PRODUCING THE NEW MOTHER

SURVEILLANCE, NORMALISATION AND MATERNAL LEARNING

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CERTIFICATE OF AUTHORSHIP/ORIGINALITY

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of Candidate

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ACKNOWLEDGMENTS

Over the past 7 years, I have been privileged to meet fifteen very special women who so willingly shared their experiences of learning to mother. It was with great sadness at the end of the third interview that I left each of their homes for the last time. I will always treasure the camaraderie, tears and laughter we shared during the interviews. I hope, they will approve of the readings I have provided of their stories about motherhood.

I have been very fortunate to have Alison Lee as my supervisor. Alison has willingly shared her knowledge and insights, and provided a rigorous training in scholarly writing. I will always be appreciative of the respect and feelings of confidence in my ability to complete this study that Alison has provided during the past 7 years. I would also like to thank Jill White for her encouragement and for sharing her understandings gained as a nurse, midwife and mother. Griff Foley for the support and encouragement he provided as my supervisor during the beginning stages of this study.

This doctoral experience would have been very lonely without two very special friends Jill Molan and Jane Durie who have supported me during the past years and months as I struggled, at times, to complete this thesis. I have particularly appreciated their honesty and laughter as we tried to untangle and understand many of the poststructural texts. Jill and Jane also read many of the initial chapters and provided valuable guidance during the early writing stage. Jane, thank you for providing chapter 5 with a title, *Motherhood under surveillance?* Several friends, Vivian Morrigan, Chris Rossiter, Ann De-Belin and Nick Kowalenko, have assisted by listening to my ideas, reading parts of this thesis and offering feedback at different stages.

I have left the most important acknowledgments to the end. My husband Brian and sons Hugh and Martin have sustained and helped me balance the many demands placed on my time with such love and good humour. Unconditional support and love

has been provided by my family and close friends even when it would have been easier to encourage me to stop. Thank you.

NOTES ON NOTATION

For convenience I will refer to this research project throughout the thesis as the *New Mother research study* to distinguish it from other research projects about mothering.

The names of participants and some identifying details have been changed in accordance with confidentiality agreements. My name has been maintained in the examples of transcript data to avoid confusion when reading the extracts.

Extracts of the transcribed tapes are indented. Since the approach taken with these extracts is not a linguistic one, the conventions of linguistic transcription have not been appropriate to the investigation in this thesis and therefore, in the interest of readability, have not been employed.

The women's pauses occurring within the interviews have been identified by .... of differing lengths within the extracts to denote the length of the pause.

In preparing the transcripts, in most instances, hesitation phenomena such as ummhs, arrhs and other background utterances have been replaced with equivalent .....

Italics are used to signal words of a participant that are being repeated within the analysis. The purpose of this notation is to achieve a more readable text.

'Scare quotes' are used to enclose a term and draw attention to its use which is in some way under revision.

ABSTRACT

This thesis is an investigation of maternal learning through the experiences of fifteen women who were learning to mother their first born infants within a white anglo-centric culture. These women provided stories about their experiences of pregnancy, birth and the early days of mothering during a series of interviews.

Poststructural and feminist approaches have been used to inform this research study. These approaches have resulted in an analysis that troubles several of the dominant maternal discourses that are frequently used in two complementary ways: first, to explain the seemingly inexplicable ability to mother as 'maternal instinct', and second, within a specific culture, to provide the criteria for maternal attitudes and behaviours. The use of a poststructural framing has enabled an unsettling of the frequently accepted and taken-for-granted understandings about maternal learning through asking *how it works and why women act in certain ways and not in other ways?*

There are two major sections to this thesis. The first section provides a theoretical positioning within the practice disciplines of adult education, parent education and nursing, and an overview of poststructural and feminist understandings and research applications of discourse analysis. The analysis work of this thesis commences within the second section where maternal discourses are examined and the resulting discursive constructions of maternal subject positions are foregrounded. Tensions and contradictions within the women's stories are explored and taken-for-granted explanations about women's apparently inexplicable or 'natural' ability to mother are challenged. Counter constructions for the taken-for-granted understandings about maternal ability are offered through the use of the discourses of memory, habitus and incidental learning. These three discourses assist in thinking about maternal learning and why some women have such difficulty taking on the multiple subject positions of motherhood, while the ability to mother seems to 'just happen' for other women.

Of importance to this study is the inability of language to provide a common meaning for maternal experiences or to adequately portray the complexity of

maternal experience, learning and knowledge. This understanding signals the possibility for maternal knowledge being a predominantly 'somatically' based knowledge acquired throughout a woman's life as an outcome of incidental learning. The recognition of somatic knowledge as an important element in the development of maternal knowledge has significant implications for nursing practice, and the way in which maternal learning is facilitated.

Chapter 1

Positioning the Study

This thesis is about the experience of learning to mother for the first time. The thesis will also be about learning and the ongoing construction of knowledge as the women within this New Mother study explore and challenge the circulating discourses which are used to define and control motherhood within western knowledge systems.[1] In attempting to gain understandings about how women learn to mother I will draw on poststructural and feminist approaches. These approaches will be used to understand the complex and often subtle interplay of subject positions, language, memories and experiences. This interplay is frequently mediated by several factors: the régimes of truth, disciplinary practices of bio-power; the women's use of surveillance and disciplinary practices; and their active participation in the subversion of surveillance and disciplinary practices.[2] Poststructural and feminist understandings provide a useful and powerful research approach for exploring the tensions, similarities and contradictions within the research data and the professional literature and everyday information about maternal learning. These understandings and research approaches will be explored within Chapters 2 and 3.

The underlying argument of this thesis is that mothering is a complex and socially mediated experience, which cannot be quantified or standardised to a framework which seems to normalise the act of learning to mother. Women construct their maternal knowledge to meet their situational needs and make sense of what is occurring in their lives. They frequently use professional and others' knowledge about mothering, and predominantly draw on informal and incidental knowledge gained

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1 This research project will be referred to as the New Mother study throughout this thesis.

2 The term 'bio-power' is used by Foucault (1978) to describe the practices used to control and make more productive subjects of a particular society in which they live. A detailed discussion of this term will occur in Chapter 2 and 5.

from memories, experiences and previous understandings, adapting these to create new knowledge to meet their needs. Learning to mother can be constructed as a constant process of shifting positions, trying to fulfil maternal, infant and community desires and expectations, and of overcoming physical and emotional obstacles.[3]

The professional literature about maternal learning has a primary focus on assisting women acquire maternal knowledge using formal learning approaches through attendance at childbirth and parenting groups.[4] Within the professional literature minimal attention has been given to investigating other constructs of learning such as informal and incidental learning, which I argue provide a significant contribution in assisting women learn to mother.[5]

Informal and incidental knowledge are frequently gained through everyday experiences, which are often more closely linked to the immediate learning needs of women. The recognition of informal and incidental learning challenges the focus and reliance on formal education approaches to assist women learn to mother and raises questions about knowledge and learning such as: what does it mean to learn to mother; how do women achieve this learning; what assistance do they need to learn; how does a mother's knowledge differ from professional knowledge about mothering; and how are women positioned while endeavouring to learn about mothering?
This thesis does not attempt to provide a model or framework of how to prepare women to 'become' mothers. To the contrary, it will problematise such things as the

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3 Physical obstacles new mothers may experience include: ill health, a difficult childbirth experience, breastfeeding problems and sleep deprivation. Emotional obstacles which mothers may experience include: conflicting information, failure to fulfil expectations, perceived loss of previous subject positions, diminished access to adult interaction and learning to separate from their infants.

4 Professional literature about maternal learning is mainly found in nursing, psychology or medicine journals.

5 The major theoretical understandings about informal and incidental learning have come from the area of workplace learning, for example see the work of Marsick and Watkins (1990); and Garrick (1998; 1996).

régimes of truth or beliefs and rules which have been established about mothering; what is accepted as maternal knowledge; and the way women are discursively positioned through the stories they construct.

