogacy to form their family. Gay men have difficult decisions to make regarding surrogacy that have parallels with the lengthy decision-making process lesbian couples go through to conceive (see Dempsey 2013). Like Kathleen, Jack said his and his partner's decision to go ahead with surrogacy overseas had followed many years of planning. Echoing Kathleen's comments about a sense of loss of control, Jack explained that they had felt very disengaged from their surrogate's pregnancy because it was often difficult to get information from their agency. As is evident from Jack's account, he and his partner were devastated when they received the news that their first surrogate had prematurely given birth to twins, one a stillbirth and the other alive:

> I remember we got a call from the doctor at maybe 26 weeks [of pregnancy] saying … 'I can't find a heartbeat for one of the children. I'm

> going have to do an emergency caesarean' … and two hours later, she texted again and said, 'You had a boy but he was stillborn and there's another boy and he survived and he's gone to neonatal intensive care.' … It was mixed emotions, it was celebrating the fact that we had a child there overseas, a long way away, and we had a child who died.

The men travelled overseas and were able to spend several weeks with the second twin before he, too, died. They were grief-stricken but discovered they did not know where to get help, and that the Australian health and social care system did not acknowledge their loss. 'Overseas surrogacy still isn't well recognised by the health organisations in Australia. So, to them, our babies never existed. They were invisible babies. … To them, we'd never, we'd never had a pregnancy.'

Eventually, Jack said, he and his partner were offered support through a Sudden Infant Death Syndrome (SIDS) support group. He also comments that they found it hard to seek support because as men, they were supposed to 'be tough.' They found it easier to seek support through social media from other gay dads and parents going through surrogacy because this way, they could remain more anonymous. Jack and his partner came through their difficult surrogacy experience realising that there was a significant need for local support for gay men, and that social media could help meet this need: 'I mean I've realised in the last few years that lots of men go through all this, more pain over this but we didn't realise there wasn't support out there for the men. … I think it's slowly changing. Men in Australia aren't very good at seeking help either, I must confess. They think they'll deal with it on their own. But social media is a good way for men.'

Jack and his partner subsequently became parents of two healthy babies through a different surrogacy agency abroad but they had never imagined how difficult it would be. As Jack summarises,

> We got there … in the end, but it was just a painful pathway … things that happened along the way that we didn't ever think we'd have to deal with. … Many people go into this kind of IVF surrogacy fairly naively. … So, we learnt a lot along the way about best practice … it's been a wonderful experience to be a father and I'd never go back … it was

> terrific. We were just lucky we were able to survive the process of it and our kids are healthy.

Under the strain of new parenthood Robert realised how important it was to connect with other new parents and described attending a local mothers' group that was very supportive. He was later motivated to establish a new branch of an existing gay dads group in his area to enable other men who were primary caregivers to connect and get support. It is evident in Robert's and Jack's accounts that existing support groups for new parents, or for those grieving pregnancy loss or death of a child, are not readily accessible or appropriate for gay men, due to both their gendered and family formation mode. Robert feels that gay men may need to forge new networks to gain the emotional support they need.

Negotiating Parental and Familial Identities

Australian LGBT community surveys indicate that parenting is still a minority experience, in that only 11% of gay men and 33% of lesbians have children (Leonard et al. 2012). There are not yet any reliable statistics on parenting amongst trans people. Negotiating combined identities as a parent and as LGB or T is still an emotional challenge facing these families. Historically, some radical lesbian feminist and gay male cultures saw parenthood as aligned with heterosexuality and construed parenting and lesbian or gay identities as mutually exclusive (see Dempsey 2005; Hequembourg and Farrell 1999; Borthwick and Bloch 1993). Although the identities 'gay or lesbian' and 'parent' have long been successfully combined, as early work by Lewin (1993) and Hequembourg and Farrell (1999) demonstrates, many recent parents take this for granted, and significant compromises often still need to occur. For example, some women in Hequembourg's study who became mothers struggled with the fact that their 'marginal' identity as lesbian was obscured by the 'mainstream' identity of mother. Other women strove 'to be a conventional good mother while forging unconventional meanings of family' (1999, p. 553). For transgender men becoming parents either during or after transitioning, there may be considerable identity work involved in reconciling the experience of becoming pregnant and birthing a child

with living in an otherwise masculine body (Riggs 2013). Transgender parents who affirm their gender after children are born also have to negotiate complex changes in their parenting identity, relationship status, and relationship with their children (Haines et al. 2014).

Struggles over how to combine parenting with gendered and sexual identities manifest in a number of ways, as the interviews with the gay and lesbian parents demonstrate. Jack and Robert, both men in their 40s who came out in the 1990s, explain that they initially suppressed their desires to be parents due to the strong anti-parenting culture that they perceived at the time in their local gay communities. As Jack explains, 'in my early 20s, I [had] quite a bit of difficulty coming out and accepting my sexuality because I didn't want to give up the chance of having a family. That was quite hard at the time but I did give up that chance.'

In late twentieth-century Australia, it was unusual for gay men to openly embrace full-time parenthood. Although some gay men had children through previous heterosexual relationships, and others had become foster carers or sperm donors for lesbian friends, substantial primary carer responsibilities were rare. In the first decade of the twenty-first century, family formation through surrogacy became more common for Australian gay men, and local support groups and social networks began to form (Dempsey 2013, 2015). For Robert and Jack, it was only around the age of 40 that it had felt possible to take steps to become a primary parent via surrogacy. As Robert put it, 'from an early age I worked in early childhood… . So, I was really interested in parenting and being a parent. And I guess that was one of the issues I had with coming to terms with my sexuality was [the] perception at the time that I wouldn't be able to have children. So, a bit of a struggle … but that desire, of course, didn't go away.'

It is apparent from Jack's account that gay men becoming parents may struggle with feelings of inadequacy due to their gender. There can be a belief that women 'naturally' know what to do when they become mothers, whereas for men there is no cultural convention supporting 'paternal instinct.' This internalised belief system that only women instinctively know how to parent manifested for Jack and his partner when they were caring for their newborn twin girls in an international

hotel room. After the babies were born, they found themselves alone with them and soon realised they did not know what to do. Believing they knew less than a woman might, Jack describes he and his partner 'running around the hotel to find any woman who could explain to [them] the proper way to mix up formula milk.' At the time, the new fathers' concern had been that 'when you are two men you are going to do something wrong,' reflecting a crisis of confidence that was exacerbated by their social isolation in a foreign country.

For the same-sex couples in the study, navigating parental identities was fraught. This was evident in two important ways: either having to negotiate seemingly incompatible parenting desires or having unexpectedly dissimilar experiences within the couple of pregnancy and early parenting. Kathleen and Jack found themselves in relationships with partners whose aspirations for parenthood differed from their own. This created some conflict within their relationships for a time. When two women decide to have children, they may assume they will respond in similar ways to the pregnancy and early parenting, only to find that their expectations and experiences are very different. As Kathleen comments early in her interview, 'being in a relationship with another woman it gives you this amazingly equal platform to go through something based on being a female.' However, her account of the actual parenting experience with her partner is quite different:

> Our daughter is a magnifying glass for the differences between us. It really took a tax on our relationship and I guess we've sort of tried to pull apart what was really going on. It's really difficult to understand fully why we were suddenly at each other and not getting along and me feeling misunderstood. … [B]eing the biological mother is a different experience to being the non-biological parent, and so I guess it's very difficult for the non-birthing parent to understand just how taxing pregnancy and birth and breastfeeding is on the body and on the energy levels.

For Kathleen, the differences of experiencing fertility treatment and pregnancy as the birth mother compared with the non-birth mother's less embodied perspective created conflict in her relationship. In Kathleen's account, the relationship had previously been very egalitarian

and to be in different realms of experience regarding pregnancy, birth, and breastfeeding created tension.

Biological Relatedness and Parental Identity

Research over the past 15 years has identified strengths within lesbian-parented families including more egalitarian parenting and other divisions of labour within the household (Ciano-Boyce and Shelley-Sireci 2002; Werner 2008). Some lesbian couples decide that just one will conceive and bear the children, whereas others will alternate biological motherhood (see McNair et al. 2002; Dempsey 2010; Power et al. 2010). A more recent and controversial practice made available through fertility clinics is 'reciprocal IVF,' whereby one partner can contribute the egg and the other becomes pregnant and gives birth (Rainbow Fertility 2016). In the absence of fertility problems that necessitate IVF, there are some ethical and moral concerns about this practice, to the extent that it is banned in Sweden (Zeiler and Malmquist 2014). These concerns particularly relate to the over-medicalisation of the pregnancy and concomitant risks to health just to ensure that both partners have a biological link to the child. Other concerns relate to the need for clarity over who is the biological parent because this is perceived to be in children's best interests.

No matter what the status of the biological relationship between parents and their children, it is common for biological and non-biological mothers to share the parenting relatively equally and to each take time out from the paid workforce to become primary carers. For example, analysis of 331 same-sex attracted parents in the Work Love Play study, compared with a matched sample of 958 heterosexual couples in the Longitudinal Study of Australian Children, found same-sex couples more equally divided the household labour, and lesbian couples shared more parenting tasks together (Perlesz et al. 2010). They made deliberate decisions about their respective parenting and household roles based on their perceived strengths and skills.

A potentially highly emotive issue for lesbian and gay prospective parents is whether or not to use known or anonymous gamete donors,

and there are different practices among gay and lesbian couples to address this. Australian social policy strongly supports the premise that children are entitled to have information about their biogenetic origins, and many lesbian mothers are known to support this premise (see McNair et al. 2002; Dempsey 2010). Some lesbians desire to have a known sperm donor who can develop a relationship with the child, while others prefer anonymous donors sourced through clinics, who, in Australia, can be identified should this be considered desirable in the future (Crouch et al. 2013; McNair et al. 2002; Dempsey 2010; Kelly and Dempsey 2017). A small number of lesbians and gay men form co-parenting families in which the sperm donor and his partner are also considered to be parents (Dempsey 2010, 2012; Power et al. 2010). For lesbians who want the known donor to have a social relationship with the children, there can be tensions about the extent to which this is a parental or family relationship, and sometimes, there are disagreements about how the donor is related (Dempsey 2010, 2012).

In all situations in which the status of a donor or surrogate needs to be negotiated, there is potential to disrupt the couple relationship to some extent, even if the donor is anonymous (Naziri and Feld-Elzon 2012). Some lesbian non-biological mothers feel vulnerable about their status as a parent when there is a known sperm donor, and more so if their legal parenting status is not secure. They may be marginalised by family members who do not refer to them as mothers or parents. As Brown and Perlesz (2008, p. 453) note, 'language has the power not only to acknowledge and affirm but also to negate and render invisible the position and distinctive contribution of lesbian mothers who have not given birth to their children.' Disputes about the status of family relationships between lesbian mothers and known donors can be emotionally devastating for all concerned when they occur; there have been a number of legal cases worldwide in which lesbian parents and known donors in dispute about the status of family relationships have ended up in court (see Arnup and Boyd 1995; Dempsey 2004; Kelly 2005; Riggs 2008). By contrast, when gay men become parents through surrogacy and/or egg donation, the egg donor will usually be anonymous and few disputes between gay parents and surrogates have been reported, to date.

Reflecting the range of complex emotions involved in decision-making about known or anonymous donors, Kathleen and her partner had deliberated for many months about this. Finally, she and her partner decided to use an anonymous sperm donor, to remove their concerns about whether the donor relationship would work for both them and their child. This decision was made in spite of the fact that their choice of clinic-recruited donor was very limited.

Helen and her partner chose a known sperm donor who had already had children of his own. He is not involved as a parent but remains happy for the children to know him. This arrangement was central to the basis on which they chose their donor:

> As far as the involvement of the donor my partner and I had decided before we actually went through with anything that we just wanted to be parents. We didn't want like a third parent…. We decided that we'd just like to find someone who was happy just to donate without expecting to have a parental role. So we, we discussed that with the donor and he was happy for that because he's got his own two kids. So far fortunately everyone's stuck to what was discussed and I know again from speaking to other families that it doesn't always work out that way, and that people can have discussions and then a child comes into the world and changes everyone's feelings and it can, you know, get very complicated. So, we feel very lucky that we've had someone who's stuck to what they said they were going to. One discussion with the donor was that if our child ever wanted to meet their biological father at some point when they were older, which I know that children often want to do, that our child would be able to meet that person and so the donor agreed to that.

It was also apparent from the accounts of Jack and Robert that gay men are influenced by the notion that children are entitled to know their biogenetic origins or have access to a relationship with the surrogate who gave birth to them. Unlike many gay men conceiving through reproductive medicine clinics overseas, where available egg donors tend to be anonymous (see Dempsey 2015), Robert was able to choose a known egg donor and maintains contact with her in the hope that his child will meet her in the future.

> I got in contact with the [international] egg donor agency, and they gave me a list of people to look at in terms of choosing an egg donor and I think I probably got my fourth or fifth choice in the end. But that worked out well, because now, the egg donor and I have contact over Facebook, which is really nice. … That was really important to me to have that contact, and I think it's important for a child as well.

Robert explained that he took comfort in this contact with the egg donor because he knew it would be very difficult to locate the Indian surrogate in the future. By contrast, in studies of gay men conceiving through surrogacy in the USA, men tend to emphasise the importance of the child's potential to have a relationship with the surrogate, because it is feasible for the men to maintain contact with their surrogate (see Dempsey 2015).

Conclusion

Parenting among LGBT people continues to have a pioneering, radical flavour, involving the forging of new pathways with limited cultural supports or road maps. Jeffrey Weeks suggests this is an unfinished revolution as new styles of families of choice emerge (Weeks et al. 2001). The revolution continues, with transgender parenting being one of the new frontiers that is destabilising 'socio-legal notions of identity, marriage, normativity, and parenthood' (Pfeffer 2012, p. 574). Pathways to parenthood necessitate consideration of varied methods of conception from home insemination to surrogacy, selections of family structure from single-by-choice to multiple parent families, and choices regarding known or anonymous gamete donors. In the context of the continued presence of negative attitudes towards LGBT parenting, within both the LGBT community and the wider community, there is a huge burden on individuals to prove their competence and legitimacy as parents.

There are several implications for health and social care practitioners that arise from our analysis of the emotional experiences of early parenting for LGBT people. Their mental and emotional health needs may be similar to heterosexual new parents or compounded by experiences

of discrimination and homophobia. Access to LGBT inclusive and knowledgeable health and social care providers can be critical. There are guidelines available for health practitioners on how to provide inclusive care for LGBT parented families (von Doussa et al. 2015). This includes awareness of the legislative environment, particularly the fact that altruistic surrogacy is now legal everywhere except South Australia and Western Australia, and lesbian couples are recognised on the child's birth certificate in all Australian states and territories (Australian Human Rights Commission 2015). It is important to be aware that families of origin or even partners and other assumed supports may not be available for some LGBT parents and to be able to facilitate other support avenues. Stress related to levels of discrimination can be ever present, and while these parents can be adept at navigating this, they may need additional guidance. The trauma associated with problems in pregnancy or pregnancy loss may be hidden and unsupported, particularly for gay men using international surrogacy. Health care practitioners can fulfil an important role in de-stigmatising surrogacy through willingness to discuss it, encouraging men to explore local arrangements where possible and facilitating access to the growing number of surrogacy support groups. Finally, affirming the legitimacy of non-birth parents in LGBT families aids the emotional health of all family members. Those counselling prospective and new parents can encourage them to discuss and clarify as far as possible the varying roles that may be adopted by non-birth parents, partners of the birth parent, and donors.

It is vital that we continue to reveal and respect the personal stories of LGBT parents, given, as Helen says, 'some of our experiences are just the same and some are different.' It is particularly important to challenge stereotypes and false assumptions. Attitudes are slowly changing in society to become more accepting and affirming of LGBT parents and their children. Hopefully, we are moving towards a future in which the emotional struggles of early parenting for these parents will be just the same as those of any other parent, with the same levels of family, peer, and professional support. Same-sex parented families should not have to feel 'lucky to survive.' Rather, they are entitled to navigate a smooth and fulfilling path to parenthood.

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6

The Turbulent Emotions of Early Parenthood

Leah Williams Veazey

Becoming a parent is an intensely personal experience that takes place in the context of powerful cultural institutions of the family and work, and is shaped by dominant and often conflicting discourses. It is a situated, relational experience, defined by personal histories, by cultural norms, and by the many intersecting social locations embodied by the parents and the people around them. Mothering in particular takes place in what Ruth Quiney argues is 'bewilderingly overdetermined discursive territory, in which the individual female body bears the weight of historical oppressions, and of the confusions wrought by contemporary socio-economic upheaval' (2007, p. 36). For the parents at the heart of it, the transition to parenthood involves complex renegotiations of the self in relation to partners, children, career, health care professionals, family, and friends.

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These complex changes are accompanied by extremes of emotion, which many new parents find both surprising and overwhelming (Crouch and Manderson 1993; Daws and de Rementeria 2015; Lupton 2000; Rogan et al. 1997; Sanders et al. 2014). The focus on the birth of the child, and concomitant lack of attention paid to the birth of the parent, leaves many parents without the necessary tools to navigate successfully this important phase of their lives. The physical intensity of new parenthood, particularly new motherhood, can come as a shock, as the maternal body is taken over by pregnancy, labour, recovery, sleep deprivation, and breastfeeding. For many women, the emotions attached to the change in self-identity, intimate relationships, and social positioning are as raw and intense as those attached to the physical experiences (Garvan 2016). At the same time, many parents experience a flood of positively perceived emotions, including awestruck love, and pride in their role in the creation of new life. While each parent experiences a unique journey through the emotional turbulence, the initial intensity tends to wane after the first weeks or months, followed by a period of adjustment and acceptance. Despite this waning of intensity, parents may continue to experience emotional turbulence, and the residual effects of the initial shock may endure.

The 'turn to parenting' (Daly 2013) and the widespread use of gender-neutral terms in contemporary policymaking obscure that fact that parents' experiences of family life in Australia continue to be heavily gendered (Craig and Mullan 2010). The concept of parenting as both gender-neutral and removed from its social context (Daly 2013; Gillies 2005) sits in tension with the normative and distinct ideals of motherhood and fatherhood that shape parents' lived experiences. Motherhood scholars have demonstrated how women's expectations of reproduction and motherhood are shaped by powerful ideals and discourses that call on notions of nature, science, and good/bad motherhood to reinforce their dominance (Goodwin and Huppatz 2010; Hager et al. 2017; Hays 1996; Kawash 2011; Miller 2007; Sanders et al. 2014; Thurer 1995). The biology of pregnancy, birth, and lactation, often viewed as universal experiences, serves to conceal the socially constructed elements of motherhood. Early parenthood in Australia remains a deeply gendered

experience, shaped by numerous intersecting factors, including cultural context, migration, sexuality, and class (Fox 2009).

In twenty-first-century Australia, three key discursive constructs shape women's experiences of motherhood. Firstly, 'intensive mothering,' defined by American sociologist Sharon Hays as 'child-centred, expert-guided, emotionally absorbing, labour-intensive, and financially expensive' (Hays 1996, p. 8). In this framework, the mother must be the primary carer; although the father may share some of the tasks, the ultimate responsibility lies with her. A mother must be guided by her child, expert advice, and her own instincts. She must breastfeed and tend to her child's needs at all times. Intensive mothering draws on a framework of individualisation, of 'life as a planning project,' and makes explicit the mother's role in getting a child's 'life project' off to an appropriately managed start (Beck-Gernsheim 1998). Yet, intensive mothering conflicts with that same framework of individualisation as applied to women's own life plans and their value as paid workers within a market society, as well as with feminist discourses around equal parenting and women's right to access the public sphere. These tensions are characterised by Quiney (2007, p. 33) as 'the double binds of new capitalist motherhood.' Research suggests that in contexts where intensive mothering ideals dominate, even those mothers who do not adhere to them are affected by them (Henderson et al. 2016; Newman and Henderson 2014).

Alongside intensive mothering ideals sit essentialist discourses that portray women as intrinsically suited to bear, birth, and nurture children. Within this framework, women's reproductive and childrearing role becomes their *raison d'être*. Often involving a deep conflation of mothering and nature, the implication in contemporary Australian society is that motherhood ought to come to women naturally and therefore easily. As historical studies of motherhood make clear, this depiction erases histories of commonplace maternal death, of wet nursing for women unable or unwilling to breastfeed, and of infanticide and child abandonment (Goc 2013; Loudon 1992; J. H. Wolf 2001). One effect of essentialist discourses is that women who struggle with any aspect of motherhood feel themselves to be 'unnatural,' and failures at their one true role in life. Such attitudes inhibit them from

seeking support or sharing their experiences, contributing to what has been termed the 'conspiracy of silence' around motherhood (Crittenden 2001; Foster 2005; Maushart 1997; McVeigh 1997; Thurer 1995; N. Wolf 2001).

The third key maternal framework focuses on the affective response to motherhood and is the focus of this chapter. It shapes which emotions are deemed appropriate for mothers to experience and which are inappropriate, excessive, or destructive. As Shari Thurer notes, 'it has become mandatory to enjoy mothering. So we work at enjoying it' (1995, p. xiv). Mothers must feel love, affection, kindness, and patience at all times. Mothers must feel these emotions not just because it is better for their child that they do (and better for child means compulsory), but also because it is integral to what motherhood is. Although the literature on maternal ambivalence exists, particularly in the psychoanalytic sphere (Parker 1995; Raphael-Leff 2010) and some first-person narratives (Cusk 2001; Enright 2004), this does not appear to have led to an acceptance of ambivalence as a normal part of motherhood within popular, everyday discourses. Rozsika Parker argues that, far from being abnormal, maternal ambivalence is both necessary and potentially productive, leading to deeper knowledge and understanding of the baby and to a greater sense of independent identity for the mother (Parker 1995, pp. 7, 137). The anxiety and silences around ambivalence are, Parker argues, where the real problem lies.

Fathers' experiences are also framed by discursive representations of normative fatherhood, although as Miller (2011) argues, those discourses are less 'totalising' than those framing motherhood. Whereas discursive representations of motherhood emphasise women's biological capacities and the need for self-sacrifice, leaving little room to manoeuvre, fatherhood discourses retain the possibility of men's agency and capacity to choose the level of involvement in caregiving without being considered deviant. Constructions of hegemonic masculinities, such as that of the provider and protector, coexist with notions of caring masculinity that emphasise 'involved fatherhood' (Connell and Messerschmidt 2005; Miller 2011; Wall and Arnold 2007) without requiring the kind of intensive and continuous presence demanded of mothers.

Involved fatherhood does not require men to subsume themselves within a paternal identity (Miller 2011, p. 1101).

The early days, weeks, and months of parenthood are a time of intense emotions and also a time of intensive emotion work. Emotion work involves 'trying to change in degree or quality an emotion or feeling,' particularly when the experienced emotions do not align with the 'feeling rules' attached to a given situation within a particular ideological framework (Hochschild 1979, p. 561). In this chapter, I will use Hochschild's concepts of emotion work, feeling rules, and deep acting, alongside the concepts outlined above, to explore the powerful and ambivalent emotions of early parenthood. The emotion work performed by new parents and the concomitant silences around the challenges of early parenthood are both a result of dominant gendered discourses and a means by which those discourses are sustained and reproduced. Despite widespread availability of parenting books, blogs, and apps, many new parents in Australia feel that vital knowledge has been withheld from them. In this chapter, I will argue that a more complex dynamic of desire for, and refusal of, knowledge is at play here, rather than a one-sided 'conspiracy of silence.'