Within this first chapter there are three sections. The first section provides an overview of this New Mother study, and a brief insight into the reasons I chose to investigate 'how women learn to mother for the first time'. In the second section, the research project is positioned within a context of parent education, adult education, and the nursing practice areas of midwifery and child and family health nursing.[6] This second section introduces the education discourses of formal, informal and incidental learning used in this thesis. The third section outlines the thesis content by providing a summary of each of the following chapters.

1.1 The New Mother study: an overview

1.1.1 The women and their stories

The women who participated in this New Mother study have played a central part in constructing the story that is this thesis. Fifteen women participated in a limited longitudinal study of nine-to-twelve months duration, during the time the interview data were collected. These data consist of three extended semi-structured interviews which are based on a dialogue with each woman. The interviews explore the women's learning and experiences of pregnancy, childbirth and the first months of mothering.

At their instigation, the women met as a group to share their experiences of participating in this research project. This group meeting occurred after the series of three interviews were completed. The meeting also provided an opportunity to feed back initial findings of the research.

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6 The term nursing will often be used throughout this thesis to encompass child and family health nursing and midwifery. In combining these two nursing specialities I acknowledge that midwifery may be described as being outside nursing, particularly in countries where a midwifery direct entry system exists; that is midwifery is offered as an undergraduate degree.

The geographical and contextual focus of this New Mother study is Australia, and in particular, Sydney, New South Wales. This study was limited to Sydney for practical reasons as each state within Australia has its own infrastructure for the offering of health and education services to its citizens, and the fifteen women who participated within the New Mother study lived in the greater metropolitan area of Sydney. Acknowledgement is given that this New Mother study does not attempt to explicitly investigate differences among various cultural groups and their practices of mothering.

Committing the women's stories of mothering to written text has on first reading reduced the stories to a one dimensional experience which does not capture the joy, pain and ambivalence which frequently envelops motherhood. A second reading, using techniques of discursive analysis drawing on the work of Michel Foucault, starts to tease out the complexity of the stories and reveals the problematic relationships of the discourses and régimes of truth which circulate about mothering.

During each interview the women told stories about their maternal experiences and other related experiences as children, with their own mothers and their partners. These stories were often interwoven with the experiences of other mothers they knew, providing additional examples, comparisons and frequently justification for maintaining or infringing the dominant discourses of motherhood.

The women's stories are not being used within this thesis as the authentic representation of their experiences (Usher & Edwards 1994) or as 'objects of knowledge'. As Code argues "when subjects become objects of knowledge, reliance upon simple observational paradigms has the consequence of assimilating those subjects to physical objects, reducing their subjectivity and specificity to interchangeable, observable features" (1993, p. 32). Rather, these stories are being used to identify and trouble the social practices and discourses which produce the 'new mother'.

1.1.2 Shifting positions

> Sitting on the kitchen floor nursing my four week old son the tears flowed. Feelings of sadness, isolation and loss engulfed me. Motherhood was meant to be easy. So many people had told me it would be, especially for me as a nurse and midwife. I knew so much about babies. Even though many mothers had tried, no-one had been able to prepare me for the indescribable tiredness, the never ending physical and emotional demands on my exhausted body, and the horrible moments of panic, doubt and uncertainty. What would it be like if I had a sick or unsettled baby? Luckily my baby was a 'good' baby!

This introductory story is mine; it was written as part of the reflective process used to identify the reason for becoming interested in the question of 'how women learn to mother for the first time'. The story is a snapshot into my past as a mother of a newborn baby and the initial lack of awareness I had of the differences between my knowledge of mothering, as a mother and as a nurse. The story is partial and it is a construction of an experience of seventeen years ago, when my first son was a four week old infant. There remain many untold parts of the story, in particular, the moments of overwhelming feelings of love, joy and wonder in nurturing my son. Several important things have happened to this story: firstly, the story is being told with hindsight and only the parts of the story which are within my conscious recall have been told. Secondly, it has also been edited for the readers of this thesis to make sense and to provide an understanding of the mothering positions I occupy as part of the multiple positions which have been taken up and which influence this New Mother study.

I became a mother believing that my professional knowledge and experience would support me, that I would 'know' how to care for my newborn son. To my utter amazement, mothering my own infant was a totally alien experience, which did not match with the understandings I had developed as a health professional. Advice that I had given and which I had assumed worked for other women sounded inappropriate and often impossible to implement with my own baby.

After returning to the paid workforce as a child and family health nurse, I experienced a growing uncertainty and dissatisfaction with the advice and strategies I offered to women as they learned to care for their babies and negotiate the multitude of problems they encountered each day. The dissatisfaction I experienced grew out of a feeling of inhabiting two different worlds, nursing and mothering.

The first is the reasonably organised world of nursing which assumes there is usually an answer for most problems and that safe and accepted nursing practice should always be uppermost in any advice giving.[7] This advice giving is frequently based on the knowledge, explicit rules and surveillance practices developed by expert health professionals, governments and the communities in which women and their families live, often resulting in conflicts with the nurse's own experiences of mothering.[8] There is also an unspoken rule of keeping an emotional distance from mothers and only very cautiously using a nurse's own maternal experience. This unspoken rule is often invoked in the name of maintaining a professional distance from the people whom we nurse.

The second world is the disconnected, chaotic world of mothering, which differs from the more predictable world of an adult without an infant.[9] This world of mothering frequently results in women not knowing what will happen or what physical or emotional responses will be necessary to care for their infants as developmental changes start to occur and the infant achieves new skills. These changes frequently result in emotional and physical challenges for women to respond to the infant's

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7 This need to provide advice is compounded by the overwhelming desperation of many mothers (parents) to find answers and solutions to the child rearing problems they are confronted with on a daily basis, which they have often constructed as being abnormal or that there is something wrong with their baby.

8 These rules are identified as population based rather than individual in origin which inevitably results in frequent tensions and misfits.

9 It is not uncommon for women to talk about feelings of disconnection and isolation from the adult world of work and friends without young children. These feelings can escalate into feelings of abandonment and a total lack of spontaneity (LeBlanc 1999).

demands before their own needs or desires. The often conflicting challenges and emotions of motherhood have been named by Benn (1998) as 'entanglement'. She proposes that entanglement can be called maternal 'anxiety' or 'love', depending on a person's inclination or reading of the situation. The outcome can be feelings of ambivalence and even anger as an incongruity occurs between the once joyfully anticipated fantasy of mothering and the actual embodied experience of mothering.

To inhabit these two worlds simultaneously is difficult because, at their various points of intersection, the everyday experiences of caring for an infant and the régimes of truth which have been set up to guide and discipline women and health professionals collide. The resulting near misses and collisions cause contradictions and tensions to develop between the multiple positions of mother and nurse.

The disjuncture between professional and maternal knowledge and experience raises a challenge to the status of professional knowledge and practice and the way in which maternal knowledge and experience is constructed. For example, can health professionals who have not experienced the turbulence, ambivalence and joy of motherhood adequately connect to women's experiences as mothers; does having had the experience of learning to mother enhance or cause conflicts and contradictions in the way a health professional works with mothers; and do understandings about the status of professional knowledge, judgement and practice in relationship to maternal knowledge need to be altered?

In sharing this story of an incident during the early days of learning to mother my own child, I want to expose several issues: how maternal experience can bring into question the authority I had assumed as a health professional; the contradiction and confusion which exist in many aspects of maternal functions; and the lack of appropriate preparation and understandings that can occur even for a seemingly competent, well prepared and experienced child and family health nurse and midwife.

1.2 Positioning the research

In Australia, it is acknowledged that the provision of parent education for pregnant women and women in the early months of motherhood is a needed and an accepted activity for health professionals (Standing Committee on Social Issues [SCSI] 1998; Tomison 1998; New South Wales Health Department 1995; Northern Sydney Area Health 1995; Parent Education Review Committee 1991; Southern Community Health Services Research Unit 1990; Shearman Report 1989).[10] This provision of parent education has been confirmed as being crucially important by a recent NSW Parliamentary inquiry into the state of parent education and support in New South Wales. Two of the resulting major findings of this inquiry were the identification of, first the long term physical and mental health benefits for the child, family and the community in general; and, second, the importance of providing a diverse range of programs to meet the differing needs of parents (SCSI 1998).

Parent education is clearly a political act with economic and social implications. Providing parents with skills development programs is often identified as an investment in the future of children and families, through the improvement of the children's developmental potential, improved nutrition and thereby the health of children, improvement in the immunisation rates, reduction in the incidence and perpetuation of inter-generational violence, and the development of social support networks for mothers with young children to reduce the onset or impact of mental health disorders (SCSI 1998; Tomison 1998).[11]

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10 The term parent education will be used to encompass one-to-one advice giving and parent education groups.

11 The long term importance of parent education was identified as a recommendation from a telephone survey of Queensland parents with children under twelve years of age about their disciplinary techniques where the results pointed to the need for the provision of education for parents prior to or just after birth (Sanders, Tully, Baade, Lynch, Heywood, Pollard & Youlden 1999). The provision of parent education programs from an early stage of parenting may have the effect of developing parents' potential to being able to set and apply consistent behaviour limits.

Programs and information-giving are often altered to include the latest government policies and guidelines, cultural and religious beliefs, and the personal beliefs of the educator. Parent education can be identified as an accepted means by which parents and, in particular, women, are moulded and constrained to conform to the current discourses and practices of how a 'good' mother (parent) should behave.

The nursing specialities of child and family health and midwifery, and the field of adult education, in particular, parent education will provide the contexts from which to position this research and the activities of parent education. In using these two fields of practice as the primary positions from which to speak, I acknowledge the need to blur the boundaries of nursing and education in which this research and I as the researcher, position myself and will be positioned by others.

Learning to mother requires much more in terms of knowledge and skills than can be offered by nursing and education, as this thesis will attempt to demonstrate.[12] However, the identification of the complexity and diversity of sites of learning maternal knowledge does not diminish the important and at times vital functions nursing and education have in supporting and assisting women during the early stages of maternal learning.

The following section will start to explore the construction of how women learn to mother within the relevant literatures and identify the factors in the practice areas of parent education, adult education and nursing which have influenced this New Mother study. The literature about maternal learning which has been used to inform this research study has been drawn from a number of disciplines — nursing, midwifery, women's studies, education, psychology, sociology, anthropology and medicine.

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12 The same implications are extended to other health professions — as nursing draws from and contributes to other health professions.

1.2.1 Parent education

Parent education has become a diverse field of practice encompassing education from pre-conception and usually offered until the end of the teenage years (SCSI 1998; Allan 1994). However, because the New Mother study will concentrate on the periods of pregnancy, childbirth and the first months after the birth of the baby, this period will be the principal focus of this literature review. In this section the focus and provision of parent education within the literature will be discussed.

Even within this limited time frame of the period encompassing pregnancy, childbirth and the early months of motherhood, the literature identifies and promotes a diversity of programs for 'expectant' (e.g. Underdown 1998; Nolan & Hicks 1997; East 1996; Evans & Jeffery 1995; Vehviläinen-Julkunen 1995; Sargent & Stark 1989) and 'new' parents (e.g. Regan & Lydon-Rochelle 1995). Expectant and new parent programs often focus on the learning needs of new mothers to prepare them to manage the first months of their infants' lives. The usual bases of these programs are the developmental stages of the child or parent and the health professional perception of what specific information parents require at each new developmental stage, or programs to address specific issues such as breastfeeding (e.g. Cox & Turnbull 1998), very low birth weight infants (e.g. Brooten, Gennaro, Knapp, Brown & York 1989) and postnatal depression (e.g. Pitts 1999; Mauthner 1997; Morgan, Matthey, Barnett & Richardson 1997).

Of all the programs during the childbearing period, childbirth programs seem to be the most readily accessible, as they are available in hospitals, within community health centres and through private organisations. However, in a survey of childbirth classes of the Illawarra area of NSW it was found that of the one hundred and forty three postnatal women surveyed only thirty five percent attended childbirth classes (Lee & Shorten 1998/99, p. 137). The women who attended the classes found them informative and valuable in reducing anxiety and increasing confidence. Of interest in

this survey are the sixty five percent of women who did not attend classes and the reasons for this non-attendance. Unfortunately, only minimal information is available about the non-attendance of the women at the classes.[13]

General agreement exists that childbirth classes "... aim to prepare women and their partners for childbirth and early parenting, but beyond that there is as much diversity of content as there is diversity of style and structure" (Brown, Lumley, Small & Astbury 1994, p. 84). The diversity of program content is frequently a result of the belief structure of the organisation and the qualifications of the educators (SCSI 1998; Nolan & Hicks 1997).[14]

In England, Riley (1995) identified that most childbirth classes are attended by middle-class women and, if working class women did attend, they had a higher drop-out rate. A similar situation has been alluded to by Brown et. al. (1994) as existing in Australia. For example, more women with private obstetricians attend childbirth classes than women who attend public hospital antenatal clinics (Brown et. al. 1994). The issue of appropriateness of parent education program content and access to parent education was a significant focus of the recent Parliamentary SCSI (1998) inquiry into parent education and support programs. Concerns were raised by many of the submissions that, even with widespread availability of parent education and support programs, these programs are rarely sought by parents and especially disadvantaged families. (SCSI 1998).

For example, this lack of attendance at formal parenting classes was identified through a survey conducted for the NSW Parliamentary Standing Committee on Social Issues,

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13 Only women who had attended and completed the program were included in the research. Some of the reasons provided for non-attendance at the antenatal education program included conflicting time with other commitments, pregnancy-related health problems and two women had partners who found the classes boring.

14 Parent educators are not limited to health professionals, but reflect a number of professional disciplines, as well as non-professionals (SCSI 1998).

in April 1998, of seventy six families who are clients of Barnardo[15] (these clients comprised families from disadvantaged backgrounds) and found that: forty one families had never used formal parenting classes; fifty one families had used self education to find out about parenting; and sixty seven families had used early childhood health services while eight families had not used these services (Turvey 1998, p. 12).[16] A similar result was found in a Western Australian survey where only ten percent of parents identified that they had attended formal parenting classes (AGB McNair 1994, p. 20).

It can therefore be proposed that formal parent education programs and groups are a minor aspect of the education process for many women when learning to mother (SCSI 1998). In taking this view, an argument can be developed that the majority of maternal learning occurs through informal mechanisms such as: learning through trial and error; learning from their infants, the media, parenting books and resources; learning from their own mothers or other mothers; and through observing interaction between other people and young children.

However, the parent education and mothering literature provides an overview almost overwhelmingly of maternal learning which is mainly achieved through formal programs and contact with health professionals. These learning opportunities are often discussed in terms of: formal program evaluation (e.g. Morgan et. al. 1997; Handfield & Bell 1995; Regan & Lydon-Rochelle 1995; Stamp, Sved Williams, & Crowther, 1995; O'Meara 1993)[17] performance of women as mothers (e.g. Evans,

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15 Barnardo is a non-profit organisation which supports and assists families experiencing disadvantage and/or crisis.