The transcripts of interviews with a diverse range of new parents in Australia were reviewed, and then, thirteen were selected for closer analysis. Nine women and four men spoke in detail about the transition to parenthood and their emotional response to it. The selected interviews were coded and analysed thematically (Braun and Clarke 2006), employing an initial inductive coding for broad themes, commonalities, and contrasts, followed by 'emotion coding,' tracking the emotional journey as recalled by the participants (Saldaña 2013, p. 106). Seven key themes were constructed out of this analysis: joyful birth; bodies and emotions; overwhelming responsibility; changes to the couple relationship; changes to self and identity; the dynamics of silence, ignorance, and knowledge; and the changes over time as parents adjust to their new reality.

Joy, Love, Exhaustion

Positive emotions of pride and joy are often associated with the birth of a child. Yet, while these were indeed expressed by many participants, their narratives revealed that these joyful emotions were far from universal and were often transient or intermingled with more negative emotions.

The moment of the birth or emergence of a child is a classic joyful trope in birth narratives: the baby held aloft or snuggled close, announced to the world while the shell-shocked parent(s) share a moment of recognition and a wave of love for their new child. Lua, a Sāmoan father of three, encapsulates the momentous joy of his first child's birth seventeen years earlier. As he puts it, 'It was like there was chaos everywhere but as soon as my daughter was born, I felt like there was a bright light just shining straight into the room and I just saw, before my own eyes, a miracle.' For Sylvia, a married migrant from Europe, her child's birth was 'the most incredible day of my life,' eliciting an 'avalanche of love.' This kind of 'magic moment' (Nina) occurred in some of the narratives, but it was by no means universal. Indeed, Lucy, a 29-year-old Anglo-Australian mother of two, reflects on how her rather chaotic and confusing experience of childbirth contrasted with the idealised 'image of what happens in the movies.'

Even when a parent is not present at the birth, the first moments together can create strong emotional and sensory memories. Robert, a single, gay, Anglo-Australian father, whose baby was born through surrogacy overseas, was not able to see his daughter for more than a few moments until the afternoon after she was born. His memories of meeting his baby echoed many new parents' enchantment with the physicality of their long-anticipated child: 'It was just fascination really. This tiny little baby and … just—so delicate, you know, translucent almost, the skin, and the smell.' These moments of joy often retained significance beyond the moment of birth, becoming memories that parents could use to sustain them through the more challenging times that followed.

It was notable that most respondents tended to speak only briefly, if at all, about the positive aspects of the early days of parenthood. Sometimes, the only mentions of pride, love, or joy appeared almost as an afterthought, to balance a long discussion of the challenges. Many of the parents made no mention of joyful responses or instantaneous bonding. In other accounts, positive emotions appeared inseparable from the challenges of childbirth or other difficult circumstances, or swiftly faded into the chaos of the early days of sleeplessness, breastfeeding challenges, and baby care, only to re-emerge periodically. Sylvia used the memory of her baby's arrival, as well as photographs taken in happy moments, to sustain her through the more challenging times, observing that 'photos of your baby taken so regularly become a source of comfort for you. But when she's crying in the middle of the night … I look at the photo when I took it the week before and she's smiling. … You need to see that she is a happy baby to remind you that these crying moments pass.' Sylvia consciously managed her positive emotion as a precious resource to be deployed in support of her mothering role. This strategic management of joy suggests that parents' emotions are more than just spontaneous affective responses. They are a resource to be judiciously managed and operationalised.

During these early days, parents find joy in their baby's growth and development, and their own development of new parental skills and confidence. Yet, this joy remains tempered by the challenges of the period. Laura explains how the 'combination of just exhaustion and delight' in the first eight weeks was 'terrible' and has left her with few memories of that time. 'Then at some point,' she notes, 'you get into a rhythm.' Several of the parents echoed Laura's sense that early parenthood constituted a discrete period, one which felt qualitatively different to any other time in their lives, and during which they experienced an intensity of emotion simultaneously 'terrible' and 'beautiful.'

Throughout the interviews, parents evaluated their own experiences with reference to idealised norms of maternal bodies and behaviour, families, and intimate relationships. If parents did not experience the positive emotions they expected to feel, their sense that they were not normal or not coping was magnified.

Bodies and Emotions

Parents' stories of fatigue and perpetually uncombed hair testify to the deeply embodied nature of early parenthood. New parents' corporeal experiences are closely linked to their emotional state. Difficulties performing the physical tasks of parenting can lead to feelings of failure, guilt, and shame. Exhaustion leaves parents less able to manage their emotions in ways deemed appropriate. Both physical exhaustion and the concomitant emotions are experienced in deeply gendered ways.

For mothers who have experienced childbirth, the early days of parenthood are marked by recovery from the exertion, surgery, haemorrhages, or injuries, or the process of coming to terms with the emotional impact of traumatic birth experiences. Fathers, too, may be deeply affected by their witnessing of, and involvement in, childbirth (Inglis et al. 2016). However, often there is little time or energy to focus on physical or emotional recovery as the baby's needs are immediate and constant, as is evident in Laura's account: 'I just remembered thinking: I know I'm being hormonal but I am so fragile right now. I have just had my vagina ripped from front to back and I am in pain and I am trying to work this all out and I'm exhausted.'

Sleep deprivation was an almost universal experience, and many parents referred to its detrimental impact on their ability to manage their emotions. Failure to control (negative) emotions was framed as potentially damaging to their child or destructive to their couple relationship. Rebecca, a 39-year-old Anglo-Australian mother of two, describes sleep deprivation as 'the most damaging' and 'the hardest thing to manage,' leading her to 'snap' at her husband and children, despite her best efforts to the contrary. The emotion work involved in these attempts at emotional containment can be seen as an additional drain on parents' already depleted psychological resources. The costs of intensive mothering can be seen here, as even at times of intense emotional strain, mothers felt their primary concern should be for their children, leaving little time to tend to their own needs.

Breastfeeding is an embodied practice in which the logics of intensive motherhood, biological essentialism, and 'breast is best' medical

discourses combine to create an emotionally fraught and deeply gendered experience. Expectations of gender-neutral shared parenting disappeared as many couples 'fell back into gender' (Miller 2011), with women taking primary responsibility for baby care as the perceived logical consequence of breastfeeding. Many women found breastfeeding more difficult than anticipated, and feelings of corporeal failure and the inability to meet their 'moral obligation' to their child (Wall 2001, p. 605) compounded their sleep deprivation and physical exhaustion. The need to be available to feed their baby on demand enhanced some women's sense of existing only for the baby's needs, to the detriment of their own, and some described a sense of relief once they stopped breastfeeding. For Lola, who struggled with perinatal depression, not breastfeeding was 'liberating,' enabling her to share baby care with her mother, mother-in-law, and partner, creating 'a little bit of time to myself here and there.'

Some mothers, like Laura, questioned why they had been unaware that 'breastfeeding isn't something that just happens.' The guilt and shame expressed by many of the mothers who struggled to breastfeed suggest an answer. Believing they have failed to perform one of the most basic tasks of motherhood, women stay silent. Even when women do speak, the narratives suggest that prospective mothers, unwilling to consider that they too might fail at this integral womanly function, prefer not to listen.

Inexperience and Responsibility

As with breastfeeding, the underlying expectation that parenting ought to come naturally, combined with minimal prior experience with babies, left many participants feeling underprepared and sometimes afraid, incompetent, and overwhelmed. Rebecca described feeling 'completely terrified' that she might hurt her child, who seemed to her 'so tiny and so fragile and so extremely vulnerable.' Both mothers and fathers remember feeling unprepared and lacking key skills, but mothers in particular describe an almost crushing sense of responsibility for which they were not equipped. The account related by Hannah

exemplifies this: 'When everybody left, when my husband eventually left I looked at my child, … and I just burst into tears and went: "I've got you for another 18 years. I don't know what I'm gonna do." … I was exhausted and I thought, "I don't know how to do the next part. … Everything's prepared me for this day. … I don't know what to do for the next part, and if anything happens, I'm stuck with you."' Compounding the stress of being unsure how to care for their new baby, many mothers referred to the pressure to be the 'perfect mother.' There was an almost palpable sense of failure when they were not able to live up to it, as Rebecca's account demonstrates: 'I remember holding him when he was asleep or … the last kiss at night and promising him that I'd be a better mum and that I'd get it right and I never did.'

The one parent who emphasised how well equipped he was to look after his baby was Robert, the single, gay father by surrogacy. He explained how his personal and professional experience of caring for children gave him confidence in his new role, saying, 'I took one or two really good reference books, just to look things up, but I felt fairly confident about looking after her, which I think was a good thing. Like, I knew how to feed a newborn and change nappies and all that kind of stuff, so I didn't get too scared.' Surrounded by people and messages that cast doubt on his suitability and capability to raise a child, due to his sexuality and relationship status, Robert emphasised how his skills, experience, and disposition made his transition to parenthood a smooth one on a personal level. The challenges he faced, he asserted, were the result of societal judgements and bureaucratic arrangements that obstructed his parenting. His account provides a stark contrast to the many mothers in the study who attributed their struggles to personal inadequacy.

Families and Relationships

Esther observed that her 'expectation was, okay, a child is born and when a child is born it brings mum and dad closer to each other, but it was very different from what I experienced. My child was born, but it created a gap, a very deep gap, between me and my husband.'

Her assumption that becoming parents brings couples closer together is a common one, based on dominant narratives about the family as a central building block of society and about parenthood as the ultimate goal of a couple relationship. Some parents in the study described how parenthood triggered emotional distress for themselves or their partner, or abusive behaviour. Even moderate changes can be deeply distressing, such as the feeling that the father has little understanding of the mother's reality, or that the focus on the child has left little time and space for the adults in the relationship. Esther described deep resentment towards her baby, triggered by the pressure she felt to suppress her own needs, a lack of appreciation for doing so, and her husband's focus on the baby, which she experienced as a withdrawal of affection for her.

An 'unobtainable parental ideal' (Parker 1995, p. 46), of a partnership united by their love for their baby, magnified Esther's maternal ambivalence. Following their migration from Iran to Australia, Esther and her husband managed to renegotiate their relationship and their expectations of each other. Her doctor and mothers' group encouraged her to focus more on her own needs. She returned to university, her husband agreed to share childcare responsibilities, and that, she maintained, 'was almost the end of my motherhood challenge and the start of a new life for me.'

In the heterosexual couple relationships, parents struggled with the sudden divergence in their daily lived experiences. Fathers' stories mostly illustrated their absence from the day-to-day experience of hands-on parenting and, significantly, from the minute-to-minute intimate attentiveness that the care of a newborn entails. Mothers described long days of loneliness and isolation as they grappled with the unfamiliar tasks required to keep a baby safe, clean, fed, and nurtured. As gaps emerged between parents' lived experiences of parenthood, there was less common ground and a diminished sense of parenting as a 'joint project' (Fox 2009, p. 144). Australian-born mother of three, Vivienne, felt her husband had demonstrated little understanding of her life, and what she has 'given up' to take care of their children, while he has travelled extensively for work. Only the insight gained by the experience of full-time parenting himself has enabled Alexander, now a father of four, to recognise the insufficient support he offered his wife as she

struggled with prematurely born twins. Suffering severe sleep deprivation, Alexander's wife was admitted to a psychiatric unit, while he was largely absent due to the demands of his paid employment.

These accounts exemplify the 'separate spheres' pattern experienced by many of the parents and the serious impact that can have on the parent at home. They also echo Miller's finding that fathers often retreat into normative gendered behaviours once they return to a daily routine of work (Miller 2011, p. 1094). The fathers' absence was not always by choice, as Jon's account illustrates. Jon, a 36-year-old white British migrant to Australia, described how his desire to be an involved father was thwarted by the need for at least one partner to undertake paid work to support the family, and his wife's resistance to him becoming a 'stay-at-home dad.' Jon challenged the normative masculine worker identity and 'long hours culture,' but in most narratives, a prioritisation of men's work and their greater freedom to negotiate presence and absence from their child's daily life was evident. Even where parenting is experienced as a 'shared creative project' (Parker 1995, p. 46), the all-encompassing focus on family dynamics can have a deleterious impact on what Rebecca called 'in-love togetherness.'

The normative model of the nuclear family, in which child-raising responsibilities reside with the parents alone, as well as the expectations of companionate marriages to provide sufficient emotional support for both parents, places intense pressure on couples. Those parents whose own families live far away, or are otherwise unwilling or unable to help, rely to an even greater extent on each other for emotional and practical support. If that anticipated support does not materialise, mothers' sense of aloneness can become overwhelming. Gendered divisions of labour may lead to a prioritisation of men's paid employment (and their need for sleep) and to an increasing childcare-related skills gap between mothers who are ever-present with their child and fathers who are only intermittently present.

Self and Sacrifice

The gendered change in daily activities brought about by the transition to parenthood can also be seen in changes to parents' sense of self and identity. As Sylvia explains, 'my thoughts, daily, naturally, belong to her, I don't even think for myself.' For many of the women, becoming a mother involved an enforced change of identity, personality, and lifestyle. By contrast, men mostly noted changes in lifestyle and the couple relationship. The mothers' experiences align with intensive mothering ideology (Hays 1996), which privileges the child's needs above the mother's. Some mothers experienced a loss of their sense of self, exacerbated in some cases by a shift from a perceived career-based identity. Some struggled with these expectations and a few resisted vigorously.

For Rebecca, this near-compulsory self-transformation began during pregnancy. Now a mother of two, she reflected on how she felt her expectations of herself changing as she swam during pregnancy: 'I was conscious … that what I was thinking and the aggression that I was feeling towards the slow person in front of me in the fast lane. Somehow I felt that that would be all transferred to the baby so—ridiculous—but I was thinking, I was forcing myself to think kind thoughts. … I'm not like that at all now. I'm much kinder to the world.' Rebecca's conscious management of her emotions during this transitionary period can be seen as 'deep acting.' She is not just changing her public display of emotion, or 'surface acting,' but consciously trying to change her actual emotions to align with socially acceptable 'feeling rules' for motherhood (Hochschild 1983/2012). These 'feeling rules' have been made explicit in advice given to pregnant women for over 150 years (Lupton 1999, p. 64) that they should avoid strong emotions or stress for fear of affecting the foetus or future child. By comparison, Isobelle's statement about putting on her mask and her 'happy face' and Lola's attempts to contain her potentially 'destructive' emotions at the request of her husband demonstrate a performance for others. Isobelle displays the face of a happy, capable mother, but recognises that no amount of emotion work will transform her into that mother.

Whether superficial or deep, these attempts to become a 'good mother' and a 'better person' constitute a moral project in which the mother consciously strives to become a more virtuous woman in order to meet the needs of her child. Exemplifying this sense of maternal moral transformation, Sylvia asserted that motherhood 'requires selflessness and these qualities, maybe are not naturally leading our character. In fact, patience is certainly not one of my virtues, but patience is one of the key characteristics a parent needs. And so [my daughter is] teaching me, I think, to be a better person.' She struggles to reconcile two incompatible requirements of the 'individualised achievement society,' which demands that women in the Global North develop 'desires and life plans which no longer refer to the family alone' (Beck-Gernsheim 1998, p. 146), and which also chirrups the 'ever recurring chorus: that inattention to the needs of children leads to irreversible damage' (p. 143). Sylvia continues: 'How can you possibly hand them over to someone and for your own benefit go and work out? … Because at the end, like I said, it is—you are second and she is the first. But you want to regain your own sense of normality and you want to feel that you're back to where you feel like you were.' A simultaneous desire for separation and togetherness is, Parker argues, 'vital for the project of separation' inherent in motherhood, and 'provides a woman with a sense of her independent identity' (Parker 1995, p. 101). Yet, there appears to be little cultural acceptance of ambivalence as a necessary part of motherhood.

By managing their emotions and suppressing their own needs, these mothers are attempting to perform the emotions and duties of good motherhood, in accordance with contemporary discourses prominent in Australia, the UK, and the USA, for example, that require mothers to be self-sacrificing, instinctively competent, kind, patient, loving, and happy. As Lola explains, 'a mother is wholly nurturing, wholly loving, wholly devoted, doesn't have ambivalence, doesn't think darkly about their baby.' Anything else, she asserts, 'goes against all of the stereotypes of what a good mother' is. Women do not want to find themselves on the wrong side of the divide between mothers who are 'good and containing' and those 'who require explaining' (Parker 1995, p. 99).

By contrast, Hannah strongly resisted the subsumption of her identity into motherhood and refused to perform the emotion management she knew was expected of her. 'I am a person, a scientist, as well as a mother,' she asserts. 'The children are not my defining part of my life. They are a part of my life but, as I said, it doesn't define who I am, a mother. I still wanna be seen as an individual person, not just that part of a family type thing.' Hannah also contested the expectation that mothers put their children's needs before their own and should change themselves to enable this, noting that she is 'not good with sick children,' sometimes leaves them to cry alone and does not tolerate her children's tantrums. By 'maintaining an alternative set of feeling rights and obligations' and 'by refusing to perform the emotion management necessary to feel what, according to the official frame, it would seem fitting to feel' (Hochschild 1979, p. 567), Hannah defied the discourses of intensive and essentialist motherhood. This came at a personal cost, however. She wondered, in retrospect, whether she might have been depressed, based on her 'emotional deviance' (Hochschild 1983/2012) from the conventions of motherhood. In this way, she softened her implicit critique of intensive mothering ideology by individualising the responsibility and moving the focus away from the untenable expectations placed on new mothers. Hannah stopped short of asserting that the ambivalence she felt might be commonplace, apposite, or even, as Parker contends, creatively productive (Parker 1995, p. 6). Individualising and pathologising their struggle in this way leave unchallenged the cultural discourses and structural arrangements surrounding motherhood (Garvan 2016, p. 11).

Silences and Ignorance

Normative discourses of motherhood and fatherhood shape parents' expectations of, and affective responses to, early parenthood. They also shape what kind of information is shared with others, or withheld from them. Several parents imply a conspiracy of silence around some of the more challenging aspects of early parenthood. At the same time, parents describe dismissing the attempts of more experienced parents to share

information about the challenges they had faced, suggesting a more complex interplay of desire for, and refusal of, knowledge in this area.

Vivienne's twin IVF pregnancy was characterised by worries about the health and viability of her babies. She describes how her sense of deviating from the prescribed emotional script of pregnancy had increased her emotional isolation, and how, even nine years later 'people just don't talk about it.' Similarly, Sylvia observes that her friends had not talked about the challenges in their relationships caused by the arrival of a baby: 'No other couple that we know ever disclosed to us that having a newborn in the house created arguments.' During the newborn period, this lack of information about the diversity of parental experiences increased parents' feelings of isolation and failure to live up to idealised norms of pregnancy and motherhood. Reflecting on their experiences, they suggest that important information had been withheld from them by other parents, information that could have prepared them better for what lay ahead.

Two years after becoming a mother, Georgina reflected on how far her experiences had veered from her expectations. She remembered the early days of parenthood as exhausting and anxiety-inducing. Diagnosed with postnatal depression and anxiety, she had been hospitalised for a month and treated with medication. She found this treatment helpful, but it was a difficult time and has influenced her decision to have no further children. Once she shared her experiences, other parents told her that they too had faced serious challenges. But for Georgina, this came too late. Why had they not warned her beforehand, she wondered, so she could have made an informed choice, or at least been better prepared? The absence of a shared understanding of maternal ambivalence or parental struggles means that mothers are often left with no means to 'conceptualise the co-existence of her hating and loving feelings. She simply feels inadequate or guilty' (Parker 1995, p. 139). Guilt and shame may perpetuate the silences that in turn maintain the unrealistic ideals, as women feel they can only be truly open with others who have 'failed.'

Despite understanding the impact these silences had on them and their relationships, some of the mothers in the study found it difficult to share with other women the challenges they experienced. Even four

years after seeking help for perinatal depression, Isobelle remained reticent about sharing her experiences, due to the social stigma around emotional distress in early parenthood, and the implication that requiring medical intervention represents a personal maternal failure. Whether in cases of acute distress like Isobelle's, or more common difficulties with breastfeeding, pregnancy, or relationships, women's unwillingness to discuss their experiences of emotional distress with family, friends, and health professionals provides some insight into how the dominant narratives remain unchallenged and women remain unprepared for pregnancy and motherhood. Their accounts suggest that women remain 'card-carrying co-conspirators' in the conspiracy of silence around motherhood (Maushart 1997), for fear of revealing that they do not match up to an unachievable maternal ideal.

Although less of a theme in the fathers' interviews, some were affected by silencing created by the limited opportunities to meet and share experiences with other fathers, and by an expectation that, as men, they would not want to talk about emotions. As Jon noted, 'there's always an assumption that, that a guy can cope with everything that's thrown at him and there's not so much availability for support networks. And there's an assumption that a guy can get through this without any help.' Jon's experience suggests that fathers, too, may be inhibited from sharing their emotional experiences and challenges of early parenthood for fear of exposing their perceived inadequacy in relation to gendered expectations of expressing emotions and behaviours.

Contradicting their claims that 'nobody told them,' some women disclosed having received 'warnings' about the challenges of early parenthood ahead and having dismissed them. Daphne described her attitude to breastfeeding as 'naïve,' particularly in the face of her mother's attempts to prepare her. Lola remembered reading *The Mask of motherhood* (Maushart 1997) during pregnancy and casting it aside, thinking 'no, not reading this—[this] can't possibly be what I'm facing.' Kelly had read the same book and attributed to it her decision not to have children in her twenties. Later, when she 'met the right person,' her desire to have children with him overrode the 'warnings' she had previously heeded.

In her first interview, carried out while she was pregnant, Sylvia rejects the advice offered by colleagues that she would not want to return 'early' to work. Work would remain an important part of her identity, she asserted. In the postnatal interview, she acknowledges the change in her perspective, 'I understood people's advice that baby needs me more but again, you don't know until you experience it. … It probably comes down to being able to understand others only once you experience it for yourself.' Lola, Daphne, Kelly, and Sylvia did not take into account the knowledge offered to them by other parents. They assumed their experience would be different and they would attain the maternal ideal to which they aspired. This suggests a complex interplay of desire for knowledge and yet resistance to heeding other parents' experiences. While silences and stigma play a role, so too does the privileging of insights gained through personal experience over propositional knowledge. The willingness of many mothers to accept personal responsibility for their challenging experiences, and the dynamic interplay of desiring yet rejecting, and then withholding, knowledge, speaks to the power of motherhood discourses, particularly in the context of a society that places a high value on individualised responsibility.

Settling into Parenthood

The intensity of early parenthood tends to settle with time, whether as a result of the passage of time and child development, increasing parental experience, assistance from health or social care services, or a combination of these. Parents adjust, learn new skills, get help for emotional distress, and build links with people who can support them. The children settle into patterns of sleeping, need feeding less frequently, and start to interact with their parents and surroundings. In this way, some of the instrumental causes of the maelstrom of emotions abate to a level that appears more manageable. If parents have struggled with the changes to their lifestyle, relationships, and sense of self, they may start to accept those changes, renegotiate expectations with their personal networks, and start to share some responsibility with carers outside their nuclear family. Miller (2007) notes that over time, as women become more

confident in their mothering, they become able to challenge the dominant discourses, although such discourses remain salient and pervasive.

For some parents, accepting the lifetime responsibilities that parenthood entails is an important step. Others find confidence when they identify a mode of parenthood that suits them. Nina describes the importance of finding 'an authentic way of parenting … that resonates with your personality and your values' and developing the confidence to push back against rigid parenting methodologies. Her increased assurance in her mothering abilities translated into a happier experience with her second child. Rebecca, too, explains that her more relaxed approach with her second child had made her happier, but she nevertheless continues to aspire to an idealised and somewhat unattainable maternal model: 'I'd like to be more of an ideal mother. I'm still looking for my gold star.' The elusive, idealised good mother remains a 'nagging lack' in her maternal narrative (Quiney 2007, p. 24), even as she has found a mode of motherhood that suits her.

Many of the parents found that the memory of the emotional turbulence of those early days, weeks, and months remained, shaping their present and future. Decisions about having further children, for example, were informed by memories of this period. Georgina experienced postnatal depression and decided not to have any more children, because she 'wouldn't want to go through it again.' Jon had gone on to have a second child, but wondered whether his fear of doing so was linked to his first experience of fatherhood. He had had to 'block out' those memories before being able to contemplate doing it again.

Parenthood continues to elicit ambivalent emotions beyond the early period. Relationship difficulties may continue, either because the issues remain unresolved or because the resentment experienced is not easily forgotten. Some parents can put the fading memories of their early challenges behind them, but for others, those memories have an enduring impact.

Conclusion

Sara Ruddick writes that 'It is difficult when writing about motherhood—or experiencing it—to be balanced about both its grim and its satisfying aspects' (Ruddick 1980, p. 345). Culturally sanctioned, idealised, and normative expectations of the transition to parenthood often bear little resemblance to parents' lived experiences, yet those expectations significantly shape their emotional responses to it. The 'feeling rules' of early parenthood are the emotional 'underside' (Hochschild 1979, p. 557) of parenting ideologies and dictate which emotions are deemed appropriate. On top of the physical and emotional work of caring for a new baby, mothers undertake significant 'emotion work' in an attempt to fit the profile of a 'good mother.' This additional work of emotion management, mostly undertaken in secrecy and silence, exacts a harsh psychological toll on new mothers. Both mothers and fathers make conscious and unconscious efforts to feel or perform appropriate emotions, to conceal any ambivalence, and they worry if they cannot achieve these tasks. However, due to the more strongly codified ideologies and idealisations of motherhood, and the oft-asserted causal relationship between the mother's emotions and the well-being of her child, the emotion work performed by mothers is usually more intensive. Mothers, in short, have more to lose by letting their mask slip.

The image of Lola casting aside her copy of *The Mask of motherhood* in an act of wilful refusal of the kind of knowledge incorporated in this book calls into question the notion of a conspiracy of silence. While it is undeniable that for many men and women, the emotional turbulence of early parenthood is unexpected, and that many mothers and fathers feel a pressure to conceal their struggles from other parents and health professionals, this is not simply an absence of prior knowledge, but also an active, dynamic ignorance (Mills 2007, p. 13). It is an ignorance actively maintained in the face of widely available popular and academic explorations of the challenges facing new parents. Lola both desires to know (procures the book and starts to read) and refuses to know (puts the book down).

What is the purpose of this active attachment to 'non-knowing' (Mills 2007, p. 20)? What sustains it in a contemporary Australian context, in which a wealth of parent-related information, experiences, and opinions is accessible at the touch of a button, through internet searches and online forums? I offer three explanations. Firstly, parents remain invested in successfully attaining a parental ideal that is intrinsically linked to their femininity, masculinity, or functional adulthood, and hence reject any possibility of failure until forced to do so by personal experience. Secondly, if 'social silence around unsettling knowledge' helps to maintain social and political orders (McGoey 2012, p. 4), the strategic ignorance around new parenthood perhaps serves to maintain a patriarchal order of parenting that works to the detriment of the mental and physical health of new mothers. And finally, in Sylvia's words, 'you don't know until you experience it.' No matter how much information and testimony they are exposed to, for some parents, personal experiential knowledge is the privileged route to insight.

Thus, the darker emotions of new parenthood remain both unspeakable and, if spoken, unhearable. Negative or ambivalent emotions are to be masked, suppressed, shared only with a select few, or retrospectively reframed as depression. Mothers must contain their emotions, for fear of becoming 'mothers who need explaining' (Parker 1995, p. 99), or of letting down the child(ren) for whom they have an intense and individualised responsibility. Running through the narratives of the mothers who experienced the transition to parenthood as a challenging time is the shadow figure of the 'good mother,' in comparison with whom they will always fall short.

This chapter has explored the emotional experiences of new mothers and fathers, and in doing so appears to corroborate previous research pointing to the enduringly gendered nature of this life experience (Fox 2009; Miller 2007, 2011). Not only does there appear to be a disparity in the impact of new parenthood on the physical health, work practices, and life course of women and men, there also seems to be a gender difference in the emotional experience of new parenthood. Health and social care practitioners and family policymakers would be well advised to take account of the gendered behaviours and discourses around early

parenthood, and not obscure it behind 'gender blind' language and policies (Daly 2013, p. 227).

Experiences of guilt, shame, anger, resentment, regret, frustration, sadness, loneliness, and fear appear to be as much a part of the transition to parenthood in Australia as the more widely acknowledged experiences of joy, delight, and love. That each new parent seems to have to discover this for herself or himself anew is testament to the powerful discourses that both shape parents' expectations and discourage them from sharing their struggles with others. Additional social support and a restructure of normative gendered parenting regimes could reduce the intensity of pressures experienced by new mothers in particular. Wider acceptance of the normality, even necessity, of intense and ambivalent emotions during the transition to parenthood and beyond, would render emotion work less necessary, leaving more energy for themselves and their new baby.

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7

‘What Have I Done?’: An Exploration of the Ambivalent, Unimaginable Emotions of New Motherhood

Kate Huppatz

In early 2017, the freshly inaugurated American President, Donald Trump, signed an order to prohibit the distribution of family planning funds to foreign aid groups that discuss abortion. Several months later, on the other side of the world, New Zealand’s incoming Labour leader was asked about her baby plans only seven hours into the job. Both of these acts appeal to normative assumptions about motherhood, childhood, and the relationship between motherhood and femininity. Alongside these political events, the taut, trim maternal bodies of celebrities like Natalie Portman, Serena Williams, and Beyoncé set the social media standard for mothers and their children. Various new ‘expert’ medical, physical, educative, and aesthetic, but also moral maternal knowledges proliferate to construct a mythology about maternal femininity. These events, images, and discourses form the context in which women’s expectations of early motherhood are established.

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Women are presented with all manner of information about what motherhood is like and how it should be done. These sometimes dialogic, sometimes competing scripts shape expectations, but often fail to prepare parents-to-be for what is to come.

Making use of two diverse case study interviews with Australian mothers, this chapter explores the disunity between pre-birth expectations and the lived bodily experience of new motherhood. These disconnections occur around appearance, birth, relationships, self-concept, and career, and point to the ideological nature of much parenting discourse. Mothers report a range of emotional responses to new parenthood that often do not fit with the dominant romantic narratives that are constructed around baby making including anxiety, anger, guilt, and grief. While this disconnect sometimes encourages women to resist dominant ideology, they also demonstrate commitment to gender norms and a complicated relationship with good mothering discourse.

Conceptualising Motherhood

Feminists argue that gender essentialism continues to inform commonly held understandings of motherhood. Motherhood is seen as a normal, natural, and inevitable event for women, and motherhood and femininity are intimately connected, so that gender is 'done' through mothering (West and Zimmerman 1987). As it is interchanged with womanhood and seen as anatomical, motherhood is conceived of as a universal experience across time and culture and outside of power relationships. At the same time, practices and identities of mothering are constructed as either good or bad depending on a woman's social position, as determined by factors such as her class, ethnicity, and sexuality. In this way, mothering is ideological and intrinsic to gender inequality. Ideologies of mothering 'interpellate' (Althusser 1970, p. 160) women as particular subjects. Through a mechanism of recognition, ideology calls women into place and confers on them a gender identity that is informed by maternity—irrespective of whether or not they are mothers—and dictates to them the terms of maternal identity. This process can occur through various discursive channels, including via the communication

of expert knowledges, media images, and fashion. Feminists have identified that the impossibility of these expectations leads to experiences of failed femininity, to women feeling as though they do not add up to the 'good mother' ideal.

In order to ensure the possibility of alternate subject positions, feminists have also long engaged in a scholarly project of naming and resisting good mother ideology. In her review of a decade of North American mothering scholarship that spans roughly between 1990 and 2000, Arendell (2000) finds that feminist social constructionists have worked to expose motherhood as it exists outside of narrow normative definitions, particularly as it exists outside of the traditional nuclear family. This project has allowed feminists to 'take the familiar and attempt to make it strange' (Hays 1996, p. x). Presenting one of the best-known theories of mothering as ideologically produced, Hays (1996) proposes that the hegemonic ideology of mothering in North America is intensive mothering, a pattern which is also discernible in other wealthy nations. Within this ideology, the nuclear family continues to be prioritised despite the increasing visibility of diversity, and mothering is conceived of as child-centred, involving the total dedication of a mother's emotions and time. Mothering is therefore a woman's primary purpose; she has no needs or interests of her own (Arendell 2000, p. 1194). In her study, Hays (1996) found that this ideology places exceptional demands on mothers in paid employment. As the norm of the so-called ideal worker requires an intensive attitude to employment alongside this intensive approach to mothering, women attempt to be 'super mums'—to be both career minded and child focused. These norms are always relational and so they do not only construct 'good' identities and practices, they also construct the deviant. Mothers who fall outside of this figuration, such as mothers who are viewed as self-interested or disconnected from their children, are seen as maternal failures or 'bad mums.'

Arendell's (2000, p. 1196) review points to the importance of the 'phenomenology of mothering' for feminist researchers who have resisted this ideology. The phenomenology of mothering is the study of mothering experience, and this form of knowledge production has been important in exposing the disjuncture between ideology and reality. To engage with everyday mothering is to engage with

the 'dialectic tensions' of mothering, such as the tensions between power and burden, or between fulfilment and distress (Arendell 2000). Feminists have found that these tensions can result in women experiencing motherhood with greater ambivalence than dominant discourse suggests. However, perhaps because of the strength of intensive mothering ideology, Arendell finds that, in the decade of scholarship spanning from 1990 to 2000, there was very little research on the negative feelings mothers may experience. In an exceptional study, Ross and Van Willigen (1996, p. 582) discovered that mothers feel anger more frequently than fathers, that economic stress and childcare are the greatest triggers for this emotion, and that their anger is directed firstly to fathers and then to children. Other research has indicated that mothers experience more parental strain than fathers, and that this may be the result of more intensive involvement with their children (see Scott and Alwin 1989, p. 500).

Despite the lack of research on mothers' negative feelings, Arendell's (2000) review finds that feminist scholars do detail the many damaging effects of intensive mothering ideology. These effects, some of which are explored in other chapters, include but are not limited to: high levels of psychological distress among mothers; a lack of social support; greater work–family tension for employed mothers than for employed fathers; high rates of poverty, especially among single mothers; and poor support from social policy. Although not identified in Arendell's analysis, feminist theorists and health researchers have also found that intensive mothering ideology shares a complex relationship with postnatal depression and may compound its impact. For example, Lazarre (1997) proposes that postnatal depression is associated with the unrealistic standards of motherhood that are dictated by the medical model. Similarly, in their literature review of 40 international peer-reviewed research articles on postpartum depression published between 1966 and 2005, Dennis and Chung-Lee (2006, p. 328) found that regardless of sociocultural background, all mothers who presented with postpartum distress 'struggled to fulfil their ideal perception of motherhood while at the same time concealing their needs.' Dennis and Chung-Lee argue that the conflation of motherhood with happiness makes mothers reluctant to seek help for depression.

The ideology of mothering is a social and historical construct and so is neither universal nor unchanging. This means that the collection of data on its constitution and impacts must be an ongoing project. Recently, researchers who have engaged with the phenomenology of mothering have been more likely to find examples of resistances, counter-narratives, and alternative 'micro ideologies' (Dow 2016, p. 182). For example, in her study of mothers' experiences of the first year of parenthood, Miller (2007) found that women have a complicated relationship with the dominant mothering ideology. Her participants often constructed their early postnatal and birthing experiences as failures in relation to both the 'optimistic stories' that regularly feature in good mothering discourses and the silences on childbirth pain in natural birthing discourse. Yet birth experiences, along with the confusion of the early period of new mothering, also acted as discursive turning points (Miller 2007, p. 330), so that after time the mothers felt capable of challenging good mothering ideology.

Other researchers have found that tensions between paid work and mothering can be the catalyst for alternative or resistive practice. In Christopher's (2012) study of married and single mothers in paid employment, women delegated mothering tasks, practising what she terms, 'extensive mothering.' Her participants distanced themselves from the self-sacrifice discourse and justified their paid employment by highlighting the advantages it brings, not just to their children, but also to themselves. Dow (2016) found a most subversive form of mothering in her research with African-American women employed in professions. Paid employment was expressed as a normal and natural obligation of motherhood, whereas stay-at-home motherhood was not, and childcare was considered an interdependent activity rather than the responsibility of individual mothers. Dow (2016, p. 180) proposes that this alternative ideology might be termed 'integrated mothering.' Unlike the women who participated in Christopher's study, none of Dow's (2016, p. 193) interviewees felt 'accountable' to intensive mothering but instead rationalised their decisions in relation to integrated mothering. Dow suggests that this unique orientation to mothering is a consequence of her participants' social and historical context. It has long been economically necessary for African-American women to seek out employment, and this has been reinforced by social

policy and political rhetoric, whereas the opposite is true for white, middle-class, married women. In addition, in resistance to racial oppression, African-American women have sought to carve out their own worth and cultural position, in this case via participation in the paid workforce.

Given the intimate relationship between femininity and mothering, it should not be surprising that what counts as good mothering may also change with time, as gender relations take different formations in the course of late capitalism. For example, Blair-Loy (2003), in her study of women executives, encountered a generational shift in women's relationships to the dominant discourse—younger women were more likely to see children as independent and to delegate childcare, whereas older women were more likely to see children as vulnerable and take an intensive approach. Focusing on the aesthetics of motherhood, Goodwin and Huppatz (2010) argue that, in recent years, maternity style and maternal bodies have become increasingly important in defining what constitutes good and bad mothering; 'yummy' and 'slummy' visual archetypes have become significant for the making of maternal selves. In a similar vein, McRobbie (2013, p. 119) suggests that we are witnessing the making of a 'new maternal feminine' whereby neoliberal feminism is 'at least partly realized and embodied through the ubiquitous figure of the middle-class professional wife and mother.' This sexualised mother figure conforms to mainstream aesthetic ideals, invests in marriage and motherhood in order to demonstrate successful femininity, and is constructed in opposition to the single mother who is viewed as lazy and welfare dependent. At the same time, motherhood has become 'professionalised'—it has become a more viable alternative for women who give up or do not pursue careers, and this has enabled the creation of a new market of parenting products and media. In professionalised domestic life, the well-run 'corporate family' uses intensive mothering discourse to ensure that children take up middle-class positions (McRobbie 2013, p. 130). This new maternal feminine therefore not only has consequence for the regulation of women but is also part of the construction and reproduction of social-class hierarchies.

Unpacking Emotional Narratives of Motherhood

This chapter contributes to the feminist tradition of 'making the familiar strange' by examining the ways in which Australian mothers make sense of the tensions between ideological expectations and the realities of lived motherhood. As mothering is constructed around notions of love, devotion, and care, emotion is often central to mothering practice. Within intensive motherhood discourse, mothering is expected to fulfil some kind of natural urge or instinct, producing a sense of fulfilment and the emotion of happiness for 'good mothers.' This narrative does not leave room for bad days, fatigue, and frustration, and the shock of disunity between ideology and experience can create intense, negative emotional responses from women (Choi et al. 2005). Emotion is therefore important to consider in the study of mothering ideology; emotion is at the coalface of both identification and resistance.

For the purpose of this chapter, two interview narratives—Kathleen's and Esther's—were analysed using thematic narrative analysis. They were chosen as exemplars as they illustrate some of the diverse ways that women respond to good mothering ideology. Kathleen and Esther are alike in that they are of similar ages, and at the time of the interview, both had one child and self-identified as experiencing perinatal depression. Kathleen is in a same-sex relationship, and Esther is a new migrant to Australia from Iran in a heterosexual marriage. The women's unique cultural positions may orient them differently to dominant cultural scripts. As the literature shows, material context, culture, and ethnic history may shape women's relationships with hegemonic ideology. Marginal or liminal positions may result in the development of 'micro ideologies,' or at least in mothering being done differently.

Kathleen's Story

Kathleen is a 36-year-old woman who is in a lesbian de facto relationship and works part-time in a professional occupation. At the time of the interview her child was one year old, and, perhaps because the

emotions of pregnancy and birthing were especially recent for her, she had a lot to say about this period. Kathleen reported the most sanguine expectations in relation to pregnancy and birth, indicating an early alignment with the 'optimistic stories' (Miller 2007) of good motherhood. However, her actual experience of pregnancy and birth was narrated through feelings of failure and immense loss. She stated: 'I felt, I felt good for like a week. I'm like, "I can totally do this pregnant thing" and I just had this feeling, I just had this ridiculous idea that I'd be a bump and I'd be rosy and glowing and I could still walk and I could wear those tops to show off the belly.'

Having embraced the optimistic story of aesthetic maternity, her initial disappointment was around health and body image. Kathleen expected to be 'rosy' and 'glowing' and to 'show off' her body, just as celebrity mothers do. As Goodwin and Huppatz (2010) describe, what mothers look like has now been added into understandings of good motherhood. Although self-sacrifice still stands as an essential tenet of good mothering, the new figuration of the 'yummy mummy' has meant that ideal mothers manage to remain child-focused while 'not letting themselves go.' Maintenance of a slim and fit body is therefore part of so-called successful motherhood, and the bodywork that must be done in order to achieve this begins in pregnancy.

As Kathleen found out, this expectation does not necessarily fit the corporeal reality of motherhood. She attests to having 'put on 10 kilos within about 30 seconds of being pregnant. I now know that it's because I developed a form of arthritis which messes with your metabolism.' This weight gain is something that Kathleen returned to multiple times throughout the interview. The story of loss she articulated is as much about her body as it is about her identity; indeed, these two stories appear one and the same. McRobbie (2015, p. 7) suggests that in late modernity, as community and collectivity become less important, and individualisation grows, women conflate unviable forms of selfhood with unviable forms of corporeality. In this context: 'To gain weight is to "let oneself down," to risk social disapprobation, to lose status and self-respect. In such a milieu, the young woman is involved in a constant "battle" to ensure that her body does not suddenly deteriorate' (McRobbie 2015, p. 7). For Kathleen, who appeared to be undertaking

this battle, the reality of the pregnancy therefore came as a blow. Instead of enjoying her pregnancy, she felt 'conflicted,' 'awful,' and 'miserable,' which impacted her new sense of self as well as her relationship with her partner:

> So, it was a really awful pregnancy and I felt really conflicted through the whole thing because this is all I wanted my whole life, and not only is this what I wanted my whole life but I left a heterosexual relationship and a heterosexual identity to be true to myself and I still am managing to have this amazing gift and living my dream and I am hating every single second of it. [But] I feel awful, I don't know who I am, my whole relationship with my body has changed, I can't do anything, I feel like a lousy partner, what if I'm a terrible mother as well? It was awful, it was really awful. And you're not supposed to be miserable when you're pregnant.

Kathleen's discontent may be amplified because intensive mothering ideology dictates that mothering is to be enjoyed. An unhappy pregnancy therefore conjures feelings of failure. Kathleen asks, 'what if I'm a terrible mother as well?'; her bodily and emotional experience informs her relationship with her partner and sets the scene for her relationship with her child.

Kathleen's narrative of failure is carried through to the birthing process:

> So the reality was I had absolutely no self-esteem, I felt like I'd failed because the labour was such a disaster even though I know it wasn't my fault. It wasn't the painkillers, it was that it was so traumatic and I lost my shit. I lost my decorum if that's even the right word. I was a screaming mess. I made my partner feel powerless and awful. … And that's how I felt about the situation is that I had done a bad job of labour and a bad job of birthing and a bad job of pregnancy. And so it just followed that I thought that I'd do a bad job of mothering and I did do a bad job of mothering in the beginning because I, I was angry.

Kathleen is not alone in expecting that birthing will be easier than it is. Miller's (2007) study shows that the natural birthing discourse is often silent on birthing pain. The fact that Kathleen thought that birthing

could be done with 'decorum' shows how misleading this discourse can be. Unfortunately, as Kathleen perceived her experience to be outside of the norm, as individual, she assumed that she would not succeed as a mother, that she would do a 'bad job of mothering.' These early experiences are interpreted as definitive of her identity as a mother, which is again perhaps due to the strength of the naturalisation discourse, in which birthing and the body are prioritised over sociality in mothering relationships. Here, we also see that, as was the case in her description of the pregnancy, Kathleen dichotomised mothering. Mothers are good or bad, and there is no room for alternatives within this schema. However, it is at this point that Kathleen also began to articulate anger, to really actively resist the narrow confines of mothering discourse. As Miller (2007) found, birth can be the discursive turning point for women in their relationship with mothering ideology. It is also important to note that Kathleen's expression of any unhappiness or disconnect between ideology and practice is in some way a resistive strategy, even if she also spoke with the ideological discourse.

When real life did not replicate ideological expectations, Kathleen's reaction was disbelief, but also grief. Grief for 'failed femininity,' for having 'no idea what we were doing,' but also for an identity that is lost under the weight of responsibility: 'It was just so bad, but we had no idea what we were doing. I remember sitting on the couch, watching the Olympics—because it was, you know, in the UK—until all hours of the morning just crying, thinking, "What have I done? I can't go to a gig, I can't go out for dinner. What the fuck have I done?"' Kathleen suggests that one reason why her expectations may have been so disconnected from reality is that she received inadequate prenatal and parenting education and information:

> [M]y partner and I went to go home from hospital. She picked up my bag and she put it on the bed and I realised at that point I did not bring any clothes to go home in—not on the list, didn't occur to me. Everything about … childbirth preparation is about getting to the hospital. Massage balls and essential oils for the labour and a play list for your iPod. I mean we packed all that and none of it got used. … I'm so angry still about the pre-baby preparation. At no point did they run through

> with us, 'Okay, so when you get, when you walk through that door with that baby…' I remember literally walking in the door, I was holding the baby, and I turned and said to my partner, 'Where do we put her?' … [W]e started out parenthood from a very angry place … and that sort of began this really conflicting period where we had this divine, precious little bundle of gorgeousness who had changed our life forever and I had no idea what to do and the grief that I felt was just like nothing I had ever imagined. I cried for two weeks straight.

Kathleen's narrative communicates ambivalence—joy in meeting her child and grief for the unexpected pain and effort maternity induced. Kathleen's disappointment with the level of information offered by antenatal education is not unusual. Previous research has shown that antenatal education tends to focus on labour and birth and so women feel unprepared for the reality of the postnatal period which impacts their transitional experience (Deave et al. 2008). This silence in education programs is perhaps an indicator of how institutions and knowledges support and perpetuate intensive mothering ideology; postnatal education may be limited because it is assumed that this transition will occur 'naturally.'

Kathleen talks about the difficulty of integrating her paid work identity with a mothering identity, but also coming to terms with needing to take time off from paid work in order to deliver and raise a baby:

> The reality was I didn't know who I was anymore. I couldn't run still… I'm a workaholic, I run my own business, I couldn't work. I was working up until my water's broke, I had no time off before I had the baby which was stupid but I was working on a huge project and … and I should say, had anyone said to me—and I'm sure people did try, my business partner, did try and say to me – 'You need to take some time out, you don't know when this baby's going to come.' I was like 'Oh, whatever, I'll be fine.' People did try and say, but you just for some reason can't hear, you just can't hear it.