16 One family did not respond to this question.

17 For examples of formal program evaluation see Handfield & Bell (1995) who evaluate the role of childbirth education at the Royal Women's Hospital Family Birth Centre, Melbourne; Lee and Shorten (1998/99) evaluated childbirth classes in the Illawara area of NSW; and Morgan et. al. (1997) for an evaluation of a group program for postnatally depressed women and their partners.

Dick & Clark 1995; Prodromidis, Field, Arendt, Singer, Yando & Bendell 1995)[18]; and the identification and/or amelioration of potential mental (e.g. Pitts 1999; Beck 1996; Gottlieb & Mendelson 1995; Rodd 1992)[19] and physical (e.g. Beger & Loveland Cook 1998; Small, Astbury, Brown & Lumley 1994; Smith 1989)[20] health problems encountered by women and young children. Unfortunately, the resulting discussions have rarely acknowledged or explored the possible interplay of different ways of learning[21], or the resulting types of maternal knowledge.

The major focus of research on parent education programs has been the evaluation of preparation for childbirth and parenting, which usually include the father/partner (e.g. Lumley & Brown 1993; Barclay 1994). Evaluation of these programs is often based on the criteria set by the program facilitators with minimal account of the needs of the parents who attended the program (SCSI 1998; Shearer 1993). This point is reinforced by Barclay: "classes often were instituted by hospitals to provide the information that women had not been provided with in a rushed antenatal consultation in a doctor's rooms or clinic. They were also a part of creating expert's knowledge and discouraging a reliance on community wisdom" (1994, p. 17). Nevertheless, prenatal and postnatal education provision has been found by Moran, Holt and Martin (1997) to not adequately address a new mother's need for self-care and infant care

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18 For example, Prodromidis et. al. (1995) found that mothers rooming in with their infants looked at, talked to and touched their new baby more and in more intimate places than mothers with minimal contact.

19 These mental health promotion activities include interventions to minimise postnatal mood disorders and maternal adjustment disorders, and improve infant-maternal attachment. Kelly, Morissett, Barnard & Patterson (1996) studied the risk factors for children's intellectual development possibly resulting from low maternal intelligence. Case studies are used to demonstrate how low cognitive functioning compromises maternal caregiving.

20 These physical health promotion activities include the provision of education about the importance of breastfeeding, immunisation, and hand washing. Health promotion activities are also aimed at alleviating maternal fatigue and improving parental lifestyle factors (exercise, reduce alcohol consumption and stop smoking programs).

21 For example, no discussions were found about the interplay of learning styles which draw on formal, informal and incidental learning adult education discourses. These discourses will be discussed in greater detail later in this chapter.

information. Further, Field and Houston (1991) found parenting information during the postpartum period was provided at a superficial level with minimal time available for reinforcement of the information that had been provided. In part these difficulties of appropriateness of information provided may be due to differing perceptions, as Freda, Andersen, Damus and Merkatz (1993) identified in their research that the perceptions of what were important and interesting topics for maternal education were significantly different between pregnant women and health professionals.

Much of the literature about parent education activities is descriptive, using case studies to outline the parenting group activities and the positive outcomes identified by the program facilitators. For example, these descriptions of parent education activities include: breastfeeding programs implemented during the antenatal period (e.g. Duffy, Percival & Kershaw 1997; Hartley & O'Connor 1996); a support group for mothers (e.g. Gordon, Robertson & Swan 1995); an early discharge education program (e.g. Harrison 1990); and a program to assist women recognise the onset of labour (e.g. Bonovich 1990). These program descriptions are often useful, as they provide sufficient detail for replication of the programs by other health professionals. More complex evaluations of programs are starting to occur, particularly due to the increasing interest in perinatal mood disorders and the potential of education programs to act as a form of social support (Barnett 1995).

However, a more specific focus on areas of research related to mothers' learning have been investigations of maternal cognitive themes during pregnancy which demonstrated the need for women "... to reconcile multiple changes in their searching to cope with many unknown dimensions" (Affonso & Sheptak 1989, p.156). The outcome of this research found that cognitive imbalances of uncertainty and confusion were triggered by pregnancy. Factors that have been associated with maternal cognition include beliefs about maternal role; postpartum reconstruction of labour and delivery experiences (Affonso & Sheptak 1989; Konrad 1987); expectations of newborn behaviour; perceptions of changing body image; and wishful thinking and fantasies in securing acceptance of the new baby by others (Affonso & Sheptak 1989).

The provision of 'accurate' information during pregnancy and childbirth was identified to increase the degree of control and subsequent emotional well-being of the mother (Green, Coupland & Kitzinger 1990). However, the provision of conflicting advice was found to cause difficulties for new mothers (Bondas-Salonen 1998). For example, Levy (1999) found that midwives provided or withheld information as a form of protective gatekeeping where information was suppressed or released to protect the woman and, the midwife. Levy identified that the amount of time given to the discussion of a topic was frequently based on the importance attributed to the topic by the midwife; the time available for the interaction; the requirement for the woman to make an immediate decision; and the possible options about the topic or issue available to the woman.

A commonly discussed and accepted method for providing childbirth, mothering and child-rearing information is through the use of groups. Cliff and Deery (1997) found in their research that an important factor in attending antenatal groups was the opportunity to meet other women and share information with other people who were 'like me'. These groups have the added advantage of providing social support, which is frequently identified within the literature as an essential requirement for healthy motherhood (Pitts 1999; Morgan et. al. 1997; Holden 1994; Knapman 1993; Kitzinger 1992a; Oakley 1992; Bastien 1992; Dix 1991; Brouse 1988), as the lack of social support has been linked with an increased risk of women developing postnatal depression within the first year of their babies lives (Riley 1995; Brown et. al. 1994). However, negative aspects of childbirth or parenting groups are rarely referred to in the literature. One such example by Radojevic (1991) who found in her research of public and privately facilitated antenatal groups an oppressive element within the attitudes and approaches of the childbirth educators towards the promotion of childbirth with minimal intervention. Radojevic (1991, p. 28) observes that:

> most ante-natal programmes are conducted by female, non-medical health professionals such as nurses and physiotherapists, or by trained lay women. Within this culture of female, non-medical practitioners, an institutionalised system of beliefs based upon the principles of relaxation and psychoprophylaxis has established itself with an insidious coerciveness which enjoins women to develop

> the correct mental attitude towards childbirth in a context in which the 'educators' have made themselves the arbiters of the correct mental attitude. The insidiousness of the coercion lies substantially in the fact that pregnant women are placing their trust in fellow women who, precisely in not being doctors, are perceived as being more empathically attuned to their needs and anxieties.

Radojevic, through her observations, is not trying to privilege a medical approach to childbirth, but rather questions the discourses of 'natural' childbirth and choice despite their laudable ideals "... to initiate an autonomy enhancing system whereby the individual woman has a **real** choice in making a guilt-free, informed decision about her own labour if it is at variance with institutional prescriptions" (Radojevic 1991, p. 30) (original emphasis). This questioning results in a foregrounding of the potential for women to feel guilty if they are unable to fulfil the criteria for 'natural' pain-free childbirth.

This section has provided a brief review of the parent education literature, which identifies a focus on the provision and evaluation of parent education groups. A major feature of this review has been the absence of substantive investigation within the parent education literature about maternal learning through the use of informal and incidental learning. These concepts of informal and incidental learning will be discussed within the following section.

1.2.2 Learning as a field of practice

Parent and mothering education are possibly the ultimate 'life long learning experience' for many women, because it can be argued that maternal learning continues throughout the life span, due to the frequent challenges caused by changing maternal and child developmental characteristics.[22] These challenges continue as a

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[22] For example, see Blaffer Hrdy's (1999) accounts of the changing family functions and responsibilities of postmenopausal women; Wearing and Wearing (1996) research into 'grandmotherhood'; and Royee & Balk (1996) evaluation of an intergenerational program for pregnant and parenting adolescents that identified the importance of including grandmothers in the program. This statement is also based on my experience as a child and family health nurse facilitating grandparent groups, where grandparents especially grandmothers are eager to learn about the latest child rearing information and trends.

woman ages, resulting in a need to accept her children as adults, and often learning how to position herself as a grandparent. Within this section the discussion will encompass three issues: the use of adult education discourses within the parent education literature; the notion of learning from experience; and the neglect of incidental and informal maternal learning within the adult education literature as major learning strategies.