The difficulty that Kathleen expresses shows that the transition into motherhood can be overwhelming and take time. While she criticised herself for not heeding the advice of others, it is not surprising

that she expected that motherhood would fit seamlessly around her work responsibilities as this is what intensive mothering suggests—that women be 'supermums' who fit within the norms of both the ideal worker and the ideal mother (Hays 1996; Choi et al. 2005).

Throughout her interview, Kathleen referred to her partner not only as someone she did not want to disappoint, but also as a source of support. Most importantly, her partner sometimes helped to disrupt damaging good motherhood discourse. She narrates how her partner helped her move beyond perfectionism:

> She was amazing and she just had this never-ending patience for the, for our baby and when she would cry she'd hold her and she would let her sleep on her and I was just this tense hormonal horridness rigid rocks type thing and my partner was just this mothering ball of love and really taught me so much about patience and about love and about perfection not needing to be what I thought it was.

Towards the end of her interview, Kathleen attempted to resist harmful ideology and frame her own position outside of 'good' or 'bad' mothering: 'I don't say, I'm not saying I'm a bad mother but it is, it comes more instinctively to her than it does to me which I've been very surprised by. I think I, I'm good with toddlers probably, [laughs], but I'm terrible with newborn babies. Terrible.' However, she also individualised her experience and framed it within biological discourse—she lacks 'instinct,' whereas her partner does not.

Esther's Story

At the time of the interview, Esther was 32 years old and had recently migrated from Iran. She was in a heterosexual marriage, had a four-year-old child, and, like Kathleen, worked part-time in a professional occupation. Esther's narrative shows the difficulties of mothering across cultures which feature different norms and ideologies of gender and family. She gave some unique insights into the structure of good mothering in Australia, which she also, at times, tried to resist. Her narrative

is similar to Kathleen's in that she gave reference to the significance of the aesthetics of maternity and to the ambivalence of motherhood, but hers is unique in that she discussed how that ambivalence can be exacerbated by 'in-betweenness'—by straddling two cultures.

Although Esther does not say much about pregnancy, she indicates that it was a particularly fraught time:

> Like having those funny sicknesses, pregnant morning sicknesses, and having this baby bump which doesn't let you sleep and then having another mental pressure, 'What if the child is born with disability?' and looking at the future. And, again, after all, this is the mother who is going to bear everything and everything. The child will be a very big burden on mother and in traditional societies at least it is, it is still the case.

Here, Esther expresses ambivalence about what new motherhood might bring, especially in terms of her independence and sense of identity. Esther also describes her fear of the stigma of disability as a 'traditional' Iranian preoccupation, but her concerns are not uncommon in all 'risk societies' (Beck 1992) of late modernity, in which people are hyperaware of the health dangers of pregnancy. Unlike Kathleen, Esther expected to take on the majority of the caring responsibilities in her household, as her position is, in her view, influenced by Iranian 'traditional culture.'

At times, Esther talked about feeling disconnected from her baby during the period of early motherhood. Within her narrative, she resists the dominant discourse of the emotionally connected and selfless mother by referring to hate rather than love and communicating a desire to engage in self-focused activity:

> They all looked at the baby, 'Wow how nice,' how cute she was, so I—I can clearly remember that I hated her. I remember that when she—and all the—the first three months after she was born, I was struggling with everyone. I was to find a way for myself, to find some free time for myself, like going shopping, watching movies and I just asked my mum to look after her, her grandchild. I told my mum, 'Okay, now that you love her, you can look after her and I'm going to do whatever I used to do.'

This resistance occurs alongside expression of guilt and disbelief about her lack of initial positive emotional connection with her baby: 'After nine months of living under extreme pressure and stress I had enough reasons to be happy, I had a very healthy happy baby, so why still I was rejecting her? I—I can't—the word—using the word hate is not really easy but I use this word.' Once again, we see how mothers feel compelled to work on their emotions so that they fit within romanticised narratives of motherhood (see also Chapter 6). Happiness is presented as the natural disposition of so-called successful mothers, and this is seen in all manner of social representation from advertisements for tissues to self-help books. As such, when mothers' emotions do not conform to this template, they are likely to feel that they need to change their attitudes to parenting, rather than look for the cause of their discontent. Not living up to the image of the happy, innately connected mother clearly added to the anxiety Esther experienced.

Esther compared herself to the other mothers she encountered in mothers' group, observing that 'when I joined that mothers group, it was like, "Wow, what's happening here? They are all mums, some of them even more than one or two kids, but they are all very happy, none of them are depressed like me." None of them hated their babies, they were all real mums.' We see here how the construction of good mothering and bad mothering is always relational and created in opposition to the 'other.' As Esther experienced herself as an 'unhappy mother' who did not feel an immediate positive emotional connection to her child, she constructed herself as defective, as an 'unreal' mother, in opposition to the happy, natural, 'real mums.' Within the ideology of mothering, judgements of the self occur within a dichotomous logic: happy/sad, real/unreal, love/hate, and good/bad. As was also made clear in Kathleen's narrative, this kind of dualistic thinking makes it difficult for mothers to admit ambivalence or the tensions of motherhood, including experiencing negative emotions, without constructing themselves as failures. As Ahmed (2010, p. 13) puts it, 'ideas of happiness involve social as well as moral distinctions insofar as they rest on ideas of who is worthy as well as capable of being happy "in the right way."' In this case, happiness is viewed as a desirable quality that indicates fulfilment via mothering; it indicates a seemingly natural alignment between mother and child. This conflation of happiness with mothering success

reverses the second-wave feminist assertion that mothering is monotonous and boring (see, e.g., Friedan 1963) and overlooks the structural conditions of much mother work such as isolation, poverty, and the gendered division of domestic labour (McRobbie 2013, p. 130).

Esther's narrative is complicated by her migration experience. She prefaced her discussion of mothers' group by saying that 'Australian culture is very different from Eastern culture.' Those 'happy,' 'good' mothers whom she describes in opposition to herself are also 'Australian' mothers rather than new migrant mothers. Immediately after discussing those allegedly happy mothers, Esther returned to the topic of adjusting to Australian life, saying, 'if you look at the photos that I – I took in the first two years of my arrival in Australia, there is no word of me, the photo is just about Australia or maybe my child or maybe my husband, but there's no word of me. I was lost in my life for two years.' At another point in the interview, she stated: 'maybe I was lost in very funny traditions of my home country and then the new attitudes of Australian cultures to mums and motherhood, I was lost, something in-between. I couldn't find my – I couldn't locate myself.' Her story of an ambivalent transition into motherhood, of being *lost* between two identities, is also a story of her ambivalent transition into a new culture, of the '(re)invention' and '(re)negotiation' (Ang 2001, p. 36) of ethnic identity.

Like Kathleen, Esther spent some time talking about the postnatal body. She talked about how women in Iran are expected to be entirely child-focused, which includes a disregard for their own appearance after giving birth:

> [S]ometimes you see a lady who is very young, brilliant, slim, very good-looking. But as soon as she is a mum, you can hardly identify her. She gains lots of weight, the way she dresses changes, the way she behaves, changes everything. The primary focus is on baby, which is totally wrong. Of course, when – when you live in that context you cannot understand it, but as soon as you – you move far away and when you look from an outsider perspective, you have the chance to see what's happening really.

Here, Esther understands the yummy mummy discourse as providing freedom. This is the seduction of this new maternal feminine—it presents women as enabled by choice, as self-determining. However,

as McRobbie (2013) explains, it is also a frame for gender relations to be re-traditionalised. Women continue to be subject to self-regulation and subjectification under the masculine gaze. The move to the 'yummy mummy' is therefore by no means a straightforward story of cultural advancement. Esther also showed how aesthetics are conflated with successful parenting. She described good-looking mothers as happy mothers: 'They were all very happy mums, good-looking, they had, I mean they laughed; they were very happy inside and outside.' Happiness and appearance are therefore once again connected to mothering success. The problem with this of course is that good looks are narrowly defined within an aesthetic that is classed, raced, able-bodied, and young, which makes this an inaccessible ideal for the majority of women.

Perhaps because she experienced being in-between cultures, at times Esther appeared quite reflexive about the constitution of good motherhood and her desire to fulfil its promise. She explains: 'I have a strong connection and I was challenging to gain it, I was challenging to achieve it. I was thinking of the ways to help me achieve it. On one hand, I didn't like to lose my face in front of people, you know, I like to show that, yes, I'm a very good mum too, like you.' Her reference to loss of face and wanting to be a 'good mum too, like you' shows that good mothering is a social ambition, an aspirational concept, and so always impossible to fulfil, but also related to social standing, social capital, and belonging in complex ways. Again, it is constituted with reference to an ideal 'other,' 'like you.' Esther also indicates here that her will to save face actually made her persevere with her relationship with her child, so it seems the regulatory function of ideology has actually strengthened her relationship despite also creating anxiety and ambivalence.

Esther made it very clear that, for her, good motherhood is not only about mothers' emotions, but also about being seen to make the right choices according to public perception:

> Later maybe in the eye of public, but after two years, no, after two years I found that, yes, being a good mother is very much dependent on other factors. Like, for example, I decided to send my daughter to different centres, like day care, childcare, kindergarten to give her the chance to have a

> very happy childhood. But that mother didn't, they didn't send their children to any other centres, so the children are still at home playing with the mother, she has two. But I—I guess I can say I was more successful than her.

Here, good mothering extends to choosing employment and childcare indicative of good family management. She presents herself in competition with another mother, who does not appear to be in paid employment. In this narrative, successful motherhood is achieved by socialising children through early childhood institutions. However, Esther's story also shows the presence of competing discourses of motherhood and the always shifting ground of perceptions of good mothering. While intensive mothering is seen as valuable earlier in her narrative, in depictions of the happy attentive mother, here high-quality childcare choices are prioritised. The presence of competing discourses makes successful motherhood very difficult to achieve, despite Esther proclaiming success. In Australia, childcare is sometimes judged as compromising development in early childhood, and as no substitute for maternal care, this means that what Esther sees as good mothering may not necessarily be recognised as such by others.

Conclusion

The two case studies offer insights into the tensions between expectations and lived pregnancy, birth, and parenting experience. In these two accounts, the mothers communicate a range of challenges experienced in early motherhood. Neither woman found the transition to motherhood to be seamless; both expressed ambivalence in their new role. In fact, in many ways, both women felt ill-prepared for the realities of motherhood and this led to a range of challenging emotions including anxiety, anger, guilt, and grief. The disconnect between expectations and lived experience resulted in the women often individualising their emotional experiences and accepting, as well as rejecting, hegemonic ideological discourses of motherhood.

Despite their differences, both Kathleen's and Esther's narratives illustrate some of the key elements of the good mothering ideology.

Esther associated attaining physical attractiveness immediately after birth with good mothering and, in this way, evaluated herself against other mothers and through the sexualised gaze. But it was Kathleen's narrative in particular that demonstrated the strength of the new aesthetic ideals, as she most frequently made reference to how she expected her pre- and postnatal body to look. These expectations added to her anxiety about motherhood, disconnected her from her body and her partner and made her feel like a failed mother, a bad mother. Her desire to retain a slim fit body, to achieve a controlled birth, to experience a natural transition into motherhood, and to preserve an unchanged relationship with employment points to an allegiance to the perfectionist, mediated, 'new maternal-feminine' (McRobbie 2013). However, her partner helped her to be more reflexive about desire for the perfect, and the very telling of her less than perfect story of motherhood is a resistive strategy in itself.

Esther's narrative departs from Kathleen's in that it shows how simultaneously transitioning into a new culture and to motherhood can make the re-articulation of the self difficult. However, her position also enabled her to be reflexive about the nature of good mothering discourse even if at the same time she was regulated by it. Esther's narrative highlights the importance of the emotion of happiness for intensive mothering discourse. While happiness is often seen as an inherent good, notions of happiness are sometimes implicated in the reinforcement of harmful gender norms. In both case studies, understandings of happiness structure how the women experience themselves and perceive others as either successful or unsuccessful mothers. Perhaps anger and grief would have featured less in their narratives if their expectations for happiness were not as great. Finally, Esther's discussion of happiness is part of a tendency to understand motherhood in terms of dualisms. Mothers are good/bad, happy/sad, real/unreal, successful/unsuccessful. This conceptual ordering is a feature of intensive mothering ideology and makes it very easy to regulate women to strive for the perfect, as deviance is the only alternative.

In its focus on the emotional early motherhood experiences of two women from different social and cultural backgrounds, this chapter has contributed to a more nuanced understanding of mothering ideology.

Importantly, the chapter has presented an account of how lived experiences are framed by unrealistic ideals of motherhood. This chapter has also moved beyond existing research in that it has explicitly engaged with mothers' negative emotions. As Arendell (2000) highlights, little extant literature directly deals with negative feelings. We therefore need to call attention to and naturalise the everyday maternal emotions of anxiety, anger, guilt, and grief to show both the complexities of mothering experience and the damaging effects of restrictive understandings of motherhood and femininity in popular culture and expert discourse. To do so is to contribute to a resistive feminist scholarship. As Imogen Tyler (2008) identifies, 'coming out' through the sharing of experiential accounts of motherhood is essential for maternal politics.

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8

Narrating and Disrupting Postnatal Depression

Meredith Stone and Renata Kokanović

The distress of women diagnosed with postnatal depression (PND) has been considered from different vantages. Historically, biomedical researchers have tended to examine disease processes, hormones, and psychological vulnerabilities (O'Hara and Swain 1996; Wisner et al. 2002). They have also considered stressful life events, lack of social support, and marital discord (O'Hara and Swain 1996; Beck 2001)—largely

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within a positivist epistemology more concerned with the 'nature of disease' than women's own language about suffering.

A counterpoint is the growing body of work using feminist and health sociology perspectives, frameworks that foreground both the lived experience of early maternal distress (e.g., Edhborg et al. 2005; Rodrigues et al. 2003) and the broader social context in which that distress emerges (Oakley 1980; Nicolson 1998).

A third vantage has sought to integrate the psychic and the social. This is reflected in the growing interest in how concepts such as identity change and 'loss of self' are linked to postnatal distress (Beck 2002; Everingham et al. 2006). Despite the current popularity of these concepts, there remain theoretical gaps in our understanding of self and identity in the early maternal context. The increasingly sophisticated body of work on the psychosocial self that has been emerging elsewhere in the health sociology field is yet to be incorporated into studies of PND. In particular, growing interest in the relational self (e.g., Fullagar and O'Brien 2014; Ussher and Perz 2008), embodiment (e.g., Freund 1990; Williams 2000), and intersubjectivity (e.g., Crawford 2009) has, with the exception of work by social psychologists such as Natasha Mauthner (1999, 2002), remained largely absent from the PND literature.

PND as a sociocultural phenomenon has also received remarkably scant attention. Current studies tend to either accept the concept uncritically or dismiss it altogether. Nevertheless, there is an unspoken consensus across theoretical frameworks that women do not want to be diagnosed with PND. This is reflected in the attention paid to PND and stigma in the biomedical literature (e.g., Edwards and Timmons 2005) and conversely in the feminist literature seeking to dismantle the concept (e.g., Nicolson 1998).

The proliferation of 'mummy blogs' (see Circle of Moms 2012), celebrity memoirs (Rowe 2015; Shields 2006), and PND support groups where the diagnosis is openly discussed and actively 'claimed' has in contrast remained largely uninterrogated. Furthermore, despite asserting the centrality of identity to postnatal distress, the PND literature has yet to incorporate reflections on the identity work associated with claiming a diagnosis, as discussed in the context of 'generic' depression (Kokanović et al. 2013), terminal illness (Avrahami 2003), and chronic illness (Adams et al. 1997; Asbring 2001).

This chapter, an adapted version of our previously published research (Stone and Kokanović 2016), addresses these lacunae in the literature

and comments on their interplay. We reference the interdisciplinary turn in contemporary work on subjectivity (e.g., Butler 2001), combining feminist psychoanalytic and existential phenomenology frameworks with a post-structural reading of illness narratives. Our objective is to generate a more nuanced understanding of how distress in early maternity, and the process of diagnosing and 'storying' (constructing a potentially transformative narrative, see Bury 1982; Frank 1995) this distress, relates to maternal subjectivities as they exist in neoliberal societies.

Theoretical Framework

Most existing PND literature describes maternal identity change as a linear, narrative arc from constructs such as 'career woman' to 'stay-at-home mother.' It attributes the distress associated with this move both to structural realities and to the dissonance between how a woman experienced herself before maternity and how she sees herself, or fears others might see her, after maternity (Beck 2002; Oakley 1980; Nicolson 1998). Importantly, it is a process that is seen to occur at a conscious, speaking 'I' level.

This is at odds with the increasing emphasis on preconscious or non-verbal aspects of the self in contemporary research on subjectivity (Kokanović and Flore 2017). One thread is influenced by psychoanalytic thought. Judith Butler (2001), for instance, draws on object-relations theories and holds that when we respond to changes in our lives, we do so both at conscious and preconscious levels. Furthermore, the preconscious is populated, or indeed 'besieged' (Butler 2001, p. 74), by earlier experiences with an Other. Butler argues that before we become thinking, speaking beings there must be a 'primary, inaugurating impingement … by the Other' (2001, p. 85), where the Other is at once material caregiver and the sociocultural norms (s)he transmits. This extends the Freudian notion that our earliest relationships are 'carried over' through transference (*Übertragung*, literally carrying over) and inform how we relate to others, and feel about ourselves, in subsequent relationships (Freud 2000). It also suggests the unconscious, or preverbal, as an under-researched site for identity struggle in those experiencing early maternal distress.

Another thread of subjectivity research focuses on embodiment. This references Heidegger's idea that the body is at once body-as-object and

lived body, the vehicle through which we experience 'being-in-the-world' (Heidegger 1967). The idea that the body can mediate experience has been important for recent thinking about illness and subjectivity. Drew Leder (1990) writes about how a body in pain becomes a body-as-object, disrupting a person's sense of lived body and by extension of harmonious being-in-the-world. There is also an expanding literature on the embodied mind. Thomas Fuchs (2012) combines phenomenological ideas with psychoanalytic ones to describe the notion of 'body memory,' the corporeal storing of experience that re-emerges not as explicit memory but in posture and patterns of behaviour. Similarly, Elizabeth Wilson (2004) locates the mind, and by extension subjectivity, as much in the gut, as in the conscious self.

Subjectivity scholars have in recent years advocated a 'turn to affect' (see Wetherell 2013), seeking to expose the non-linguistic elements that shape subjective experience, and move between subjects. Authors concerned with affect focus not only on embodiment, but also on intercorporeality. Lisa Blackman (2010), for instance, has written extensively on how matter, affect, and even non-linguistic traumatic memories circulate between, and constitute, embodied subjects.

That an embodied and relational understanding of the self might be particularly relevant to early maternity is not a novel idea. French feminist psychoanalysts such as Julia Kristeva and Luce Irigaray and, more recently, maternal studies' scholars such as Baraitser (2009), Stone (2012), and Hollway (2015) have devoted considerable attention to the relational maternal self. Both Irigaray (Irigaray and Wenzel 1981) and Kristeva (1977) argue that the experience of maternity, starting with the two-in-one state of pregnancy and extending into the profoundly bodily, preverbal rhythms of early mother–infant 'being-with,' destabilises a woman's pre-existing conceptualisations of autonomous selfhood.

Bracha Ettinger (2010) calls this process 'fragilisation.' She emphasises the intersubjective potential of such a state, but cautions that it is threatening for women living in neoliberal societies who are used to functioning in an autonomous 'phallic' mode. Crucially for our understanding of early maternal distress, it is especially confronting for women whose infantile experiences of relationality were traumatic. Often such women were 'defensively' autonomous (Hollway 2015)

before becoming mothers, a characteristic at once prompted by a desire to escape the threat of relationality and rewarded by patriarchal systems requiring autonomous workers.

This brings us to the 'doubly relational' (Stone 2012) nature of the maternal self—a self constituted not only by a woman's interactions with her infant, but also by her experiences of having been an infant herself. Maternal studies scholars suggest a particularly potent form of transference in early maternity (Raphael-Leff 2000; Stone 2012). Joan Raphael-Leff (2000) posits that the postnatal haze of smells, secretions, and intimate encounters activates a woman's pre-linguistic memories of infancy, which in turn ignite infantile states of being or as Sara Beardsworth (2004, p. 263) terms it, an 'upsurge of forgotten body relationships.' A woman therefore not only encounters her baby for the first time, but also (re-)encounters her self-as-baby or, more precisely, her self-as-baby-relating-to-mother. To Raphael-Leff, early maternal distress is thus located as much in a woman's past relations, as it is in present maternal encounters.

The prominence of the preverbal and the infantile in maternal subjectivity is of course contested. Kristeva, for example, in her focus on the maternal semiotic, has been criticised for placing mothers outside culture and reifying woman-nature/man-reason binaries (Butler 1990). However, recent maternal studies scholars have engaged creatively with the problem of the relational mother who also speaks. Lisa Baraitser (2009) depicts mothers who exist at the nexus—and in the interstices—between discourse, intersubjectivity, and maternal materiality. She presents a peculiarly maternal subject, but not one existing before culture or entirely preconsciously. Instead, to paraphrase Blackman, she proposes a maternal subject living multiplicity, both through mother–infant intercorporeality and the Foucauldian Other while attempting to 'hang together' as her own 'I' (see Blackman 2010, p. 174). One way in which she might do this is through narration, a topic to which we now turn.

Critical examinations of PND narratives are conspicuously scarce (Clark 2008). In the broader illness narrative literature, there have been a number of approaches to the narrating self (Kokanović and Stone 2017). Early work in the field focused on how people use narrative to

engage in 'biographical repair' when illness interrupts storied lives (Bury 1982; Frank 1995). This approach emphasises the ability of narrative to productively answer the 'who am I now?' question for people encountering unexpected illness.

Authors influenced by Foucault have focused on the regulatory function of illness narratives. They have highlighted how people speak of illness in order to demonstrate that they are good patients and to self-regulate the deviance associated with not being a fully functioning neoliberal subject (Avrahami 2003; Kokanović and Philip 2014). In the mental health literature, the role of diagnosis has been explored by Kokanović et al. (2013), who observe that people will often actively claim and narrate diagnoses so worse forms of deviance (e.g., laziness) might be mitigated.

Recently, the illness narrative literature has also been shaped by the turn to affect. Frank's (1995) idea that non-narrated illness experiences represent 'chaos' has been questioned by authors reorienting to non-narrative ways of negotiating illness (Woods 2013). Others have turned attention to the relational function of illness narratives. Einat Avrahami (2003), for example, writes on the author Harold Brodkey's memoir of living with, and dying from, the complications of HIV, exploring how Brodkey employs narrative to mobilise audiences to engage 'emotionally and ethically' (p. 183) with his predicament.

How this scholarship might apply to PND narratives is yet to be explored. To what extent is the PND narrative an attempt to reinstate biographical coherence? How does the PND narrative articulate with broader 'good mother' discourses? In what ways does it respond to the peculiarities of the relational maternal moment? How does it say what can only be felt? We hope to begin to answer these questions in this chapter.

In our literature review, we were struck by pluralist approaches to the study of subjectivity as espoused by writers such as Judith Butler (2001), who manages to integrate psychoanalytic, Foucauldian, existential phenomenological, and feminist frameworks when exploring the nature of being. We found a similar theoretical flexibility in the work

of contemporary maternal studies scholars (Baraitser 2009; Stone 2012; Hollway 2015). This inspired our interdisciplinary approach to data analysis using a combination of phenomenological and psychoanalytic frameworks. We used both 'hermeneutics of meaning recollection' and 'hermeneutics of suspicion' (Ricoeur 1970). In the former, we seek 'an understanding of the experience on its own terms' (Davidsen 2013, p. 329), and in the latter, we try 'to shed light on the material from a more distant perspective, such as psychoanalytic … theory' (Davidsen 2013, p. 329). As well as using narratives as a rich source of qualitative data, we were interested in narrative performances, co-construction of narratives between participant and researcher/imagined public, and the ways that narratives constituted and were constituted by sociocultural realities (see also Kokanović and Stone 2017).

In our first two sections of data analysis, we use phenomenological and psychoanalytic insights to present a relational, preverbal ontology for postnatal distress, as elaborated by the women we interviewed. In our third section, we use narrative inquiry to examine how the process of having this distress diagnosed or self-diagnosed as PND and then 'narrating PND' related to early maternal subjectivities. In particular, we explore how these processes enabled a (self-)regulation of the 'disordered' maternal body and a relational response to (re)accentuated relational selves.

Postnatal (or postpartum) depression is a contested term. Reflecting uncertainty in the psychiatric community about distinctions between 'depression,' 'prepartum depression,' and 'postpartum depression,' it has recently been changed to 'depression with peripartum onset' (APA 2013) in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, popularly known as the *DSM*-5 (see Sharma and Mazmanian 2014). We tend to refer to PND, as one focus of the chapter is to interrogate how diagnoses were talked about, and PND was still the favoured term among participants. We are mindful of the conceptual difficulty with the term and all its variants (see Nicolson 1998; Fullagar and O'Brien 2014). For this reason, we refer to post/perinatal suffering/distress where possible.

The Speaking 'I' Interrupted

Several women in our study described the prominence of corporeal experiences of PND. Thirty-three-year-old Amelia describes her experiences after the birth of her daughter three years earlier: 'At first the symptoms of the actual postnatal depression were very much physical, I lost my appetite completely, I would sweat suddenly, and I—I had a dry mouth to a point that it didn't matter how much I drank, didn't matter how much I washed my teeth, my mouth was just dry and, not very pleasant.' In Amelia's account, we see both Leder's (1990) foregrounding of the body-as-object and witness her failed attempts to respond in a 'rational' way. This primacy of the body was echoed in Daphne's description of experiences of PND. Daphne, mother of an 8-month-old baby boy, describes her 'episodes' as 'purely physiological.' 'That sickness, like in the pit of my stomach like I always have that, you know that nervous sick feeling in my stomach the whole—like all the time. And like just a burning in my chest, like this is just purely physiological. … and you just have that general sort of cloudy—like my mind goes all cloudy.' In both Amelia and Daphne's narratives, we discern a hyperembodiment, meaning a body that interrupts reason spaces, resisting Amelia's 'rational' responses and clouding Daphne's mind. These descriptions are reminiscent of Sandor Ferenczi's (in Wilson 2004, p. 75) observation that when 'the psychic system fails, the organism begins to think.' They extend beyond biomedical notions of physical symptoms, invoking instead a more profound corporeal disruption of pre-maternal subjectivities.

Disruptions were not just described in physical terms. As in other studies, women described feelings of guilt (Beck 2002; Edhborg et al. 2005; Mauthner 1999), inadequacy as a mother (Edhborg et al. 2005; Mauthner 1999), and thoughts of self-harm (Beck 2002; Mauthner 2002) or harming the baby (Beck 2002; Mauthner 2002; Raphael-Leff 2000) as core features of the condition.

Not infrequently these themes appeared in the form of intrusive thoughts or obsessions, thoughts that women in our study and elsewhere (see Beck 2002) describe as being qualitatively different from

other thoughts and particularly distressing. Lola, a 37-year-old mother of a 2-year-old daughter and a 10-month-old son, tells us she had developed PND a few weeks after the birth of her daughter:

> I just started to have funny thoughts, lots of strange thoughts about, the harm that could come to her. And then it just sort of became an obsession …. It stepped into territory where I was thinking that, I would—you know, I could, you know, not only accidentally cause harm to her but purposely cause harm to her. I started to get plagued by—by this … it was almost like a 24/7 thing and trying to suppress them and push them away.

Lola is at pains to convey that the thoughts were not ones she had authored. They were 'strange thoughts' she needed to 'push … away.' Paradoxically then, although thoughts are generally considered to be part of the 'I' that emerges through language, these were thoughts that mocked such a linguistic self. They were not consciously generated, but rather experienced as intrusions. Lola suffered from similarly intrusive 'visions,' stating that 'I could feel tension, fuzziness, in my wrist. I—actually this is all coming back to me now. There was a stage where I was really uncomfortable around being around knives. Not that I thought I was going to harm myself, but that I–I was just having these sort of visions of like my—jabbing myself in the stomach, like with a knife.' Implicit in this account is a connection between the visions and the fuzziness in the wrists—a potential for action conveyed along neural pathways not involving a conscious self. The visions were therefore at once disembodied and embodied. They occurred independently of the eyes, the bodily apparatus for seeing, but somehow found their way into the wrists, heralding the possibility of transformation from vision to action.

Lola's account has an air of Heidegger's (1967) *Unheimlichkeit* (uncanniness)—the sense of a body that has lost its resonance with mind and world and instead asserts its own malignant authority. Here, it echoes Amelia's description of her body following a visceral (il)logic impervious to 'acts of reason.' However, if we examine Lola's account more closely, using our hermeneutics of suspicion, we see not

a body self-directing, but rather a body intruded upon, 'besieged by an enigmatic alterity' (Butler 2001, p. 74). Lola's account thus hints at a Kleinian hostile 'internal object' (Heimann et al. 1989)—the (m)other within—and simultaneously traces how this object might become 'enfleshed' (Blackman 2010, p. 172), here most noticeably in the wrists.

We now consider how Lola's example also reflects women's struggles with embodied selves-in-relation. Relational themes appeared both explicitly, in discussions of 'bonding' and 'attachment,' and more covertly. Women mentioned an inability to bond with their babies as a symptom of depression, and conversely, the establishment of, as Amelia puts it, a 'bond [that] is exactly like it needs to be' as a marker of recovery. This was consistent with the structure of contemporary PND memoirs (Shields 2006; Rowe 2015), the significance of which we comment on below.

We found relational references throughout women's accounts of early maternal subjectivity. Women spoke of feelings of disconnection from their babies and concomitantly discussed a more pervasive loneliness. Bethany, the mother of an 18-month-old son, describes loneliness as a key feature of postnatal suffering, saying that 'I'd just be sitting alone in this room at one o'clock, you know, then four o'clock, then, you know, seven o'clock in the morning just feeling like I was the only person in the world.' Remarkably, this is a description of breastfeeding. We also know that Bethany's mother and husband were sleeping in their respective rooms close by. Similarly, Heidi, a 33-year-old mother of 3-year-old and 1-year-old sons, describes her postnatal fear of being alone, while in a house filled with her partner, toddler, baby, mother, and sister: 'I couldn't be left alone, even going up to my bedroom—we lived in a townhouse then so my bedroom was upstairs, the living room was down. And going up to my bedroom I felt this real sense of loss. Um, it's almost like when you're at an airport saying goodbye to your friends, it's a real cut off, a closed door, isn't it?' Both of these accounts of loneliness-in-company hint at an existential loneliness, at once a Heideggerian estrangement from the world, and a pervasive feeling of 'not being held' (Winnicott 1973) or of internal abandonment.

Loneliness and abandonment have been broached elsewhere in the literature on PND (Beck 2002; Edhborg et al. 2005). Often, however,

they are conceptualised as a natural response to the very real isolation many mothers living in neoliberal societies experience. Bethany and Heidi's loneliness-in-company has been less theorised, though there are some notable exceptions in the maternal studies literature (e.g., Hollway 2015). The concept is key if we are to understand perinatal distress not only as a structural problem, but also in relational terms.

Relational troubles did not always take the form of loneliness and abandonment. Some women experienced the converse sense of being overwhelmed by closeness. Hannah found the inability to 'escape' from her first newborn harrowing, thinking 'don't they just want to hand their baby over? Don't they just want to escape for a bit? That's all I want to do, is escape.' Similarly, Georgina describes a need to 'get away,' saying, 'I could hear every single breath that he was taking, and—and I just remember thinking I just felt suffocated. I felt absolutely suffocated.' Georgina's account resonates not only with Hannah's description of PND, but also paradoxically with Bethany and Heidi's scenes of alienation. Each of these narratives is an account of intersubjective disruption, of distress that is enunciated specifically in relational terms.

Later in Georgina's interview, she describes how she called an ambulance one afternoon in the early postnatal period. Georgina's baby was crying inconsolably, and she became increasingly convinced that he was not breathing. In hindsight, Georgina identifies that it was clear the baby was breathing, 'because he wouldn't be able to cry if he wasn't breathing.' However, at the time, she found herself unable to distinguish between her own sense of suffocation and her child's state. This brings us to another central feature of the relational self—the blurring of boundaries between what is self and other.

The women's narratives frequently presented protagonists with interchangeable mother and child roles. They were reminiscent of Irigaray's observations on mother–daughter relations: 'what I love in you, in myself, no longer takes place for us: the birth that is never completed, the body never created once for all time, the face and form never definitely finished, always still to be moulded. The lips never open or closed upon one single truth' (in Hirsch 1981, p. 211). At times, women depicted themselves or their mothers as childlike

figures, or their children as having maternal qualities. Importantly, these characterisations were mutable, often changing within short sections of text.

To return to Bethany—she explicitly references her experiences with a gravely ill mother, who was in hospital when Bethany's son was born and subsequently moved in with Bethany to recuperate, when seeking to explain the cause of her early mothering distress. 'I thought maybe no one can relate to my story because … mine's quite specific to my mother being in hospital,' Bethany speculated. However, it was not just that her mother was in hospital, but also that there were 'a lot of unresolved issues from when I was young,' with a mother who frequently 'wasn't well.' She describes how this constellation of events profoundly influenced her mother–son relationship, noting that 'I remember he would wake up in the day and I would just plonk him on the floor in front of the TV because I just didn't have anything in me to give him at all … was just so focused on my mum because of—because of our strained relationship.' Bethany subsequently relates how in that period she would 'always check on her [mother] to make sure she was still alive.' This checking of the mother was reminiscent of an earlier part of Bethany's narrative in which she described checking on her newborn son.

Bethany's account poignantly illustrates the relationally contingent and historically bound nature of her maternal sense(s) of self. She explicitly privileges the daughter position by describing the need to focus on her sick mother. However, her identifications are more complicated than this. Firstly, her experiences of being a daughter have historically involved mothering, as she looked after a mother who 'wasn't well.' Secondly, in her description of 'plonking' her son on the floor, she at once identifies with her son who, like her, has been abandoned and presents herself as the one doing the abandoning. In this way, she appears to be simultaneously grandmother (i.e., the mother who abandoned her), mother, and child. This blurring of generational divisions was echoed in Lola's description of her intrusive thoughts and visions as a 'kind of madness.' When asked to clarify this, she elaborates: 'I don't want to be a psychotic mother. I've—I've got one, I don't want to be another one for my children.'

Here, Lola illustrates her experience of merging with her mother, who was diagnosed with schizophrenia when she was a child. She does this by referring to 'madness,' but also in the way she references 'another' mother. This places the psychotic mother and the potentially psychotic mother side by side, instead of one preceding the other. Both these examples illustrate identities extending beyond the unitary 'I.' They remind us of Alison Stone's observation that 'the mother is a relational subject but doubly so: she inhabits two sets of relations transposed upon one another' (Stone 2012, p. 24) and of Baraitser's (2009) idea of the cyclical nature of maternal time, existing simultaneously in the past, present, and future.

Diagnosis, Absolution, Connection

Several women spoke of relief on being diagnosed or self-diagnosing with PND. Many emphasised that when they were experiencing perinatal distress they 'did not know it was PND.' However, as we have described above, the 'not knowing' existed alongside a bodily knowing or 'unthought known' (Bollas 1987) of profound distress. Women had an embodied sense of something being amiss, but without the language to explain this sense, other explanations crept in. Lola, as we have already heard, felt that her postnatal experiences were 'a kind of madness.' For her, receiving a diagnosis made her feel that she was 'halfway towards recovery.' Other women similarly spoke of great relief in finding out that diverse experiences such as anger, bonding trouble, and relationship problems could be attributed to 'having PND.' The process of receiving a diagnosis seemed to convert the unthought known into a 'thought known' that was more palatable than alternative explanations.

What one of these alternative explanations might be is made explicit by Margaret, a mother of two: 'I was glad that I was diagnosed. But what happens if that wasn't—if that's not what was wrong with me? What if I just couldn't cope with being a mum?' Margaret taps into a fear that was implicit in many of the narratives—a fear that a woman could not cope with mothering or did not even 'want to be a mum'

(Lola). This fear of being a 'failed mother' is prevalent in the PND literature (e.g., Beck 2002; Edhborg et al. 2005). In our studies, it existed alongside the tendency, as we have already seen with Amelia, to structure narratives in a confessional mode (Avrahami 2003) that started with scenes of inattentive, uncaring mothers, to the 'penance' of medical treatment and ending with depictions of 'übermothers' harmoniously in tune with their offspring. In the structure of these narratives, we saw the reflection of dominant discourses in contemporary public health campaigns and in celebrity memoirs (Shields 2006; Rowe 2015). The diagnosis of PND thus conferred a pre-configured emplotment (Ricoeur 1984), a script in which time was linear, recovery could be expected, and most importantly, the end result was a good mother. This seemed to offer particular relief to women such as Lola and Bethany, who, as we saw above, had an embodied, 'inherited' sense that they were bad mothers.

The act of narrating the diagnosis was also important. As Butler (2001, p. 66) notes, 'the narrative "I" is reconstituted at every moment it is invoked in the narrative itself.' This need to repeatedly reconstitute the good mother 'I' was seen in Amelia's example. She reports that she had already spoken to 'many people' about her experiences of PND before participating in our study. Margaret, too, emphasises that she 'was quite happy to tell anyone' about her diagnosis.

Narratives of course do not need to be public to affect a reconstitution of the narrative 'I.' However, we found that some women did actively seek out public narrations. Towards the end of Amelia's narrative, she discusses how her family were sceptical about her PND narrations and her medical framing of distress: 'The interesting thing is—is that the only people that have had a negative response … to me speaking about this and me staying on medication have been family members.' She contrasts this to the response she got when speaking in public, asserting that 'it's really surprised me, just how little … negative response I've had and it's really affirmed—reaffirm—sorry actually strengthened my belief in humanity.' Elsewhere, Amelia details how much recognition she gained from narrating her story and how she had learned that 'I'm allowed to talk about negative things.' Again, this

contrasted with the response of her family, who reportedly asked, 'why are you reliving this all the time, why are [you] staying in this, why are you mulling in this?' At times, the desire to narrate publicly seemed to supersede other narrative considerations, such as adhering to the confessional mode. The timing of Bethany's act of public narration is a case in point. Our interview with her was interrupted briefly by a phone call, after which she returned to narrating. It was only towards the end of the interview that she revealed the call had been from a private hospital, seeking to arrange her admission for PND.

Until this point, Bethany's narrative had taken on a redemptive form. She had spoken of early struggles with bonding and juxtaposed them with her current loving mother–son relationship. However, here, her narrative veered away from its redemptive trajectory. Why was she narrating now? Why not when she had been to hospital and her story of recovery had some legitimacy? Again, as with Amelia, the answer appeared to lie in Bethany's perception that those around her, namely her mother, were unable to receive her story, observing that 'it's hard for me to talk to my mum about it because there's a lot of her involved in it.' Her decision to narrate, even while 'in transit' to hospital, was perhaps less about the 'message' and more about the desire to be a 'narratable self' (Cavarero 2000): to be heard by an Other. Or, as Butler (2001, p. 80) notes, 'surely there are moments of repetition and opacity and anguish, which usually compel a journey to the analyst, or if not to the analyst, to someone—an addressee—who might receive the story and, in receiving it, alter it some?'

Amelia and Bethany's narrations are therefore fundamentally relational acts, borne of a reawakened daughter-need to be heard, and the promise of 'intimate public' (Berlant 2008) addressees who might do the listening. Furthermore, as both Butler (1990), in the context of gender performances, and Baraitser (2009), in the early maternal setting, contend, relational acts are always iterations, but each iteration is slightly different. With new audiences come new relational configurations, new co-constructed selves, new opportunities to speak to the primary inaugurating impingement, and perhaps 'alter it some' (Butler 2001, p. 80).

Conclusion

For some women, early maternity can be conceived of as an 'involuntary experience of discontinuity' (Butler 2001, p. 59)—a traumatic intrusion of the preverbal into the storied life. In this chapter, we have attempted to expose how maternal worlds can simultaneously be experienced as 'radically non-narratable' (Butler 2001, p. 59) and prompt a narrative response.

Our chapter contributes to the current literature in two main ways. Firstly, it advances a relational ontology for perinatal distress, drawing on contemporary interdisciplinary subjectivity research, in particular as it relates to embodiment, affect, and intersubjectivity. Secondly, it considers the little-researched but increasingly widespread phenomenon of narrating PND. In particular, it examines how women use the narrative act to negotiate their early maternal relational selves. We consider the Foucauldian self-regulating function of the PND narrative, showing how women preferred to be seen, and to see themselves, as sick mothers in recovery rather than be deemed bad mothers. However, we also suggest that the PND narration was employed relationally and as a means of accessing new audiences. Here, we adopt Adriana Cavarero's position on the narratable self (2000), a self that is structured by its desire to be heard, and suggest a particular resonance in the early maternal period when the primary inaugurating impingement or abandonment is invoked. Furthermore, we hint at the agentive possibilities in finding new addressees who might help reconstitute relational selves.

We are mindful that we have presented an eclectic and at times conflicting notion of the relational self. There are a number of tensions, but also possibilities, in our approach. Firstly, psychoanalytic and phenomenological paradigms are not self-evidently aligned. However, in our attempt to synthesise the two, we have been inspired by authors such as Butler (2001), Fuchs (2012), Blackman (2010), and the maternal studies scholars, all of whom use pluralistic approaches to gain a richer understanding of how the Other within becomes 'enfleshed' (Blackman 2010, p. 172).

Secondly, our idea of relational intrusions could be criticised both for contradicting the phenomenological viewpoint that all being/becoming is relational and for reifying essentialist configurations of maternity as pre-cultural. We have attempted to address both concerns in our engagement with the maternal studies field and the thesis that the maternal moment offers a heightened embodied awareness of relational subjectivity. Writers such as Baraitser (2009) posit that in the Global North we are urged to repress our attunement to the intersubjective, but that embodied maternities make such a repression untenable. To Baraitser, maternity interrupts, not because it returns women to 'nature,' but because its practices offer modes of being that vex neoliberal logics.

Our analysis emphasises the relational in order to address what we see as a notable gap in the current PND literature. However, like Baraitser and Butler, we do not suggest that the relational and embodied are 'outside discourse.' In fact, many of the extracts we present trouble distinctions between discourse and non-linguistic being. For example, in Lola's account of the 'fuzziness' in her wrists, we have privileged the non-verbal register, but of course the fuzziness could not exist without a symbolic, discursive understanding of what knives are capable of, or of what other desperate people have used them for.

In tracing these 'entanglements of embodiment and discourse' (Wetherell 2013, p. 351) we contribute not only to the PND literature, but also to broader trends in social theory that seek to reconcile linguistic and non-linguistic ways of being and knowing. Future research might further unpack how maternal relational intrusions are socially embedded, and pay particular attention to the singularity of women with intense distress. How are their experiences different from ordinary maternal 'excess?' (see Baraitser 2009, Chapter 3). One salutary angle might be trauma, drawing on the expanding interdisciplinary literature on the embodied, biographically disruptive, nature of traumatic memory (see Blackman 2010). Certainly, a number of women in our study spoke of childhood experiences of neglect, sexual abuse, and incapacitated parents, leading us to reflect on articulations between relational trauma and early maternal distress.

Finally, in our focus on narration and the relational self, we again blur demarcations between the 'narrating I' and the 'relating I.' We engage with the work of Butler (2001) and Cavarero (2000) who elaborate how narrating selves are simultaneously performing, relating selves, seeking recognition from the Other (Kokanović and Stone 2017). We have highlighted the fluidity and complexity of notions of autonomous selfhood and intersubjectivity by demonstrating how narrations can at once seem to reinstate an autonomous disease-afflicted, rather than relationally afflicted, self and be a profoundly relational act. The distinctions become even murkier when we consider that the 'autonomy imperative' is of course a dictate of the Other—the Other as neoliberal discourse—and the hint of an agentive self is found not as a result of the autonomy, but rather as a consequence of the relationality achieved through narration. In this way, self/Other and psychic/social become thoroughly interwoven, a dialectic we hope to see taken up in future research.

Clinically, our work prompts health care workers to heed both mother and daughter subjectivities in the perinatal period. As has been found elsewhere (Dennis and Chung-Lee 2006) and confirmed in our study, women often feel uncared for after the birth of the baby. Our study echoes previous calls for maternal services that 'mother the mother' (Bilszta et al. 2010) and provides a theoretical foundation for why this is necessary.

In this chapter, we have focused less on clinical and more on narrative encounters. We have sought to critically read PND narratives and 'recover' the relational. However, we have also suggested that for women experiencing early maternal distress the relational can be rehabilitated through narrative. Here, we have attended to the PND narrative performance and its 'affective/discursive' context (Wetherell 2013). Maternal subjects have been publicly enacting such narrative performances for some time now. A relationally reflexive analysis of why they might be doing this is overdue.

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9

‘One of the Most Vulnerable Times in Your Life’: Expectations and Emotional Experiences of Support in the Early Postnatal Period

Kate Johnston-Ataata, Renata Kokanović and Paula A. Michaels

> And after having the baby, yeah, we got a good support from [my wife’s] mum, so even after [we] came back to the home, she helped both of us – how to manage the baby, how to feed the baby, how to bath the baby. … [A]nd I get a good support from my family back in India. They’re calling me regularly and asking, “How’s the baby? How are you going?” …They all want to see the baby in the Skype and they want to get the photos.
>
> Nadir

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> [I]t was just this fog of not sleeping, arguing, crying, you know, like wondering what had happened to my life, wondering why I'd ever had a baby in the first place and wanting my life back. … It was pretty much me 24/7. … I'm not great at asking for support. But I was just so determined that I was going to do it all on my own and I somehow managed to believe that I was all that my baby needed.
>
> Leah

It is widely recognised that the transition to parenthood is a time of vulnerability and need for new parents, particularly new mothers. Cultural practices marking this life-cycle event are found transhistorically and transculturally. Though they take different forms, rituals mark the period from late pregnancy through four to six weeks after birth (Eberhard-Gran et al. 2010). Postpartum customs are still widely practised in many countries, but lying-in customs once common in Europe are no longer widely observed; this transformation is equally true for Britain's former dominions in North America and Oceania: the USA, Canada, Australia, and New Zealand. In fact, for a range of reasons elaborated below, new parents in Australia today cannot necessarily expect to receive practical or emotional support at home in the early postnatal period. Consequently, many find themselves isolated and unsupported at a time of considerable physical and emotional vulnerability.

How do new parents in contemporary Australia think about support in early parenthood? What kind of support do they expect or seek, and what shapes their expectations? What support do they receive, and to what emotions do their experiences of support give rise? This chapter explores these questions through an analysis of how a diverse group of parents accounted for their expectations about social support in early parenthood and their feelings about their actual experiences. First, we outline how we understand social support and discuss its importance in the early postnatal period, defined as the first three to six months postpartum. We then contextualise the accounts presented in the

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analysis with an overview of postpartum practices in other social and historical settings and the structural and discursive factors that have contributed to the isolation of new parents in Australia.