Adult education has paid minimal attention to parent and maternal education particularly in the early years of parenting, if the publication of refered journal articles through recognised journals of adult education is used as a measure of interest in the topic. Several possibilities could be raised as to why this situation exists: that parenting and maternal knowledge are considered specialist discipline knowledge, and hence literature is exclusively published within specialist journals[23]; that childbirth and parent educators do not identify themselves as adult educators[24]; that knowledge and research about parent and maternal education do not meet the interests of editorial boards or guidelines of the various journals of adult education[25]; and that many educators providing maternal and parent education do not have the inclination and/or the necessary academic research and writing skills to research or write about their education practice to the standard required by refereed journals.[26]

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23 The parent education literature is increasingly being published within the nursing journals which in all probability reflects that nurses and midwives are responsible for the majority of childbirth and parent education programs which are offered.

24 According to Kelly and Barnard (1999), the current state of parent education as a child focused intervention could reflect a lack of training about adult education practices.

25 See the editorial discussion by Edwards in *Studies in the Education of Adults* about the need to reconsider an increase in the range and setting of adult learning. He proposes that "... the focus on the education of adults carried and indeed may still carry remnants of certain Anglocentric liberal and radical views on the value of only certain forms of learning" (1997a, p. 2).

26 NSW Parliamentary SCSI (1998) identified the diversity of educators from professional and non-professional backgrounds. An assumption can be made, because of this diversity, that many of these educators from non-professional backgrounds do not have tertiary education qualification, which potentially equip them with the necessary academic skills required to have refereed journal articles accepted for publication. Another important issue which was identified by the Committee was the reluctance of many parent educators to evaluate the programs they were facilitating.

However, within the available parenting and mothering literature the discourses of adult education are commonly used to underpin education programs and assist the preparation of women for childbirth and mothering, concepts such as: self-directed learning (e.g. Brown 1998); encouragement for educators to elicit what parents already know and then build on this knowledge (e.g. Nolan & Hicks 1997; Nolan 1997); to ensure opportunities are provided for parents to exchange experiences (e.g. Pitts 1999; Cliff & Deery 1997; Vehviläinen-Julkunen 1995); the use of experience as a learning resource (e.g. Cox & Turnbull 1998); and allowing the learner to identify their own learning needs (e.g. Evans & Jeffrey 1995; Regan & Lydon-Rochelle 1995).

Adult education discourses have been readily embraced by parent educators to explain and underpin their practice. However, minimal critical exploration of the range of possible *meanings* of these adult education discourses to the application of parent education practice has occurred. The result of this lack of a critical approach to the use of adult education discourses and the resulting practices in parent education has been a checklist of adult education principles which are privileged over other approaches. A binary is often set in place by these discourses between styles of education practice, with a preference for using a dialogue approach over a more didactic formal approach of information provision which positions the educator as expert.

For example, from an evaluation of childbirth educator teaching styles, Nolan and Hicks state:

> models of adult education require that teachers do not seek to force-feed information to clients, but to work with knowledge and skills clients already have ... Adults need to feel that they have something to contribute to their education, and to develop coping strategies which are informed by and, therefore, applicable to their own personal and social situations (1997, p. 186-187).

There is a potential in taking this generalised approach for a commonsense understanding of 'adult education' to occur. Instead of a range of educational strategies, educators focus on a narrow repertoire which is purported to meet the

'learning style' of the universal 'adult learner'. The reference to force-feeding information to clients positions the educator as the expert or even as the oppressor and the clients as victims unable to resist. Statements such as the one by Nolan and Hicks provide universalising understandings of adult education and the authors assume the position of speaking for the clients.

However, a contradiction arises in Nolan and Hicks (1997) argument about the styles of childbirth teaching, as the researchers identified that one group of nurses, who were able to maintain high attendance levels at their classes, offered an education model based on expert advice, telling parents what to expect and giving information, which contradicts the previous adult education discourse they had proposed. Nolan and Hicks acknowledge the maintenance of high attendance rates at these classes, which would suggest that parents were not dissatisfied with this educational approach or that at the very least this 'force-feeding' model of education was what they had expected.

A constant tension for parent educators are the complaints by women after the birth of their baby that they were not provided during pregnancy with adequate information about child rearing and mothering. Expectations often exist that preparation for parenthood classes and information gained while in the postnatal ward will adequately prepare women to care for their infants. Unfortunately, because of the complexity of mothering and the diversity of problems new mothers encounter, adequate preparation is not always possible through the provision of formal learning activities and must occur in an often haphazard way as part of everyday learning. It can be argued that the majority of the learning and teaching about mothering occurring during our lives has happened and continues to happen outside the classroom (Luke 1996) as informal and incidental learning.[27] Indeed, learning outside the classroom is

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[27] In this instance, classroom learning and teaching is being equated to formal parent education teaching and learning. Nevertheless, it is important to acknowledge the potential for informal and incidental learning to occur even in a formal classroom setting. However, this informal and incidental learning is usually not a planned outcome of the teaching approach.

significant within this New Mother study, as the women in most instances needed to be prompted to talk about their formal learning experiences of attending childbirth, preparation for parenting and new mothers groups. Yet the women readily provided information and talked at length about the importance of informal discussions with other new mothers, their own mothers, and the early childhood health nurse, and gaining maternal skills through trial and error experiences.

Learning through experience and informal discussion with others has been a constant for the women participating in this New Mother study as they learn to mother. Discussions with other women appear to be an important factor in the development of maternal knowledge, as it is frequently acknowledged within the professional and popular literature on mothering and identified as having the potential to reduce isolation, provide emotional and social support, and increase the women's confidence (Pitts 1999; Hendricks 1998; Holden 1994; Oakley 1992). The importance of informal discussions with other mothers could also be argued as providing a mechanism for the reproduction of mothering as a social practice — a process of learning to mother through sharing experiences.

Much has been written within the adult education literature about the concept of learning through experience as an accepted educational method in an attempt to legitimise these types of learning strategies.[28] This legitimisation of learning through experience is often based on a normative approach which has been critiqued as problematic (Edwards 1994; Usher 1992). For example, discussions about how learning through experience can be facilitated and how learning through experience can be improved are often provided with an underlying assumption of a universal learner (Edwards 1994). This privileging of experience, is also noted by Johnston and

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[28] Learning through experience has been identified as happening through some of the following: direct experience, helping people to gain insight into their own experience through the use of reflection, sharing experiences with colleagues and confirming personal experience (Andreson, Boud & Cohen 2000; Henry 1989; Boud 1987; Melamed 1987). Experiential learning is identified as being about assisting people not only 'know', but be able to 'do' through these experiences (Newman 2000; Henry 1989).

Usher (1996), as being problematic due to the underlying notion that experience assists in knowing the unitary, rational 'self' and yet at the same time that 'self' is disembedded and disembodied.

Accepting an understanding of experience as a 'given' needs to be constantly contested and unpacked, as experience does not exist outside of social relations and inherent in these social relations are issues of power relations and their interaction with gender, culture, class and age (Usher, Bryant & Johnston 1997; Johnston & Usher 1996; Brash & Hoy 1989). Power relations are constantly shifting, not only while a woman is 'within' the experience, but also during the reconstruction of an experience as she positions herself in relationship to others involved in the experience or the reconstruction of the experience. So, in trying to assist a woman learn from her experience, consideration is required about issues of power, and the resulting effect of power on the way an experience is constructed.