The concept of social support has been subject to considerable theorising and empirical research within the social sciences, including in terms of its relationship with and effects on health and illness in general (Heaney and Israel 2008) and in relation to specific health conditions (Eastwood et al. 2012). Social support is an important contributor to psychological and emotional well-being in challenging and stressful times, such as the early postnatal period; its absence can have the opposite effect (Emmanuel et al. 2012). Following Barkin et al. (2014), we understand social support in the early postnatal period as including instrumental assistance (e.g., help with housework), emotional support (e.g., empathic listening), informational support (e.g., providing information about infant care skills), and companionship. Our chapter focuses on social support provided by intimates (e.g., partners, family members) and social network members (e.g., friends, work colleagues).

Much empirical research investigating social support in early parenthood focuses on its impact on perinatal depression (PND) and on mothers. Two salient findings are that lack of social support is considered a risk factor for PND and that experiencing PND can lead to social withdrawal (Beck 2002). The literature on social support in the perinatal period more broadly in culturally and demographically similar contexts to Australia reveals that support needs and beliefs about who should provide that support vary according to social location. In a study of women from diverse ethno-cultural backgrounds in the USA, Negron et al. (2013) found that the mothers and partners of new mothers were important sources of support for all women interviewed, but that women's beliefs about asking for support and strategies for mobilising support seemed to vary by ethnicity. New African-American mothers, for example, have been found to rely on a wider range of kin members than European-American women, who tend to look more to their partners (Logsdon et al. 2000). Social support needs of new mothers from migrant backgrounds vary according to the number of years since their arrival, the number of relatives and friends in their new country, their ability to access local services, and their capacity and desire to practise postpartum customs from their country of origin (Shafiei et al. 2015; Niner et al. 2013). Similarly, adolescent

or low-income parents have particular support needs, as do same-sex attracted parents, single parents, and so on.

A range of barriers inhibit access to social support in the postnatal period. They include: negative feelings about seeking help (Negron et al. 2013; Kurth et al. 2016); unavailability of trustworthy and affordable childcare; limited availability of family; migration and mobility; and the effects of the 'individualization and institutionalization of maternity,' which leads to trust in expert systems trumping experiential knowledge and discouraging women from seeking knowledge from other women (Ketler 2000). Lack of time to nurture relationships that might provide social support can reinforce new parents' sense of isolation (Barkin et al. 2014).

From the literature on how social support benefits mental and emotional well-being, we know that the quality of the relationship between those providing and receiving support is critical (Lakey and Orehek 2011; Abiodun 2006) and that support should ideally avoid undermining recipients' sense of mastery (Logsdon et al. 2000). Research specifically investigating expectations of social support in the perinatal period is limited and is dominated by work on PND or social psychological approaches. Fragments of information on expectations can be discerned across the literature on social support in the perinatal period, but to our knowledge no studies have explicitly examined this.

Postpartum Practices in Cross-Cultural, Historical, and Contemporary Perspective

Scholars have examined postpartum practices in many parts of the world (Eberhard-Gran et al. 2010; Dennis et al. 2007), as well as among migrants living in countries such as Australia (Matthey et al. 2002; Niner et al. 2013). Postpartum practices typically comprise organised support, a designated rest period of 30–40 days, a special diet, ritual hygiene practices, infant care, and breastfeeding support (Dennis et al. 2007). Some practices are based on the belief that birthing women are 'unclean' or that babies are not yet full persons and must be sequestered for a defined period to protect the wider community (Lancy 2017). These customs are linked to fears about mothers or babies dying in childbirth, or babies not surviving infancy. Other practices are based

on the belief that becoming a mother marks a change in a woman's social status. Common to all is recognition of the physical risks and duress that women undergo in pregnancy, labour, and birth, and their need for recuperation and time to master infant care skills. Women's own perspectives on postpartum practices depend on their material and social circumstances and their views about the utility or meaning of such practices (e.g., Morton 2002).

In Australia, Great Britain, New Zealand, the USA, Canada, and many European countries, women historically observed a lying-in or confinement period beginning in late pregnancy and ending approximately one month after birth with the ritual of 'churching,' when the new mother attended a church service to symbolise her re-entry into society (Wilson 2013; Eberhard-Gran et al. 2010). Historian Adrian Wilson (2013) details this phenomenon as it occurred in early modern England. During confinement, women stayed home in a room set up as a lying-in chamber to rest in preparation for and to recover from childbirth. They received practical and social support from a midwife, 'gossips' (relatives and friends), and sometimes a hired nurse. English society observed various ritual practices during the lying-in period, which Wilson underscores was a time of physical enclosure in the home and social enclosure among fellow women. This period was known as a husband's 'gander-month,' when he had to take on his wife's work responsibilities and to endure physical separation from her (Wilson 2013, p. 194).

Today, lying-in has all but disappeared as a cultural practice in Europe, North America, and the Antipodes. Unfolding across the 1800s and into the 1900s, the dominance of biomedicine over childbirth drove this transformation. Birth and postpartum recovery moved out of the domestic realm, first into midwife-operated lying-in homes, then to lying-in hospitals (Martell 2000). From the late 1800s, lying-in hospitals evolved into women's hospitals, with a remit beyond maternity care, though until the mid-twentieth century middle-class, white women commonly stayed in hospital for 10–14 days after giving birth. Reflecting both women's preferences and cost-saving measures (James et al. 2017; Martell 2000), this practice has declined significantly; the median postnatal stay in Australia in 2015 was three days (AIHW 2017).

Along with the disappearance of lying-in practices and of the concomitant formal social structuring of the postpartum period as rite of passage or time of need for mothers and babies (Stern and Kruckman 1983), the availability of social support in the early postnatal period more broadly has also declined. Fewer relatives, friends, or older children are available to provide companionship or instrumental support to new mothers due to urbanisation and migration, which leads to the dissipation of geographically close social networks (Short et al. 2006; Brown et al. 1997). Additional factors include declining fertility and increasing age at first-time parenthood, both of which are often tied to women's uptake of paid employment outside the home (Barkin et al. 2014). Smaller family sizes have also meant the loss of opportunity to experience infant caregiving, contributing to many new parents in the Global North reporting that they feel unprepared for early parenthood (Kushner et al. 2014; Deave and Johnson 2008). Finally, there has been a gradual erosion of the idea of birth and the postpartum period as the exclusive domain of women. Following advocacy in the late 1960s and 1970s for fathers to attend births (Reiger 2001; Leavitt 2008), and the introduction of paid paternity leave, the arrival of a baby is increasingly perceived as an intimate experience for the couple.

In contemporary Australia, many women and their babies go home from hospital to comparatively limited support (Coffey and Fitzpatrick 2011). Reflecting the predominance of the nuclear family structure and the so-called 'maternal bias,' a preference for support in early parenthood from the mother's mother over the father's mother that characterises intergenerational relationships in Australia and similar societies (Marx et al. 2011), support most often comes from the woman's partner and/or mother. For women from cultural backgrounds in which family support is more common, access to such support depends on relatives either living nearby or able to travel to Australia (Rice et al. 1999). The role of government in supporting new parents in the early postnatal period includes the provision of paid parental leave (18 weeks for primary carers and 2 weeks for partners), free community-based child health and development services for a child's first four years, subsidised new parents' social groups to help participants forge local networks, and partially subsidised early childhood care and education services (Biro et al. 2012; Brinkman et al. 2012).

Romanticised images of early parenthood portrayed in popular and social media can also contribute to emotional distress in new parents in Australia. The depiction of a dyadic parental idyll works in tandem with influential parenting ideologies, such as intensive or attachment parenting, that encourage parents, particularly mothers, to prioritise their baby's needs above their own (Harries and Brown 2017; Rizzo et al. 2013). For new parents inexperienced in infant care and who believe the nuclear family ideally to be self-sufficient, the dissonance between expectations and reality can be jarring. Lacking experiential knowledge, prospective parents are more likely to base their ideas about early parenthood on unrealistic media images or expert advice. Concurrently, there has been a broader shift under neoliberalism to privatise child-rearing and, at least discursively, to cast parenthood as a private choice rather than one that merits state support. Paid parental leave and childcare subsidies aside, in Australia and comparable countries, raising preschool-aged children tends to be more a private responsibility than is raising school-aged children, where responsibility is shared with the state (Fox 2009).

Orientations Towards Social Support in Early Parenthood: Expectations and Emotions

Based on in-depth engagement with the 38 out of 48 narratives that addressed social support, we present two main 'orientations' that interviewees displayed towards social support in the early postnatal period: (1) a network, interdependent orientation, and (2) a couple, independent orientation. Our analysis indicates that expectations about social support condition the emotional experiences of this aspect of early parenthood; thus, each orientation encompasses people's attitudes and expectations towards support in this period and their emotional responses to their experiences of support.

Our chapter expands sociological understandings of a topic that has received little scholarly attention until now: the interrelationship between expectations and emotional experiences of social support in the perinatal period in societies, such as Australia, where postpartum

ritual support practices are no longer widespread. We illuminate the role of social and material circumstances, as well as cultural narratives and frameworks in shaping expectations and emotional experiences in relation to social support in early parenthood. Implications for further research and for health and social care are outlined at the end of the chapter.

We identified two major orientations towards support in the early postnatal period. Network- or interdependence-oriented parents expected early parenthood would involve and indeed require support beyond the couple, while couple- or independence-oriented parents considered the couple relationship the primary site for support. In relation to actual experience, irrespective of expectations, some participants described relying on their partner only, while others leaned on a wider network. Not all participants who hoped for wider support received it, and not all participants who wanted greater independence from family networks were able to negotiate this. Although our exploration of how people accounted for their emotional experiences in relation to the support they expected and received suggested two distinct and internally coherent orientations towards social support, forming a simple typology (Kluge 2000), the complex interplay between expectations and experiences found within each orientation highlights the multifaceted web of considerations that shape feelings about support in early parenthood.

Influences on Expectations: Network-/Interdependence-Oriented Parents

We categorised about two-thirds of the narratives we analysed as network-/interdependence-oriented. These parents seemed to have come to early parenthood with a pre-existing assumption that the experience would be challenging and therefore support beyond the couple relationship would be helpful. They described looking to other family members, friends, and even work acquaintances as well as their partners. Three major factors influenced these parents' views about support in early parenthood: coming from or being exposed to a more familialist cultural background in which family support in early parenthood is common

(Mendez-Luck et al. 2016, p. 813); perceiving that their particular circumstances might make becoming a parent additionally challenging; and experiential knowledge of early parenthood. The boundaries between these are not fixed, with some narratives including references to more than one factor.

Parents who had migrated from countries in which family life tends to be more familialist (e.g., India, Sri Lanka, Nigeria, Afghanistan, Ireland, South Sudan), as well as two Anglo-Australian mothers whose partners were from such countries, expressed the view that family support in early parenthood was to be expected. Delia, for example, describes social attitudes towards and practices associated with childbearing in South Sudan, her country of origin:

> In my country having babies is so good, like it's a blessing. … Everyone is happy when I have a baby or my sister or anyone because it's like having something new in the house and even the neighbours and all the family members, wherever they are, they all come to visit when we have a baby. And it's really very good and they share, they share, in taking care of the baby and they share in helping the mum. [I]n my country, I would want to have a baby every year … [Y]ou feel the pain for two or three hours but after that you forget when having the baby, forget everything.

Delia paints a picture of a supportive social network and a celebratory attitude towards childbearing, which she claims encourages women to have more children. In South Sudan, one of the world's least economically developed countries, with a strongly pro-natalist culture, children are considered an economic asset and enhance social status; women are valued primarily as bearers of children, particularly in the light of the demographic impact of a decades-long war with Sudan (Palmer and Storeng 2016). The majority of the population lives in villages characterised by dense kin networks, in which new mothers are supported and domestic work and childcare are shared.

While these conditions are very different from that of contemporary Australia, similar themes are found in other migrant parents' narratives, including Nadir, whose words open this chapter. He and his wife are professionals who migrated from India to Australia for employment and could afford to sponsor their parents to come for extended visits to

support them in early parenthood. Nadir's interview makes clear that he and his wife considered a high level of involvement from the new grandparents as the norm, rather than the exception.

An expectation that family support was beneficial was also evident in the narratives of Eleanor and Daphne whose partners were from Sāmoan and Filipino backgrounds respectively. Eleanor reflects on her and her partner's experience of moving in with her parents for the first six weeks of their baby's life:

> [M]y parents were amazing, you know? Basically, being there after the birth, my mum - it just meant we didn't have to do any housework. All we had to do was look after the baby, because my mum was semi-retired by that point so she was around quite a lot. … And [for] my partner it sort of fitted because, you know—if things had been different within his family, like if my mother-in-law hadn't needed to go back to Sāmoa to look after her other daughter's kids, she probably would've stayed and done the same for us.

Many women of Anglo-Australian background described receiving assistance from their own mothers in early parenthood, in keeping with the maternal bias noted earlier and documented in other studies (Marx et al. 2011). However, Eleanor was the only partnered Australian woman who temporarily moved into her parents' home with her partner and new baby, an unusual practice in Australia compared with other settings (e.g., Japan, South Korea, Malaysia).

For some interviewees, becoming a parent under circumstances that they considered challenging combined with their expectation that early parenthood would involve interdependence with others led them to desire and cultivate a wide base of support. Some of these circumstances, elaborated below, included single parenthood; giving birth to twins; physical distance from family support due to migration; family members withholding support; knowledge during pregnancy of a baby's health or developmental problems; becoming a parent at a young age and in the context of social disadvantage; or some combination of these concerns. In contrast to some couple-/independence-oriented parents who faced similar circumstances but did not solicit extra support, these

parents anticipated especially challenging early parenting experiences and sought out support accordingly.

Single parents and parents of 'multiples' (e.g., twins) often have a greater need for support in early parenthood relative to partnered parents and parents of 'singletons' (Harvey et al. 2014). The accounts of single parents Robert and Caitlyn indicated that they, too, saw themselves as needing additional support, as did most parents of twins. In Caitlyn's words, without the support of her mother, with whom she lived, she would have been 'in the foetal position.' Marie, a partnered mother of twins, described being contacted by a multiple births support group while pregnant and being strongly encouraged to accept all help offered in early parenthood. Although Marie's 'natural inclination' was to be self-sufficient, she describes overcoming when support was offered this by telling herself, 'this isn't for you, this is for other little people who really need you to be functioning and coping.'

Narratives from Helen and Robert reveal how the withholding of family support can push new parents to identify alternative sources of assistance. Both interviewees' parents, respectively, refused to provide them with any support in early parenthood because of objections to their sexuality. This was difficult for Helen and Robert to accept, both emotionally and practically. As explored in Chapter 5, Helen and her same-sex partner experienced rejection from three of their four parents. In Helen's words, the couple therefore went into parenthood 'without really any extended family having any involvement in the sense of actually providing any help.'

One couple, Rory and Sharon, became parents for the first time at age 17 and 18, respectively. In Rory's words, the pregnancy 'changed everything' for them, both partners having grown up in socially disadvantaged environments. Although they describe viewing Sharon's pregnancy as an opportunity for a new start, their narratives indicate that neither of them could rely on their parents for support. While Rory had some help from his siblings, evident in both his and Sharon's accounts was a strong orientation towards and appreciation of formal support services.

A few network-/interdependence-oriented parents indicated they had a pre-existing awareness of the challenges of caring for a baby without

wider social supports, some through direct experiential knowledge and others through exposure to realistic accounts from others. Nina's views and expectations of early parenthood were informed by personal experience of supporting several friends through this period, while Sylvia, a migrant from Europe, had been told by friends that early parenthood was 'challenging' even with family support, so described having expected it to be additionally difficult given her lack of family in Australia.

Parents who were network-/interdependence-oriented anticipated the need for extended social support for a variety of cultural, circumstantial, and experiential reasons. Regardless of their expectations, their experiences of that support varied just as greatly, as did their emotional responses.

Emotional Experiences: Network-/Interdependence-Oriented Parents

Receiving desired support in the early postnatal period mostly led to positive emotional experiences, interviewees narrating such support as 'wonderful' or 'a blessing.' For both Delia and Mary (who was from Nigeria), feeling well-supported during the perinatal period for their older children born overseas had seemed even to ameliorate labour pain. Mary recounts having her first child while away from home, but with her mother, mother-in-law, and husband present, and says, 'I felt supported so it was a good experience and throughout the pregnancy as well I didn't have any issues so I enjoyed that [laughs] and loved it even though I had a 24-hour labour [laughs] but it was–yeah, it was good.'

For some new parents, support came from outside of the family. Though her husband reportedly questioned how much time she spent helping other new mothers, Lucy defends her actions, saying, 'it fills my cup.' As an interstate migrant and having experienced antenatal depression herself, she describes helping build a mutually supportive local community as rewarding. For Mary, Lucy, Delia, and others, social support did not necessarily reduce the challenges of early parenthood, but

strengthened their ability to surmount those challenges, underpinning emotional and mental well-being.

By contrast, intermittent experiences of desired support seemed to exacerbate negative emotional experiences. According to several interviewees, having previously encountered good support, later experiences of unmet needs as a result of changed circumstances were a disappointment. The experience of Eithne, an Australian woman who married a Swedish man and gave birth to their first two children in Sweden, well illustrates this phenomenon.

> I … didn't have any other family overseas with me, other than my husband and his family. But it's not the same. You … don't have that connection. … I was really lucky because one of my girlfriends over there, she'd fallen pregnant roughly a month after I did. So, we were both on maternity leave together and it was just so much fun. We lived in the same town, so we hung out every day. … And then we found out again that both of us were pregnant within a month of each other, so with our second child, and that was also really exciting.

However, Eithne's expectations for mutual support with her friend following the births of their second children were unfulfilled. She comments that the postnatal depression she experienced following the birth of her second child was exacerbated when her friend moved away. '[T]hat was my support network and I just felt like I was flailing, because I had no-one. I couldn't talk to my husband's parents. Even though they lived close by, … it's not the same as being able to talk to a friend.' The distinction Eithne draws between her husband's family and her own friends in relation to their capacity to provide emotional support is in line with theories of social support noted earlier that emphasise the importance of the relational component (Lakey and Orehek 2011). Social support is most effective when provided in the context of close, positive relationships. Eithne's experience also highlights the fragility of social networks established in new locations and later in life (see Barkin et al. 2014).

Many network-/interdependence-oriented parents were unable to access wider support reliably or continuously, despite their desire to

do so. Their emotional responses to the divergence of their experiences from their expectations of and hopes for social support varied. Most anticipated that, for various reasons, they would lack support from their families and social networks, and this expectation seemed to temper the negative emotional impacts of the experience of limited support. After moving interstate with her husband for his job, Vivienne gave birth to premature twins. Although she had no social network locally, she reflects that knowing in advance that their babies would be born prematurely—due to developmental problems diagnosed *in utero* with one twin—meant that they could put some 'survival mechanisms' in place. Her experience was very difficult nonetheless, but had it been unexpected, it would have been a 'much bigger shock.'

When wider support networks were lacking in early parenthood, partners' capacity to support one another assumed greater importance. Implementing a shared approach can be challenging, as is widely documented in the literature (Fox 2009; Sévon 2012). Dominant cultural norms drive the assignment to mothers of primary responsibility for child-rearing and are reinforced by structural factors, such as significantly longer parental leave for primary carers, and variable access to childcare according to socio-economic status, occupation, and location. However, some couples made significant efforts to support one another. Nadir, for example, taught himself to cook, taking this task over from his wife when she began suffering from Nausea and Vomiting in Pregnancy (NVP). After the early postnatal period passed, he also negotiated part-time work to enable his wife to work full-time and build her career, and to allow him to take a greater role in caring for their child. By Nadir's own admission, these initiatives represented a significant departure from gender norms in their home country, India. His account contrasts with that of Priya, a recent migrant from Sri Lanka. Priya portrayed her postgraduate student husband as under significant pressure from his supervisor and, thus, unable to provide either instrumental or emotional support to her or their baby. As her husband was her 'only friend' and early parenthood proved challenging, his unavailability was distressing. Both examples underline the advantageousness for new parents lacking wider networks of the secondary carer being able to take flexible leave to actively participate in domestic life during the early postnatal period.

Finally, as Marie experienced, circumstances compelled some new parents to accept help, but only reluctantly. They comment that, had their situations been different, they would have preferred greater independence from family members or other supports. Rosemary's relationship with her partner broke down suddenly and unexpectedly soon after their baby's birth. She explains that, coming from an Italian background, there was no question her parents would not welcome her and her baby back into the family home. Their support was invaluable, but Rosemary narrates a protracted struggle to make sense of what had happened to her relationship and to see herself and her baby as 'a family.' As discussed in Chapter 7, Esther, who had her first baby in her home country of Iran, found her family's attention and involvement in the early postnatal period oppressive (see Chapter 7).

Influences on Expectations: Couple-/Independence-Oriented Parents

While some new parents came to rely heavily on the couple relationship for support in the early postnatal months despite a desire to lean on a wider social circle, others entered into parenthood believing that their partners or even just they themselves would be support enough. Upon finding early parenthood difficult, couple-/independence-oriented parents—approximately one-third of the narratives we analysed—struggled to recognise their need for help, or were reluctant to ask for assistance. Experiences of emotional distress were more common among these interviewees, with the majority, including one father, disclosing experiences of PND. We do not suggest that a couple-/independence orientation causes PND or emotional distress; as elaborated in Chapter 8, many mothers who experienced PND narrate it as a complex relational experience, with actual or perceived lack of social support constituting only one of its many dimensions. However, given the consistent research finding that lack of social support can contribute to PND and social withdrawal can be a consequence (Beck 2002), it is unsurprising that our analysis identified an association between the expectation that wider

support would not be needed in early parenthood on the one hand and emotional distress and difficulty asking for help on the other.

Several factors seem to influence couple-/independence-oriented parents' apparent expectation that they would not require support beyond the couple relationship during the early postnatal period. These factors, elaborated below, include: lack of pre-existing knowledge about parenthood; coming from a middle-class, 'Anglo,' or European background; and influential parenting philosophies and popular cultural notions of parenthood. These categories are not mutually exclusive, but overlap and intersect for many parents.

Many couple-/independence-oriented parents recount entering parenthood with 'no idea' of what it was 'really like.' In the absence of experience of or exposure to babies, some interviewees obtained information about early parenthood from the media, formal education programmes, or from other parents. Other interviewees recalled having assumed early parenting would come 'naturally' to them Kathleen, for example, felt that she and her partner had 'no preparation' for caring for their baby. She describes feeling 'angry' about her hospital antenatal classes reportedly having focused on labour and birth rather than early parenting. On the other hand, as discussed in Chapter 6, information about early parenthood, especially concerning experiential knowledge, does not circulate easily among or between expecting and new parents, whether because of a desire not to hear or know, or a reluctance to disclose. The 'brick wall' theory (Wiener 2002 cited in Spiteri et al. 2014) holds that pregnant women are preoccupied with childbirth and unreceptive to information about the early postnatal period. Although this explanation has been discredited in subsequent research in relation to antenatal education, it resonates with some mothers' narratives, including Leah's: 'I think because I believed that if you get [the birth] right then the rest of it sort of flows.' Isobelle offers a different perspective on expectant parents' disinterest in information about early parenthood: 'When you're pregnant you only hear the fantasy side, the good side. You don't want to hear about the reality of it, or if you do hear it you think, "That won't happen to me…"' This view speaks to both the romanticisation of parenthood and to the tendency to discredit

the relevance of personal experience to other people that Ketler (2000) argues is part of the medicalisation and individualisation of maternity.

Other couple-/independence-oriented parents observed that acquiring accurate information about early parenthood was complicated by the reported tendency of those who already have children not to share their experiences openly, something they noticed in themselves also once they became parents. Speculating on this reticence, interviewees offer several explanations. Some suggest the belief that pregnancy should be a joyous event can make parents reluctant to share challenging early parenting experiences for fear of disrupting expectant parents' happiness. Others attribute the withholding of information to the inclination of parents with older children to 'forget,' whether intentionally or unconsciously, the detail or difficulty of their own early parenthood experiences. Both these hypotheses align with the idea that romanticised images of parenting influence parents' perceptions of what can and cannot be articulated about becoming a parent. Other parents point to the fear that one is alone in finding early parenthood difficult, leading to feelings of shame at not 'coping,' as a reason for withholding honest accounts. This view aligns with Maushart's concept of the 'mask of motherhood' (2000), according to which women's failure to share openly about their experiences of early motherhood contributes to a self-perpetuating cycle of shock and disappointment, feelings of failure, fear of disclosing difficulties, and further unrealistic expectations. Still, others advance the view, again echoing Ketler (2000), that everyone's experience is unique as a reason for hesitating to disclose more challenging experiences.

Our analysis suggests that these silences and evidence of a desire to 'not know' are compounded by cultural norms prevalent among Australians of particular ethno-cultural and socio-economic backgrounds. Couple-/independence-oriented parents were demographically more homogenous than network-/interdependence-oriented parents. All were partnered, of Anglo- or European-Australian origin, and held or were partnered with those in professional occupations; all but one identified as heterosexual. These demographic markers have independent, as well as interlocking significance. As noted earlier, in Australia and societies with similar demographic, economic, and cultural features,

such as the UK or USA, couple relationships and nuclear families are seen as the main site for emotional support for partners, parents, and children (McPherson et al. 2006), particularly among middle-class families (Hansen 2005). While some support may be sought in the early postnatal period from extended family members, particularly mothers and mothers-in-law, this is not culturally elaborated to the extent it is in other cultural contexts (Stern and Kruckman 1983).

Higher education and professional work experience also seemed to contribute to these parents' expectation that they could be self-sufficient. As Leah comments: 'I think my generation have been raised to be independent and, it's reinforced in the workforce because those masculine qualities, like not saying they are exclusive to men, but those sort of qualities that further your career in the corporate world, in my experience don't work in parenthood. And they're the qualities that are most reinforced by our society.' The reality of new parenthood challenged these white, middle-class parents' assumptions that they alone or together with their partner could comfortably accommodate the responsibility of caring for a baby. Georgina, for example, 'underestimated the importance of a support network when you have a child. … [M]y husband and I both underestimated how much sort of help and support that we would need, like physically and emotionally.'

Further evidence of the influence of these norms of self-sufficiency on couple-/independence-oriented interviewees is found in the tendency of some to downplay challenging circumstances experienced on the journey to parenthood. A few interviewees and their partners lived far from their families or in isolated locations, Alexander and his wife were expecting twins following pregnancy via *in vitro* fertilisation (IVF), and Adrian and his partner had significant difficulties becoming pregnant, undergoing several miscarriages. As noted, parents of twins confront additional challenges in early parenthood. Difficulties conceiving, IVF, and miscarriage are all recognised as potentially having an adverse impact on emotional and physical well-being. Yet, unlike those among the network-/interdependence-oriented parents who faced similar challenges, none of these participants seemed to have considered that these life circumstances might necessitate support from extended social networks in early parenthood.

Finally, our analysis suggests that intensive or attachment parenting philosophies and beliefs in parenting as a private responsibility influence

couple-/independence-oriented parents' thoughts and actions in relation to the need for support beyond the nuclear family. For some interviewees, so-called good mothering meant being child-centred. This, in turn, led to mothers' priorities shifting from themselves and relationships outside the immediate family to their children. Influenced by her own mother's parenting, Sophie said she had expected that once she had a child, 'my whole focus was going to be this person, and I'd largely forget about my own personal needs.' Not until she had an unexpected premature birth with her third child and struggled to cope with the associated distress she experienced did Sophie reflect on the disadvantages of her approach. When asked about support from friends while her son was in intensive care, Sophie explains that, 'I think that I've made the mistake with my girlfriends, once I've had children, [to] just completely focus on my children and I've let a lot of my friendships just go.'

An ideal of parenting as a private responsibility informed some couple-/independence-oriented parents' expectations about social support, as illustrated by Hannah's recollection of a conversation with her mother about why she did not tell her about her (self-identified) PND. As she explains: 'it wasn't [mum's] choice for me to have children, it was my choice to have children and as an older mother, 'cause … I think I was 33 when I had him. I haven't made that decision lightly, you know. I had 10 months of trying for a child, it wasn't just an accident that happened. So, I didn't expect them to come to my aid for everything.' Hannah had a difficult birth, a baby with silent reflux who was very unsettled, and little support from her husband or parents. Nonetheless, she did not ask for much help, in part because she thought having 'chosen' to become a mother, the associated responsibilities were primarily hers to bear.

Emotional Experiences: Couple-/Independence-Oriented Parents

Most couple-/independence-oriented parents found the early postnatal period more challenging than anticipated. Not having expected to need wider support, many recounted feeling either that their partner was not sufficiently available, that they had not adequately supported their

partner (as in Alexander's case), or that early parenthood had been difficult for them as a couple. However, these parents either thought that what they were experiencing was typical and that they had been unprepared, or that their difficulties 'coping' reflected their own inadequacies. Consequently, many were reluctant to ask for support, though in time most learned to do this, often also relaxing their parenting standards and ideals. They described experiencing a range of emotions, discussed below, in response to finding they needed more social support than they had expected.

Some couple-/independence-oriented parents recounted feeling confusion, uncertainty, and frustration when new parenthood proved more challenging than anticipated. Looking back, they identified their lack of a realistic understanding of the likely demands of a new baby and one's own possible emotional fluctuations as contributing to this confusion. Hannah's experience is again illustrative. In addition to seeing parenthood as her responsibility, Hannah's lack of knowledge about early parenthood and inexperience with babies meant she had no way of gauging the relative challenges of her situation. She describes frustration at how difficult it was to coax their baby to sleep and getting 'angrier and angrier' over the loss of control over her time since her baby's birth. No longer able to cope, Hannah contacted her mother for assistance when her son was six weeks old. When asked why she had not sought help sooner, Hannah told her mother that she had thought what she was experiencing was 'normal.'

Other couple-/independence-oriented mothers blame themselves for 'not coping' and feel shame at their seeming inability to perform a role that they thought should 'come naturally.' Most were accustomed to feeling capable in the workplace, and the struggle to adapt to motherhood threatened their sense of self as a competent person. Isobelle, who experienced PND, describes the resultant emotions: 'I wasn't very happy for someone to say, "You have postnatal depression," because it felt like a personal failing, and coming from a high-achieving background, doing well at school, doing well at uni, getting a good job and then all of a sudden you fall in a heap and you have to say, "Actually, I'm not coping".' Isobelle was inclined to blame herself despite the fact that she, like Hannah, experienced significant medical and personal challenges

during pregnancy and early parenthood. Both accounts illuminate how a lack of understanding or experience of early parenthood led to an inability to contextualise experiences, self-blame, shame, and reluctance to disclose difficulties.

For other couple-/independence-oriented parents, ambivalence about seeking help, irrespective of their need for it or its ready availability, reflected different concerns. Amelia explains:

> I had all the help I could ask for around me, my mum was here every day, I had my parents-in-law staying with me asking me all the time, 'What can we do?', and I would just reject any offers of help. I would say, 'No, no, I can do this myself' …. And what it came down to, is to me my loss of my identity as a working woman, someone who even though is in a relationship is also quite independent, both from a financial point of view and also from decision-making and so on, because everything was kind of imploding on me.

So profound was her rejection of an interdependent model of early parenting that, rather than asking for or even accept help freely offered, Amelia became acutely unwell with PND. Only after her hospitalisation for PND did she yield to the need for support.

Conclusion

The postpartum practices that supported new mothers in the first weeks of parenthood that were observed in Australian, European, and North American societies until the early 1900s have gradually broken down over the last century, following a constellation of social and cultural changes that have also transformed family life. Migrants from countries where postpartum support is still provided have brought new practices to Australia, but new parents of Anglo-European heritage or migrant parents from other backgrounds who lack family networks are unlikely to experience significant family support in early parenthood. Accompanying the disappearance of lying-in and confinement practices has been a waning of the belief that new parents need support in

the early postnatal period, in spite of a large body of literature on the importance of social support for prevention of postnatal depression (Beck 2002). In this chapter, we explored how a diverse group of new parents living in Australia thought and felt about postnatal social support given this larger context. We investigated their expectations, the source of their expectations, and the emotional experiences in response to the support they did or did not receive.

Our analysis suggests that parents' emotional experiences in relation to social support in the early postnatal period are inextricably linked to their expectations. For network-/interdependence-oriented parents, an alignment between expectations of and received support appears to lead to positive emotional experiences and improve new parents' ability to pass through this challenging life stage. Those who received family or social network support unsurprisingly reported the most positive emotional responses. Even those who desired support and believed it to be important, but were prepared not to receive it given their circumstances, seemed to cope better than parents who had received good social support for prior babies, but not for subsequent children. Actual experiences of support mattered as well, of course. Sharing responsibility for one's baby with one's partner or another person was beneficial for parents who desired, but lacked wider support. In the absence of a supportive partner, relative, or friend, they struggled.

This latter finding underlines the deep challenge of sole parenting in the early postnatal period and finds resonance in couple-/independence-oriented parents' experiences. Simply holding the expectation that one could effectively do it alone, even within a couple relationship, or believing that the couple relationship would provide sufficient support seemed to predispose parents to distress upon finding early parenting more challenging than expected. The emotional effects of not anticipating the need for help included feelings of being overwhelmed, unsupported, angry, frustrated, anxious, and hopeless. Interviewees felt self-doubt, shame, and a sense of failure at not being able to fulfil the parent role.

These findings both echo and extend the limited literature in this area (Negron et al. 2013; Miller et al. 2012). They broaden the focus of earlier work to look at the significance of expectations of social support

and emotional responses to experiences of support to new parents in general, beyond focusing on those at risk of or experiencing PND. They also alert us to the myriad influences on expectations of postnatal social support in so-called super-diverse societies such as Australia, including cultural background, migrant status, socio-economic background, age, and family arrangements. Importantly, these aspects of social location also seemed to shape how parents thought about and responded to child-centric, intensive parenting approaches or idealised images of motherhood. Our analysis suggests that middle-class, couple-/independence-oriented parents whose families resemble the supposed Anglo-Australian nuclear family ideal may be vulnerable to experiencing emotional distress if they embrace unrealistic expectations of early parenthood. Not only may these parents not expect to need wider support, but also they may have no framework to contextualise their experiences if they find early parenthood challenging, be more influenced by intensive parenting discourses, and feel uncomfortable asking for help. We do not suggest that family involvement in the lives of new parents is always positive and unproblematic, but from our interviews it appears that most found such support beneficial at this critical life-cycle moment.

Second, our findings indicate that in the absence of wider support networks in the early postnatal period, the role of a partner or another trusted individual was particularly crucial for parents who were struggling. Couples' willingness to take a joint approach to caring for their baby can make a significant positive difference. However, mechanisms have to be in place to make this possible, such as paternity leave and employer flexibility or the ability of other family members to provide help in the case of single parents. Also important was the primary parent's willingness to seek or accept support, whether from their partner or another person.

Another conclusion to be drawn from our analysis is that women's role in caring for babies and young children remains foundational. Although fathers in heterosexual relationships have in recent decades become more involved with their partners and babies in the perinatal period, in most families female relatives and friends are the primary source of any additional care and support available. In this sense,

current postpartum social support demonstrates continuity with practices of earlier times. As is evident from our findings, the postpartum period remains primarily the domain of women.

Our findings suggest a need for change in some aspects of perinatal health care, including for health professionals to consider providing more tailored individual care, support, and education to expectant parents that includes questions about expectations of social support in early parenthood. We concur with Miller et al. (2012), who suggest that the Postpartum Social Support Questionnaire to be adapted for use in pregnancy to discern expectations of postnatal social support for women thought to be at risk for PND. This would be an important first step; however, as our findings demonstrate, there is a clear need for maternal health care providers to engage in discussions with all pregnant women and their partners about their expectations of social support, not just those deemed to be at risk of postnatal distress. We further suggest this be done not simply via a questionnaire, but through conversations that encourage expectant parents to reflect on this critical issue and enable health care providers to link them to appropriate sources of support.

Finally, the qualitative literature on expectations of postnatal social support is scant, reflective perhaps of the loss of the cultural concept of the early postnatal period as a time of transition and vulnerability for new parents, new mothers in particular. However, the research on the importance of social support to emotional well-being at this time is unambiguous. This finding calls for more attention to and understanding of subjective experiences of and reflections about social support, to build sociological knowledge of this phenomenon, and to facilitate health and social care providers to better understand and respond to expectant and new parents' social support desires and needs. Our work contributes to this need, tracing a series of links back from emotional responses to and experiences of postnatal social support, to expectations of support, to the array of factors influencing those expectations. A promising avenue for future research would be the exploration of this topic in the light of larger debates about the role of social networks and informal care in rapidly evolving, super-diverse societies such as our own.

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10

Labour After Labour: Negotiating Caring for Children and Paid Work

Charlotte Greenhalgh

Olivia sat crying in her study while her partner played with their daughter in the house. She had returned to work as a report writer three months after the birth of her second child because, she said, 'we didn't have any other money coming in.' Olivia had the apparent advantages of her writing skills and access to part-time work that she could do from home, submitting her reports by mail. Her partner was a loving father. While Olivia worked, he would 'be having a ball' with their daughter and served Olivia 'beautiful lunches.' The household scene reflects some of the ways that experiences of parenthood and employment in Australia have transformed since the late twentieth century, yet men's new contributions to family life and the availability of part-time employment have not solved the problems of working parents who have experienced immense demands on their time, incomes, and mental health. While Olivia's partner played with their child and cooked, for example, he would 'cover the

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kitchen with dishes' and leave the house looking like 'an absolute bomb site.' Olivia faced the clean-up. Meanwhile, it was difficult for her to work for an hourly wage as the mother of a young baby. Olivia needed to feed her daughter every two hours and sometimes took 45 minutes to get her to sleep afterwards. She was constantly aware of losing paid hours and continued working into the night to make up the time. These were some of the reasons for her tears. Like many other women in Australia and elsewhere in the developed world, Olivia suffered from the pressure of combining parenthood, domestic work, and an hourly wage in order to meet the needs of her family.

The daily lives of Australian parents and their children have been affected by large-scale changes to gender norms, politics, and the conditions of employment that have occurred since the late twentieth century. Nancy Fraser has argued that the near impossibility of combining parenthood and employment is the result of contradictions between capital and care that have intensified since the 1980s (Fraser 2016). In the twentieth century, Fraser has pointed out, many states offered social protections to some citizens—including to nuclear families—while excluding others from these benefits on the basis of their gender, race, or social class. Since the closing decades of the twentieth century, states have supported those excluded groups in their struggles for greater freedoms and social inclusion. They have simultaneously stripped away social protections from everyone, leaving families exposed to the free market. In Australia, the USA, and Great Britain, parenthood has come to be understood as an individual choice and responsibility (Craig and Mullan 2010). Public policies in these countries are designed to serve adult populations that are presumed to support themselves through work in the free market. However, policymakers have paid scant attention to the redistribution of childcare that has been made necessary by women's increased participation in the workforce. Under an alternative model, in nations such as France and Denmark, the care of children is viewed as a broad social responsibility, as well as a commitment that is made by individuals. This ideology informs a range of social policies that contribute to childcare within these nations, including mandated parental leave, shorter working hours, and the provision of childcare and early education by the state.

International developments of the twentieth and twenty-first centuries shape the experiences of Australians. Individual parents, however, are not likely to reference historical trends when they explain pressed timetables or describe household tensions. Rather, parents in Australia commonly accept sole responsibility for raising their children and for solving problems they encounter in the workplace and at home. History contributes to the reflections of Australian women when they compare their experiences to the lives of their mothers. Women are likely to feel sympathetic towards the difficult decisions about childcare and employment that have been taken by women over the generations. Conservative commentators have influenced such understandings of women's lives by arguing that it has been women's paid work, rather than inadequacies of employment conditions and social policies, that has created celebrated problems of modern families ranging from divorce to delinquent youths. Pundits have not convinced Australians that women should stay out of the workforce, especially because two incomes have become an economic necessity for many families. Instead, they have encouraged women's anxieties about the personal consequences of their professional choices. Australian women are now more likely to identify feminism as a trick by citing its false promise that women might 'have it all' than they are to identify with feminist struggles for equal pay, secure working conditions, state support for childcare, and the equal division of household labour between men and women.

Reflecting this public emphasis on the choices that have been made by working mothers in Australia, women are particularly likely to reflect at length on the predicament of working parenthood and their voices are prominent in this chapter's examination of negotiations between heterosexual couples about paid employment and childcare. How do Australian parents understand the quandary of combining work and parenthood in twentieth-century Australia? What is the consequence of their struggles to do so for the mental health of Australian women and men? This chapter shows that many Australian couples view the task of navigating paid employment and childcare as an individual responsibility that should be managed privately within families (see also, Chapter 9). Some parents describe change over time, especially the

shifting experiences of grandmothers, mothers, and daughters, but few are convinced that they face an easier task than their parents' generation did. In fact, many parents find it difficult to find common ground even with each other during periods of exhaustion and depression. Yet mutual understanding can be transformational—at least emotionally—for couples who manage to achieve it. Greater public awareness of the shared struggles of parents in contemporary Australia has the potential to turn people's attention to structural changes that are necessary to assist women and men in their efforts to work and care for their families.

Negotiating the Work-Life Balance

Parenthood in Australia creates a particularly high workload compared to other countries, and the distribution of that work is markedly unequal between mothers and fathers (Craig and Mullan 2010, p. 1359). Many Australians share the ideal that small children require the constant and focused attention of parents (see also, Chapters 6 and 7). In Britain and the USA, too, parents desire highly engaged 'family time' (Bianchi and Milkie 2010, p. 709). Reflecting these aspirations, parents in all three countries have devoted increasing amounts of their time to childcare over recent decades. The amount of time British and American parents spend with their children has been increasing since the 1960s, even as mothers have entered the workforce (Gauthier et al. 2004). In Australia, researchers have collected data since 1992 that show a similar pattern: Australian parents have devoted more time to caring for their children at the same time that they have worked longer hours (Craig et al. 2010). They do so by 'taxing' personal time, including time spent sleeping (Gauthier et al. 2004). In Australia, for example, mothers spent an additional two hours each week on childcare in 2006 compared to 1992, and the time spent by fathers increased by over three and a half hours (Craig et al. 2010, p. 36). Taking in both paid and unpaid labour, by 2006 the workload of Australian parents—just under 86 hours weekly for mothers and 79 and a half hours for fathers—was considerably greater than that the 61.3 hours and 55 and a half hours, respectively, that were worked by men and women without children.

Contemporary theories of child development and Western popular culture alike spotlight the vital contributions that mothers make in raising their children to be emotionally balanced, healthy, and successful. Such emphasis on the specific contributions of mothers, however, simultaneously raises the stakes of women's ostensible failure if they do not devote constant time, attention, money, emotion, and knowledge about an evolving list of hot topics within child development to the task of parenting. The experiences of Australian women reflect the cultural dominance of 'intensive mothering,' which has deep historical roots (Hays 1996). Historian Rebecca Jo Plant, for example, identifies historical precedent for the darker side of the high expectations of women in the mid-twentieth-century 'assault on mother love' that blamed mothers for perceived social ills ranging from childhood mental illness to the behaviour of American soldiers (Plant 2010, p. 150). Plant writes that even this mid-century onslaught had earlier roots in the 1920s, when there was a 'rebellion against the late Victorian matriarch' and psychotherapy offered new theories about the ways that mothers inflicted emotional damage on their offspring. The post-war years, in particular, are (in)famous as the period when women made their primary contributions to society through marriage and motherhood (Davis 2012). In fact, as Stephanie Coontz has pointed out, for 'most of human history' mothers have shouldered non-childcare responsibilities and thus shared the work of childrearing with others (Coontz 2000, p. 215). If anything is new in the recent past, 'it is the location, not the existence, of maternal work and nonmaternal childcare,' which have increasingly taken place outside of the family home. The post-war years remain a touchstone for those who would ignore this long history of working mothers in favour of supposedly traditional gender roles that involve mothers staying home to care for children instead of working.

Gendered social pressure and policymaking have created an imbalance in the provision of childcare by Australian women and men. The international trend is that men who become fathers do not greatly alter the allocation of their time, while women who become mothers do so in dramatic fashion (Craig and Mullan 2010, p. 1345). In fact, having children in Australia creates a gendered division of labour that is more

pronounced than in the USA, Italy, France, or Denmark. During the 1990s and early 2000s, for example, Australian fathers provided equal childcare to mothers in only one to two per cent of families (Singleton 2005, p. 146). Fathers were 'highly involved' in day-to-day care in a further five to ten per cent of families. Overall, fathers spent around 30% of the time that mothers did on childcare and often enjoyed more 'pleasant, playful or leisure-like' activities with their children. In contrast, the burden on mothers is increased by their multitasking, rigidly timetabled activities, and overall responsibility for planning childcare (Bianchi and Milkie 2010, p. 708). There have been changes to the division of unpaid household labour in Australia, but these have come about as women have purchased market services or reduced their amount of housework, rather than because men have contributed a greater proportion of this work (Broomhill and Sharp 2007).

For Australian women like Rebecca, 'work defines a sense of self' that is threatened by the all-encompassing demands of intensive mothering. Becoming a mother makes these women feel that they 'kind of disappear' as individuals. Hannah, for example, has to remind others that 'I'm a person, a scientist, as well as a mother.' Her children are not 'the defining part' of her life, in the way that idealised versions of motherhood seem to demand. Eleanor, too, describes herself as a 'parent, not as a mother' in an attempt to limit the damage wrought by the 'self-sacrificing' maternal ideal that she says is equally 'valorised' and disparaged in contemporary Australia.

Working motherhood has remained a ubiquitous subject of public debate up to today. In recent years, it has been the topic of best-selling books by authors like Sheryl Sandberg, the chief operating officer of Facebook, and Anne-Marie Slaughter, who left her position as the first female director of policy planning at the US State Department to support her teenage son (Sandberg 2013; Slaughter 2015). The personal writing of these highly successful women has sparked intense public interest in their stories. Slaughter's article describing her decision to leave her powerful position in the State Department, for example, became one of the most-read pieces in the 150-year publication history of *The Atlantic* magazine, attracting an estimated 2.7 million views. Yet popular discussion of motherhood, including on social media, has often

become personal instead of parsing structural solutions such as paid parental leave, which Slaughter advocates in order to support American parents. The so-called mother wars pitch the interests of full-time mothers who are 'projected as lazy and boring' against the interests of working mothers, labelled 'selfish' (Pocock 2005, p. 127).

Some Australian parents, however, identify the false premise of this apparent conflict between women. Kelly, for example, dislikes the 'stay-at-home mothers versus back to the workforce mothers' debate because it ignores constraints on women's decision-making. In reality, she says, 'not everyone has that choice.' In fact, the vast majority of parents in Australia do not have what Kelly calls 'true choice' about how they spend their time while their children are young, despite the judgements that are made by online commentators. Kelly describes her plans to return to work, for example, by citing financial necessity. Likewise, she describes fathers who 'would like to be home more and do more of that childcare' but lack the workplace support that is necessary to do so. Barbara Pocock has pointed out that public attention to the choices of individual women helps to obscure the economic and workplace constraints that are identified by Kelly (Pocock 2005). The 'mother wars' serve the interests of those who wish to stymie policy reforms that would help mothers in their dual tasks of working and caring for their children.