Experience is often given status "... as the 'authentic' representation and voice of the individual" (Usher & Edwards 1994, p. 187). In challenging this position, Usher and Edwards contend that these understandings do not allow for the fluidity of the experience and that interpretations are dependent on signifying processes and structures which leave the experience open to constant reassessment. This argument is supported by Scott (1992), through her questioning of a subject's vision of experience being taken as the foundation of evidence on which explanation and the origins of knowledge are built. Scott attempts to unsettle the notion of experience by asking in an ironic manner "... what could be truer, after all, than a subject's own account of what he or she lived through" (1992, p. 25). Scott goes on to state that "... it is not individuals who have experience, but subjects who are constituted through experience" (1992, p. 26). This concept of subjects being constituted through experience, in particular, the language used to describe the experience will be discussed in Chapter 2.

The problematisation of 'experience' as the 'foundation' of evidence on which

explanations of truth and knowledge are built raises the issues of what is meant by learning?; and how do women come to know about mothering? These questions will be explored further within this thesis, drawing on a general understanding of learning situations which have been constructed as formal, informal and incidental (Garrick 1996; Foley 2000; Marsick & Watkins 1990).

The term 'formal learning' is being used within this thesis to describe an identifiable parent education program where learning outcomes are often stated and evaluated — which is consistent with the adult education discourse about formal learning (Garrick 1996; Foley 2000; Marsick & Watkins 1990). Formal learning represents much of the explicit discussion about maternal learning within the health professional literature which include discussions about childbirth classes, new mothers groups and breastfeeding groups.

Within the literature about mothering, direct reference to 'learning' is not often made, although an acceptance of an implicit understanding that learning is occurring can be gained through the author's use of terms such as the development of skills, confidence or competence.[29] These terms seem to be used as an accepted measure of the success of a program, clinical intervention or maternal learning. The remaining two significant types of learning constructs that have been used to describe the majority of learning which I propose is occurring for the women participating in this New Mother study: informal and incidental learning, are remarkable in their absence.

The first is informal learning where women "... consciously try to learn from their experiences ... [this informal learning] does not involve formal instruction" (Foley 2000, p. xiv). Garrick (1996) extends the concept of informal learning further by

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[29] For example: Mercer & Ferketich (1994) investigate maternal-infant attachment and identify a correlation between attachment and maternal competence; Erickson (1996) refers to the importance of facilitating maternal competence, maternal adjustment and parenting skills with the outcome of positive maternal-infant interaction; and Fowles (1996) identified that if a woman's infant caretaking skills were strengthened and enhancement of her affective ties to the baby occurred, then maternal competence resulted.

proposing that capturing experience and thinking logically about an experience will provide the experience with meaning. Any of these processes proposed by Garrick may be difficult for a new mother, as her learning often occurs in an environment of sleep deprivation, loneliness, concern or anxiety about her ability to mother and her infant's behaviour and physical wellbeing.

Informal learning can be represented in part by the active seeking out of knowledge by women learning to mother. On the other hand, the women within this New Mother study were provided with an opportunity to talk and think about the experience of learning to mother, which they may not have had if they had not participated within this research study. Mackey (1990) identified during her research project into women's views of the childbirth experience that many of the women described actively searching for childbirth information through reading, and listening to family, friends and health professionals. Brown (1998) has interpreted this seeking out of information as a 'universal' desire for knowledge which was reflected by the women within her research project as wanting to know all they could about pregnancy and childbirth.

Universal claims about women's learning behaviour are problematic for several reasons including the following: the acknowledgement that women who participate in research programs are often highly motivated, which may not be reflected in all women's behaviour as they learn to mother; women may not actively seek information about mothering because of their confidence and competence through previous experiences with caring for children; women may have had previous difficult and unpleasant learning experiences, resulting in a reluctance to seek educational input or support; literacy problems may inhibit women's attendance at formal classes for fear of exposure, as well as limiting their access to written information; and the maternal information may be identified by women as culturally or socially inappropriate.

The second significant concept to be discussed is incidental learning which has received minimal acknowledgement within the literature about parent education or mothering. However, the use of terms such as 'intuitive' and 'intuition' seem to be an acknowledgement of maternal knowing and possibly act as an alternative to the concept of incidental learning.[30] For the purposes of this New Mother study incidental learning will be identified as learning " ... incidental to the activity in which the person is involved, and is often tacit and not seen as learning, at least not at the time of its occurrence" (Foley 2000, p. xiv). An important understanding which is linked to the tacit or unconscious characteristic of incidental learning is the inability to adequately express in language the experiences and resulting knowledge, as much of this knowledge, I would argue, is about bodily sensations and body movements — what might be called 'somatic knowledge'.[31] A common response from new mothers is 'nobody told me it would be like this', even though they have often been told many detailed stories of childbirth and mothering (Goodenough 1991).

For example, this inability to describe maternal experiences occurred for the women participating in this New Mother study, as they frequently had difficulty finding language and common meaning for the experiences of motherhood. The inability to describe experiences was particularly evident when discussing bodily sensation such as sleep deprivation, the pain of labour and the sensation of breastfeeding. So if women who are in the midst of the experience cannot find words to explain the sensation, how can health professionals who are no longer in this stage of mothering, or who have not had children be expected to adequately prepare women for these experiences?

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30 A link has been made by authors between maternal knowledge and intuitive judgement. For example see, Callery (1997); Ruddick (1989); or Belenky, Clinchy, Goldberger & Tarule (1973).

31 See Chapters 4 and 6 for a more detailed discussion of somatic knowledge.

A possibility for understanding how women gain maternal knowledge without apparent learning is through the use of memories. Some recent theorising about memory systems and the effect of experiences on memory has resulted in the construction of a framework to increase the understanding of the development of neurological systems, which support the development of learning through memory.[32] These understandings of memory have the potential to problematise the commonly dominant, even if formally problematised, concept of 'maternal instinct' as a means of 'instinctively' knowing how to mother; and to assist in theorising maternal learning as explicitly linked to incidental learning and the taking on of the 'habitus' of a mother.[33]

A substantive discussion initially drawing on the medical discourse about memory will be presented in Chapter 4. The use of memory as a discursive construct is being identified as a tool for problematising 'maternal instinct' and a concept for the understanding of incidental learning and habitus as the most significant factor in the production of the new mother.

This section has discussed adult education as a field of practice which contributes to the education of women as they learn to mother, through the use of generalised adult education discourses to guide the provision of parenting information using formal learning activities. However, the importance and significance of everyday learning through informal and incidental learning needs to be acknowledged and supported as a major component of assisting women as they learn to mother. The relationship between memory, informal and incidental learning activities of women will be identified and discussed as this thesis develops.

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32 The work which has been done on the relationship between memory and experience has often focused on the traumatic experiences of infants and the functioning of memory of adults experiencing amnesia. For example, refer to the work of Perry, Pollard, Blakley, Baker & Vigilante (1995) into childhood trauma; and LeDoux, (1998) account of the clinical case of H.M. which is a much cited case study of a man with extreme episodes of epilepsy who developed amnesia after an operation to reduce his epileptic episodes.

33 Habitus is a whole set of behaviours which have become habitual and are embodied by a subject (Bourdieu 1977). This concept of habitus will be discussed in greater detail in Chapter 2.

1.2.3 Nursing

This section will locate nursing as an important professional discipline which provides advice and support for women during the period of pregnancy, childbirth and the early months of mothering. Nurses are strategically positioned to implement surveillance practices through their regular contact with women and their infants, in particular, because maternal and infant surveillance practices are frequently taken-for-granted, and there is a widespread acceptance of nurses as a source of information about health and child rearing practices. These practices act by guiding, supporting and disciplining women as they learn to mother their infants.

Nurses play an important part, in most instances, in the birth of a baby and during the first months of a baby's life, positioning themselves as caregivers, educators, role models and as part of the woman's support network. In a survey of parents within a community in the Australian state of Victoria, the rating of sources of parenting information ranked the child, adolescent and family nurse second after information provided by the parents' own parents, family and friends. The two highest rating professionals identified as important sources of parenting information were child, adolescent and family nurses and general practitioners (Hunt, Hawkins & Goodlet 1992).

This key positioning of nurses in supporting women learning to mother has evolved out of a sometime turbulent history of traditional practices of women being cared for by other women during the time surrounding childbirth and the early months of mothering a new infant (Rogers-Clark 1998; Nolan 1997; Zwelling 1996). In part, this history has been a result of women, midwives and nurses resisting the imposition of medicalised childbirth (Oakley 1993; Kitzinger 1992a; Ehrenreich & English 1978) and mothering practices and discourses (Knapman 1993).

However, nursing as a field of practice is frequently constrained by the dominant medico-legal discourses which place social and legal restrictions on the way in which nurses practise and on what is identified as legitimate nursing knowledge. There have been significant changes to nursing as nurses research and record nursing practice and knowledge. A result of these activities have been an increasing number of nursing specialities (Taylor 1998) which have defined and laid claim to a specific age group, disease group or physiological state, for instance, midwifery, child and family health nursing, paediatrics, orthopaedics, mental health and oncology nursing.

The process of developing and recording nursing knowledge and practice has been heavily influenced and often builds on other health professions' research, claimed knowledge and truths (Lawler 1997; Delacour 1991). In part, this situation can be identified as a result of the status of nurses within the health system, and further compounded as a result of a lack of academic and research credibility.[34] In building on these other health professions' claimed knowledge and truths, the resulting nursing knowledge and practice have the potential to contribute to confirming and perpetuating the many claims of scientific 'truth' which guide and regulate mothers to conform to the dominant discourses, such as medicine, psychology, education and law, that are circulating within the societies in which children are raised.[35]

For example, the discourses about infant-maternal attachment were first identified in the psychology and medical literature, but are now interwoven within midwifery, child and family health and paediatric nursing practices, assisting to legitimise the practices of rooming in, demand feeding, and unrestricted access by parents to their infants in neonatal intensive care units.

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34 This lack of academic and research credibility was present, in particular, prior to the transfer of nursing to the tertiary sector in 1985 in NSW.

35 It could also be asserted that nursing is often only reclaiming the knowledge and practices which were appropriated and documented by other health professionals.

These dominant discourses on child rearing in the first five years clearly establish health professionals, and in particular, doctors, as the expert mothering advisor and assessor of competence (Thurer 1994; Oakley 1993; Ehrenreich & English 1978). The privileging of doctors' knowledge was established in the post World War II years as demonstrated by Spock, who advised mothers not to be concerned by advice given by neighbours, other mothers or relatives — "bringing up your child won't be a complicated job if you take it easy, trust your instincts, and follow the directions your doctor gives you" (1951, p.3).[36] This statement is an explicit message to women that doctors know best, and that nurses do not even rate a mention within this inner circle of mothering. The importance of Spock's message to this thesis is that the mothers of the 1950s who ascribed to this belief are now the grandmothers of the 1990s, assisting and advising their daughters.

Childbirth and mothering practices are increasingly constructed as being supported by the development of government policies, procedures and criteria on which to scientifically judge the health of an infant and mother through the use of objective and increasingly subjective surveillance tools.[37] These subjective surveillance tools usually focus on the maternal relationship or on the woman's mental health status as a mother.

Nurses have been placed in a key position to implement surveillance measures because of their acceptance within the communities in which they live and work. This

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36 Spock recanted much of his initial advice to mothers in later years (Spock & Morgan 1989).

37 'Objective' surveillance measures are commenced from the first antenatal visit when the woman's weight, urine and blood are tested. As the foetus grows, the testing increasingly focuses on the foetus, e.g. ultrasound, amniocentesis and foetal heart rate. At birth the use of the Apgar score which is done at one minute and five minutes; weight, length and head circumference provide a base line to measure the infant's progress which are then regularly checked during the first year of life. Surveillance is continued to a lesser extent until five years of age: developmental screening such as the Denver Developmental Screening Test; or less complex screening using expected developmental milestones to plot the baby's progress. 'Subjective' surveillance tools include the Edinburgh Postnatal Depression Scale and the Monash Infant-Mother Interaction Scale. However, these 'subjective' surveillance tools often use a scoring system to quantify the women's responses which makes them appear 'more objective'.

acceptance in part is due to the ordinariness of nurses (Taylor 1994).[38] Ordinariness allows a connection to be made between nursing and the mothering function, which is frequently conferred on nursing within the hospital setting, because of the often perceived lower status of nurses and the link with less technical and caring behaviours.

Nursing has many taken-for-granted practices which contribute to the illusion of nurses being the technical assistants and female nurturers within the world of medical dominance (Parker & Gardner 1992). Parker and Gardner have identified the significant position nurses occupy as they of all the health professionals experience a closeness to the

> .... extraordinarily rich human experiences surrounding birth, death, pain, suffering and the struggle to transcend the limitations of embodiment; however, our very familiarity with these processes can lead us to minimise their human significance (1992, p. 3).

These taken-for-granted practices of the everyday work of nurses have often had the effect of making the work of nurses invisible, thereby allowing the privileging of other health professionals (Oakley 1986b).

Frequently nurses are placed in unique situations through performing common tasks for others which encourages the development of a level of intimacy other health professionals are not often allowed (Lawler 1991; Oakley 1986b; Street 1992). For example, there is a level of intimacy which is not available to other health professionals when a nurse assists a grieving woman to express breast milk after the death of her baby. The nurse in this situation is in a privileged position which allows her to 'be with' the woman as she performs the intimate procedure of assisting the woman express breastmilk. The expression of breastmilk may have become a taboo

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[38] In researching nursing, Beverley Taylor describes the phenomena of ordinariness in nursing. Ordinariness is defined as "the common bond of humanity that ties people together" (1994, p. 37). The challenge Taylor extends to nurses is to transcend the prescriptive functions of the professional and 'be themselves'.

subject for her family and friends to talk about, because of their own grief of a baby no longer being there to take this breastmilk.

Nurses have the ability to get to know women through their everyday talk (May 1992). According to Parker & Gardner (1992), nurses help people to reconstruct their lives through the act of caring and the use of comforting everyday talk. This everyday talk allows nurses a privileged position in providing therapeutic and educational interventions, as the nurse is often left with the patient after others have delivered their message and escaped to the sanctuary of their offices.[39] The nurse is frequently the only health professional available to help people attempting to put their lives back together, or make meaning from their experiences and emotions.

Even during this New Mother study, episodes occurred which could be construed as therapeutic interventions and/or informal and incidental learning as the women reconstructed distressing stories about their pregnancy, birth or early maternal experiences. During the telling of these stories, my positioning shifts from researcher to nurse or mother, causing an infringement of the 'scientific' research discourses of maintaining objectivity, as I attempted to provide information and/or reassurance. This shifting of subject positions during the research process will be discussed in greater detail in Chapter 3.

Nurses occupy significant positions: providing maternal advice and education, emotional support, assisting women make sense of what is occurring in their attempts to mother, assisting in the maintenance of the health and safety of the mother and infant by implementing surveillance practices, and by acting as an advocate for the mother and baby. At times these functions can be contradictory and based on régimes of truth or rules which perpetuate social norms, thereby producing a 'new mother' who conforms to the current accepted discourses of motherhood.

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[39] In most instances health professionals other than nurses allocate set appointments for their clients particularly in a hospital setting e.g. one hour counselling session by a social worker; a physiotherapy session; or a ten minute doctor's visit.