Since the mid-twentieth century, Australian employers have demanded longer working hours and provided their employees less job security. The country's full-time working hours are among the longest in the OECD (Craig et al. 2010). Australian workers report new sources of stress as 'fewer people do more' in workplaces ranging from 'classrooms, factories, hospitals and banks to ambulances and building sites' (Pocock 2005, p. 118). Over the same period, it has become increasingly common that both partners work among Australian couples with children. Yet the culture of inflexible and ever-lengthening working hours is fundamentally incompatible with childcare. In this context, the 'time-poverty, uncertainty and exhaustion' of working parents grow (Pocock 2005, p. 116). Vivienne, a marketing professional, describes the contemporary workplace as 'really stressful and really hard' for both men and women. Caught in this bind, many mothers choose to limit

their hours or their level of responsibility or seniority at work. Fathers' decisions about work, though, 'barely waver' after they have children (Pocock 2005, p. 119). Vivienne points to men's assumption 'that they *have* to work these ridiculous hours to prove themselves worthy in their roles.' This, she says, is far from a 'win-win' outcome for parents, whether they work or provide childcare. Yet the choice to work part-time or to leave a job entirely has lifelong consequences for women in particular, who are likely to face problems re-entering the workforce as well as reduced earnings for future work (Bianchi and Milkie 2010).

In the Western world, increasing numbers of women have worked since the mid-twentieth century and they have done so in unequal conditions. In the late 1940s, the British state urged women to enter employment due to labour shortages. Commonly taking up roles as teachers, nurses, and clerks, women staffed the expanding welfare state of the UK. However, British men and women worked in two separate labour markets: men were 'the real workers' while women were 'considered low-paid auxiliaries working on the side' of their roles as homemakers (Davis 2012, p. 143). This was despite the fact that in 1950 part-time positions accounted for only 11% of women's jobs. In Australia, too, greater numbers of married women went to work in the 1950s, and even more did so in the 1960s and 1970s (Curthoys 1987). In the USA, the number of working mothers expanded at a rapid pace. In 1940, 28% of American mothers with children under the age of 18 were in paid work (Plant 2010, p. 148). The proportion of working mothers increased to 37% in 1960 and grew further to 43% in 1970. This produced urgent public debate about working mothers during the quintessential era of apparently traditional gender roles. Feminism made gender equality at work its 'defining goal' in response to the entrance of huge numbers of women to the workplace (Lake 1999, p. 5). Rather than encouraging women to 'have' or 'do it all,' however, second-wave feminism responded to high rates of labour participation by women (Coontz 2000, p. 154).

In Australia, the 'feminisation' of the workforce has continued alongside the persistently unequal treatment of women in the workplace. Just over a third of Australian women aged 15–64 were employed in 1996 (Broomhill and Sharp 2007, p. 91). The proportion increased to over

half of this group of women by 2002. The most significant change occurred among women who were the most likely to be caring for dependents: those aged between 20 and 54. Over the same period, men's employment decreased from 84 to 72%, mostly due to population ageing (Pocock 2005, p. 116). The rising numbers of women at work are largely explained by their employment in part-time positions that lack job security, such as the report writing that Olivia completes. The spread of such insecure, part-time work is particularly pronounced in Australia where the majority of all part-time workers (72% in 2015) are women (Broomhill and Sharp 2007, p. 92). As historian Marilyn Lake writes, women have 'taken on the world,' and yet the world is still 'structured on men's terms' (Lake 1999, p. 278). Formally, Australian women have won equal opportunities and the right to equal pay, yet the twenty-first-century workplace remains 'geared to the masculine experience of autonomy, mobility and freedom from domestic responsibilities.' Lake concludes that women in Australia 'pay a high price and carry a heavy load' for the independence they enjoy relative to past generations.

Australian governments have been slow to respond to increasing need for childcare support as a result of women entering the workforce. Rather, policy has moved from the post-war male-breadwinner model to a 'modified' male-breadwinner model that is typified in the increasing number of Australian households in which men work full time while women work part-time and care for children (Broomhill and Sharp 2007, pp. 102–103). Feminists in Australia have advocated childcare 'as a matter of women's rights, as good for children and as economic good sense' since the 1970s (Campo 2009, p. 325). Day care services that were designed to support working mothers were not widely available or well respected during the post-war years. The wartime studies of psychologist John Bowlby had convinced many Australians that children should not be away from their mothers (Curthoys 1987). During the post-war years, volunteers funded some preschools in Australia, including those that aimed to educate working-class and Aboriginal children (Curthoys 1989). Such preschools were open for a few hours on two to three days each week and aimed to edify young children rather than to assist working mothers. However, the demand for early education increased at the same time that the wages of kindergarten teachers went

up, and by the early 1970s, voluntary efforts no longer raised sufficient funds. By the 1970s, therefore, day care was a priority for Australian feminists, who lobbied the government to fund it and achieved their goal in 1972 (Curthoys 1987; Lake 1999).

During the 1970s and 1980s, feminist bureaucrats worked to implement government-subsidised childcare as well as equal employment opportunity, equal access to education, free contraceptives, and safe abortion on demand for Australian women (Lake 1999). In 1972, the Australian Arbitration Commission granted women the right to equal pay, although workplace practices have not matched this ideal up to today (Curthoys 1987). In 1984, the Labor government put women's policy 'at the heart of government' by locating the Office for the Status of Women in the Department of Prime Minister and Cabinet (Craig et al. 2010, p. 31). Over subsequent decades, however, there was only incomplete realisation of feminist goals in Australia. In 1996, for example, the conservative Coalition government reduced its spending on childcare, contributing to the privatisation of childcare in Australia (Campo 2009). At the same time, Australian 'baby bonus' payments provided financial incentive to mothers to stay out of the workforce. In 2004, the Office for the Status of Women was moved to the Department of Families and Community Services, reflecting the Australian government's reduced focus on women's rights and the reinterpretation of women's issues as family issues (Summers 2003). Both Labor and Conservative governments resisted the introduction of a state system of paid parental leave until 2011. Yet Australian parents' experiences of parental leave demonstrate the significance of such policies to family finances and the mental health of parents. Kelly, for example, had access to maternity leave and flexible working conditions after the arrival of her firstborn child, but had neither at the time of the birth of her second child, when she worked as a psychologist. She emphasises the multiple benefits of paid maternity leave, which enables parents to 'buy the things you need to have a baby' and make the best decisions about returning to work. Kelly points out that financial support communicates to parents that 'you are valued' for the work of raising children.

Most Australian parents are more likely to accept individual responsibility for solving problems of childcare and paid work than they are

to discuss historical change or describe improvements to social policies. Younger Australian women, for example, explain constraints on their decision-making by 'the limited resources they have available to them as *individual* women' (Everingham et al. 2007, p. 430). The answers to their problems, therefore, depend on personal choices and tailored 'life plans' (Everingham et al. 2007, p. 433). In part, this approach to parenting reflects the greater number of working and social arrangements that are available to young women in comparison with the options their mothers had. Mothers now combine childcare arrangements that include care by grandparents, timing shift work to fit in with the working hours of fathers, part-time work, formal childcare, working from home, and switching industries in pursuit of better hours and conditions. In line with this array of options, many young women emphasise the importance of choice over equity when they discuss their lives. Choices, however, do not make parenting seem easy compared to the experiences of earlier generations. As prominent Australian feminist Germaine Greer observed at the end of the twentieth century, 'women's lives are now better, but harder' (quoted in Lake 1999, p. 278). Alongside their generational advantages, younger women experience new difficulties such as longer hours at work, job insecurity, the necessity of two incomes per family, higher house prices, and increased uncertainty and stress (Everingham et al. 2007).

For all of these reasons, many twenty-first-century mothers feel ambivalent about the ways that life has changed for parents since the mid-twentieth century. Interviewees who participated in a recent study of motherhood in Britain, for example, frequently commented on the difficulties that working mothers faced in the twenty-first century. Perhaps informed by discussions with their daughters and granddaughters, women who belonged to older generations expressed sympathy for newer mothers and imagined their suffering when they were forced to choose between leaving established careers and doing without their earnings or missing out on time with their children (Davis 2012). British women of a range of ages struggled to see solutions to these problems. Many Australian parents feel similarly trapped. Kelly, however, argues that one way out of the bind is for parents to connect their personal stories to the social conditions that help to determine these

experiences. For example, she draws on her own experiences of early parenting to argue for greater flexibility in workplaces, noting that it is important that both parents are at home between five and seven in the evening to help with feeding, bathing, and bedtimes. Kelly expands her discussion to encompass the decisions of parents to live close to their workplaces and, even further, to the design of cities that would enable more people to do so.

Australian mothers are more likely to dismiss as false the promises of feminism than they are to invoke the movement as a rallying cry for the improved support of parents. From the mid-1990s, conservative commentators promoted the idea that feminism has a history of 'despising motherhood and damaging children' (Campo 2009, p. 327). Such arguments were part of an international trend that shifted public attention from the rights of women to the rights of children. Critics claimed that feminism denied women's maternal desires and reframed the achievement of government-funded childcare as 'feminism's biggest mistake,' claiming that paid childcare was detrimental to children. Such social conservatives failed to convince Australian mothers to leave the workplace in order to fully embrace the roles of wives and mothers they had allegedly always desired. They had more success promoting the idea that women's behaviour was the primary cause of dilemmas of modern family life. As a result, few women are 'fully self-confident in the choices they have made' about work and parenting and increasing numbers of women describe themselves as 'postfeminist' (Coontz 2000, p. 278). Vivienne, for example, identifies with a generation of women that 'fought for equality,' yet her experiences as a mother led her to conclude that 'nothing's changed.' Becoming a mother 'shattered' Lola's faith in feminism, too. The movement did not help her and, she says, has 'a lot more to do around motherhood.' Vivienne reflects that for all of the efforts of feminists, 'women are just doing two jobs now' but with an added emotional burden of guilt. Kelly agrees that 'instead of wanting it all, we're actually doing it all now.' But she did not have the choice to stay out of the workforce, and, she points out, Australian social norms and government policy have 'a long way to go' if they aim to 'encourage shared care' between parents. Australian men hold views about women's roles in working and family life that are more traditional than the

perspectives of women (Blunsdon and Reed 2005). Kelly's response to this situation is to ask whether women have been tricked. Young women in Australia do not view gender as the dominant constraint on their decision-making, and yet few among them perceive that Australia is getting closer to gender equity.

The conditions of work and parenting in Australia—the lack of state support, stressful and unequal conditions of employment, unreasonable expectations of mothers, and an individualised ethos of family life—can have devastating effects on the mental health of parents. Early parenthood, Pocock has written, is a 'steady struggle' with 'a sizeable burden of guilt and complex quandaries about care, responsibility, welfare of dependents, and the making of a healthy family as well as a personal identity' (Pocock 2005, p. 113). These difficulties affect men and women in different ways, but few emerge unscathed. Isobelle, for example, faced postnatal depression and a seemingly insurmountable workload in virtual isolation because her husband worked such long hours. She spent twelve-hour days alone with two small children, and after they went to sleep, the pressure did not ease: 'still the washing and the dishes and you've got to fix this and fix that and tidy this and tidy that.' Facing the demands of both work and family, Isobelle's husband felt 'between a rock and a hard place' and did not know how to help. As a new father and an academic, Jon also experienced 'pressure on at work' and 'pressure on at home.' He describes feeling 'strong' after the birth of his child until the demands became more overwhelming and 'I just cracked.' After Jon 'broke down' at work, he began to discuss his feeling with friends who, he discovered, also felt 'stress, panic, fear.' Jon concludes, 'it's not just me who's been going through this.' Jon and his wife plan to rearrange their roles so that he will be at home with their two children for half of the week.

Australian parents frequently describe ways that the pressures of parenting get in the way of communication between couples, yet mutual understanding becomes a source of strength for some. In fact, having children often leads parents to adopt apparently traditional gender roles that get in the way of mutuality. For example, Lola describes a 'fairly balanced' relationship with her husband that 'all went out the window' after they had children. On becoming parents, she says, their

lives became 'intensely divergent' and 'intensely traditional.' Meaghan avoided this experience while her baby was newborn because both she and her partner took time off work. She remembers that she felt that the three of them 'were in it together' when the couple put their baby to bed and, in concert, watched him sleep. However, Meaghan observes that 'the balance has shifted' since she began to study and her partner took greater financial responsibility for the family. He works longer hours and on weekends; she shops, cooks, and cleans. Even when the family spends time together at weekends, Meaghan says with frustration that she is now expected to be 'in control' of parenting. The birth of their second child pushed Kelly and her partner into just this kind of 'very gendered' relationship, despite their efforts 'to be equal.' All of these women feel 'stuck' in narrow roles that they dislike. Kelly, for example, does not enjoy the 'domestic stuff' she has to do. Meanwhile, her partner 'doesn't make a lot of money' as an artist, but he is responsible for the family's earnings. The arrangement, she says, threatens 'the fundamentals of who we are.' Many Australian parents struggle to discuss such feelings. Olivia, for instance, describes the effects of having children on her relationship with her partner as dramatic: 'a bomb going off.' While caring for their young baby, the couple are 'hardly speaking' because it is 'so difficult, juggling the work, and no sleep and feeding every two hours.' Likewise, Kelly has two children and, with the new arrival, finds even 'less time' with her partner 'to even talk to each other' or think about their relationship.

Direct experience of their partner's lot helps some parents to feel happier about the compromises that each of them has made. Alexander, for example, began his story as his family's 'breadwinner.' He often worked away from home and was not 'as helpful as I wanted to be' with his children. This changed when, after having twins, his wife experienced '84 consecutive days of no sleep' and was admitted to a psychiatric ward for a month. Being a full-time parent and, eventually, a father to four children gave Alexander 'a deeper understanding' of the challenges that his wife faced. He says, 'I've had to eat humble pie and say sorry quite a few times for how I used to behave,' including when he felt critical of his wife for failing to do housework. In turn, Alexander discusses the difficulty of getting his wife 'to switch off from work' and give him the 'adult attention

and conversation that I crave.' Both agree, he says, that 'it is an easier option to head off to work and earn the bread.' Yet Alexander does not miss the 'tight deadlines and unrealistic expectations' his wife must navigate in the workplace. Eleanor traded roles with her husband in this way after he lost his job when their baby was ten months old. Initially, her husband had expected that Eleanor's work in higher education would be scaled back because she earned less than he did. Eleanor felt that her husband was unsupportive and resented that he continued to pursue 'the same life he'd had in the past.' After she became the family's primary earner, however, Eleanor realised that she, too, had made unfair assumptions. Eleanor had anticipated a degree of freedom to pursue work on the basis of her interest rather than pay and had therefore assigned her husband responsibility for keeping the family finances afloat. Eleanor celebrates the couple's new empathy and 'understanding of each other's situation,' which she calls the 'blessing in disguise' of a seemingly desperate situation.

Conclusion

The difficulties of negotiating paid work and childcare are widely shared. Australian parents identify hardships that cross lines of gender and generation and connect to the historical and contemporary experiences of parents in the USA and Britain. Since the 1980s, policymaking in these countries has commonly required parents to work and increasingly allocated care for children to the market (Broomhill and Sharp 2007). At the same time, states have removed social support and pushed the responsibilities of care back on to families. Consequences include inadequate services for children; poor quality and expensive childcare; inadequate training, pay, and conditions of employment for those who work in care; unrewarded unpaid labour, especially by women; and difficulties that are caused by the migration of families in search of work away from grandparents and others who might otherwise help. Working mothers, in particular, struggle with 'the contradictions of their lives, the utter impossibility of their predicament' (Lake 1999, p. 278). Interviews with Australian parents reveal some of the personal costs of the high and uneven workload and time poverty that is evident in national and international data.

Despite the broad reach of these problems, many parents believe that the responsibility falls to them alone to solve the knotty concerns of work and parenthood. Over the past 70 years, public discussions of work and childcare in Australia have most often spotlighted the behaviour of mothers instead of fathers, typically in place of considering structural solutions. Conservative voices have undermined the explanatory framework that was once offered by the collective goals of feminism by arguing that the movement has undermined the maternal instincts of women and their freedom to choose to care for children. In fact, women worked in considerable and increasing numbers before the advent of women's liberation. Plant reminds us that 'diminishing respect for motherhood and homemaking' also predated the resurgence of feminism in the USA (Plant 2010, p. 149). Yet critical accounts of feminism have reversed these explanations for the causes and effects of women's employment and have therefore misrepresented the legacies of feminist politics. The argument that feminism wrongly encouraged women to think that they could 'have it all,' for example, is an 'over-optimistic assessment of feminism's reach' and ignores the work of important feminists who put motherhood at the centre of their activism (Pocock 2005, p. 130). Yet the criticism rings true to many Australian mothers dealing with impossible demands on their time. In fact, the explanation for their predicament is the incomplete realisation of feminist goals that has left women's wages low, their working conditions stressful, and many men unwilling to do their share of child raising and domestic work (Coontz 2000).

Interviews with Australian parents demonstrate the emotional benefits that some couples experience after learning that their hardships are shared. These couples have not solved their impossible predicament, which urgently requires attention from governments and employers. Some among them imagine potential structural reforms ranging from equal household contributions by mothers and fathers, to the improved designs of cities. Most, however, share Olivia's feeling that the challenges of parenthood are impossible to plan for and the best couples 'can hope for is that you can travel it together and support each other.' Taken together, the voices of Australian parents demonstrate how often individuals feel personally responsible for systemic failures and highlight

the sad consequences of these misattributions for the mental health of women and men. The ways that parents negotiate paid work and childcare reveal serious constraints on the decision-making of couples who juggle multiple obligations between two people, but rarely receive sustained support from outside the nuclear family. Australian parents are not able to make choices based on enjoyment or parental attachment alone, a point that is commonly ignored in popular appraisals of the behaviour of mothers. The common hardships of working parents present a potential source of emotional strength and collective motivation to demand the social and political change that is necessary to their lives.

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Appendix

Emotional Experiences of Early Parenthood in Australian Families Project: Participant Demographic Characteristics

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Pseudonym	Gender[1]	Age	Occupation[2]	Employment[3]	Relationship status[4]	Number of children	Number of persons in household	Migrant?[5]	If international migrant, region of origin[6]	Migrant partner?[7]
Adrian	m	40–49	Professional	f/t	m	2	3	I	EAP	No
Alexander	m	30–39	At-home parent	f/t	m	4	6	No		No
Amelia	f	30–39	Professional	p/t	m	1	3	I	E	I
Ava	f	40–49	Professional	p/t	s	2	2	No		n/a
Ayesha	f	Nr	At-home parent	f/t	m	4	13	I	SCA	I
Bethany	f	30–39	Community and personal services worker	p/t	df	1	3	No		No
Brett	m	30–39	Professional	f/t	df	3	5	No		No
Caitlyn	f	30–39	At-home parent	f/t	s	3	5	D		n/a
Celine	f	40–49	Professional	f/t	m	3	5	No		No
Daphne	f	30–39	Sales worker	p/t	m	1	3	No		Nr
Delia	f	30–39	Student	f/t	sp	5	6	I	A	n/a
Eithne	f	40–49	Professional	p/t	m	6	8	No		I
Eleanor	f	30–39	Professional	f/t	m	2	3	No		I
Elsa	f	40–49	Professional	p/t	m	2	4	No		Nr
Esther	f	30–39	Professional	p/t	m	1	3	I	SCA	I
Freya	f	30–39	Manager	p/t	m	1	3	No		I
Georgina	f	30–39	Professional	p/t	m	1	3	No		D
Graeme	m	40–49	Community and personal services worker	f/t	sp	2	3	No		n/a

(continued)

(continued)

Pseudonym	Gender[1]	Age	Occupation[2]	Employment[3]	Relationship status[4]	Number of children	Number of persons in household	Migrant?[5]	If international migrant, region of origin[6]	Migrant partner?[7]
Hannah	f	30–39	Professional	p/t	m	2	4	No		I
Helen	f	40–49	Professional	f/t	df	1	3	No		No
Isobelle	f	30–39	Professional	p/t	m	2	4	No		No
Jack	m	40–49	Manager	f/t	df	2	4	No		No
Jon	m	30–39	Professional	f/t	m	2	4	I	E	I
Kathleen	f	30–39	Professional	p/t	df	1	3	I	NA	Nr
Kelly	f	30–39	Professional	p/t	df	2	4	No		No
Laura	f	30–39	Professional	p/t	dv	2	3	No		No
Leah	f	30–39	At-home parent	f/t	df	1	3	D		D
Lola	f	30–39	Professional	p/t	m	2	4	D		No
Lua	m	40–49	Student	p/t	m	3	1	I	EAP	Nr
Lucy	f	20–29	At-home parent	f/t	df	2	4	D		I
Maddy	f	20–29	Student	p/t	m	2	4	No		No
Margaret	f	30–39	Manager	f/t	m	2	4	No		Nr
Marie	f	40–49	At-home parent	f/t	m	2	2	I	EAP	I
Mary	f	30–39	Professional	f/t	m	2	4	I	A	I
Meaghan	f	30–39	Professional	p/t	df	1	3	I	E	No
Nadir	m	Nr	Professional	f/t	m	1	3	I	SCA	I
Nina	f	30–39	Professional	p/t	df	2	4	No		No
Olivia	f	40–49	Professional	f/t	df	2	4	No		No
Priya	f	30–39	At-home parent	f/t	m	1	3	I	SCA	I

(continued)

(continued)

Pseudonym	Gender[1]	Age	Occupation[2]	Employment[3]	Relationship status[4]	Number of children	Number of persons in household	Migrant?[5]	If international migrant, region of origin[6]	Migrant partner?[7]
Raha	f	30–39	Student	f/t	d	1	4	I	SCA	n/a
Rebecca	f	30–39	Professional	p/t	m	2	4	No		No
Robert	m	40–49	Professional	f/t	s	1	2	No		n/a
Rory	m	<20	Student	f/t	e	1	3	No		No
Rosemary	f	30–39	Professional	p/t	sp	1	2	No		n/a
Sharon	f	<20	Student	f/t	df	1	3	No		No
Sophie	f	30–39	Manager	f/t	m	3	5	No		No
Sylvia	f	30–30	Student	f/t	m	1	2	I	E	No
Vivienne	f	40–49	Manager	p/t	m	3	5	No		No

NB: responses reflect status at time of the interview. In cases when an interviewee, for whatever reason, did not respond to a question, this is noted (nr)

[1]All interviewees gave their gender as either male (m) or female (f)

[2]Australian Bureau of Statistics. (2013). *Australian and New Zealand Standard Classification of Occupations, 2013, Version 2*. Retrieved from http://www.abs.gov.au/AUSSTATS/abs@.nsf/allprimarymainfeatures/4AF138F6DB4FFD4BCA2571E200096BAD?opendocument

[3]full-time (f/t); part-time (p/t)

[4]de facto marriage (df); divorced (dv); married (m); single (s); separated (sp)

[5]Australian-born (No); international migrant (I); interstate, domestic migrant (D)

[6]Africa (A); East Asia and Pacific (EAP); Europe (E); North America (NA); South and Central Asia (SCA)

[7]For interviewees without partners this question was not applicable (n/a). For those who responded in the affirmative, a distinction was made between international (I) or interstate, domestic (D) migrants

Author Index

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Subject Index

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