This section has attempted to position this New Mother study within adult education, parent education and nursing by providing an overview of important issues. These three fields of practice have specific discourses, understandings and practices which are used to describe and guide practice. These include some of the following: the use of experience for learning; informal and incidental learning; privileging of scientific knowledge; nursing surveillance; and nurses' use of everyday talk. The literature review which has commenced in this chapter will be ongoing and used in two ways within this New Mother study: to support the understandings which have been gained from this research into mothering; and to problematise the way in which mothering and maternal learning has been theorised by other authors.

1.3 The thesis outline

The chapters in this thesis are about learning to mother for the first time. These chapters seek to construct an account of the way new mothers are produced, through the use of surveillance and normalisation practices, and how these women often produce their own knowledge about mothering.

This first chapter has provided an overview of this New Mother study and positions this research study within the practice fields of parent education, adult education and nursing. Several issues have been highlighted about these practice fields. The first is the lack of acknowledgement of incidental and informal learning within the parent education literature. The second is the potential use of adult education discourses in a universalising manner to encompass all the learning styles of parents. The third is the inability to claim 'experience' as a 'given' or authentic representation of the subject. The final issue is the positioning of nurses to implement surveillance and assist in the production of the new mother.

The concept of informal and incidental learning has been foregrounded as understandings which will be used within the analysis chapters of this thesis. These two learning activities will draw on understandings of experience and memory as significant links in developing maternal knowledge.

Chapter 2 provides a discussion of mothering and essentialism; and the poststructural approaches used within this thesis. An important understanding which is raised within this chapter when discussing motherhood and essentalist approaches is the ease that these understandings are accepted, reinforced and often go unchallenged. A possible explanation for this easy acceptance is that attributing maternal behaviour to nature is a comfortable and known position to justify behaviours and judgements about women as they mother. Poststructural approaches, on the other hand, identify tensions and contradictions and challenge accepted discourses about mothering.

A discussion of the major concepts of a poststructuralist approach is provided — these concepts include: subjectivity and its relationship to Bourdieu's notion of 'habitus'; language and discourse; and power and knowledge. This chapter concludes with an overview of Foucault's concept of bio-power and the practices which are used to try to bring populations into the realm of social control, through the attempted use of population regulation and the disciplining of the body to make it docile and productive.

An outline of the research methodology used to undertake this New Mother study is provided in Chapter 3 with a discussion of the issues which required consideration in the management of this research study. The relationship between poststructural and feminist approaches to research, and the use of reflexivity, power relations and subject positions is foregrounded.

The potential ethical issues and processes used to conduct the research interviews are described; in particular, how spaces of engagement were generated using a semi-structured conversational approach to the interviewing process. The ethical issues,

which were identified prior to the commencement of the interviews, were in relationship to my responsibilities as a registered nurse and the requirement to maintain a 'duty of care'.

The final section of Chapter 3 discusses the analysis process which forms the basis of this thesis. An outline is provided of the experience of transcribing the interview tapes, the sorting process, and the use of discourse analysis.

The analysis work of the thesis is commenced in the following four chapters. The first two of these analysis chapters provide a context for maternal learning to occur. In Chapter 4 the women's stories are used to investigate several of the commonsense or taken-for-granted concepts of motherhood which influence the way we think about motherhood and mothering. The invasive notion of 'maternal instinct' is explored and the resulting restrictions of the subject positions that are available for women to describe their maternal experiences are discussed. Alternative constructs are proposed which may assist thinking about the way women learn to mother and why some women have such difficulty taking on the multiple positions of mother, by using the constructs of memory and habitus.

Chapter 5 explores Foucault's notion of bio-power and how it is used to produce new mothers who conform to the expectations of the communities in which they live by bringing women often willingly under a normalising gaze, resulting in the development and use of surveillance techniques and the production of docile bodies. The notion of surveillance is extended to include confessional practices, and the women's willingness and resistance to participation in these practices is explored. Within this chapter the implications of bio-power for health professionals are raised and the tensions which are generated to balance the intention of providing support and assistance with that of being required to provide surveillance of the maternal practices to protect the infant.

Chapter 6 focuses on the importance of incidental learning and its relationship to somatic knowledge. Within this chapter three important factors are explored: the first is the use of opportunistic education as an important strategy to enhance maternal learning. The second is the disjuncture between professional and maternal knowledge and the ease in which maternal knowledge can be discounted and then subjugated. Finally the infant's contribution to the development of maternal knowledge is acknowledged.

The recurring theme within this thesis of the difficulty in discursively constructing maternal experiences will be discussed within Chapter 7. The concept of a conspiracy of silence is troubled and a counter-reading will be provided of the possibility of this silence being due to the limitations of the available language to describe maternal experiences. The final section of this chapter uses drawings provided by the four women who attended the group meeting. These drawings are used as a mechanism to assist the women describe their maternal experiences.

Chapter 8 concludes this thesis by identifying the challenges poststructural approaches offer health professionals to rethink how they theorise motherhood and maternal learning. These challenges have the potential to impact on their clinical practice as they work with women learning to mother for the first time.

Chapter 2

The Problematic of Motherhood: Framing the Research

Juggling an infant's needs and a woman's own needs requires often subtle, but constant realignment of the subject positions which are taken up and the power relations between the mother, infant, family and wider community. Unfortunately, understandings within professional parenting education literature concerning motherhood are frequently based on essentialist beliefs which has the potential to limit the acknowledged and accepted social practices of mothering within specific cultures. Through the use of poststructural approaches I will demonstrate that women manage their daily lives as mothers in a far more complex and intricate way, rather than the frequently normalised and decontextualised discourses of motherhood, which are often presented within the professional and popular parenting literature.

Discourses of motherhood frequently rely on the concept of 'maternal instinct' to allocate child rearing functions to women as a natural extension of their ability to give birth and lactate. The difficulty arising when questioning the existence of 'maternal instinct' is that as a concept it has been inextricably confused with the ability to care for children in a loving manner; even though this acceptance of 'maternal instinct' may be manifested in hidden ways. The frequent outcome of this questioning of the existence or value of 'maternal instinct', results in accusation of the 'value of mothering' being vilified. This troubling of the concept of 'maternal instinct' using poststructural understandings will continue in the following sections of this chapter and in Chapter 4.

Poststructuralism, "...in short, involves a critique of metaphysics, of concepts of causality, of identity, of the subject, and of truth" (Sarup 1993, p. 3). Poststructuralism can be identified as complementary to postmodernism which is

designated by Lyotard as the "... state of our culture following the transformations which, since the end of the nineteenth century, have altered the game rules for science, literature and the arts" (1984, p. xxiii).[1] A growing unease with the grand narratives of modernity has resulted in the accepted stability of scientific knowledge and truth being eroded, as an "... incredulity toward metanarratives" (Lyotard 1984, p. xxiv) starts to ensue. Poststructuralism allows a foregrounding of difference, uncertainty, complexity and heterogeneity (Usher 1996a), thereby acknowledging the tensions which arise within everyday lives of new mothers. Of importance for this New Mother study is the questioning of the dominant essentialist understandings of mothering that are frequently offered within the health professional and popular literature, and the identification of the resulting restrictions in thinking about motherhood within western knowledge systems.

Poststructuralism has been chosen as the main theoretical framing for use within this New Mother study. So by purposefully locating this New Mother study within the postmodern I am positioning myself at the fringes of current nursing research and rejecting the essentialist notions which underpin a great deal of the research into mothering. As Walker (1997, p. 3) notes, nursing research is still firmly positioned in an "... authoritative modernity and an as yet only partially legitimate postmodernity".

In using poststructural and feminist understandings and research practices to underpin this research, a risk is being taken of exposing and questioning the institutional system in which I am often positioned as a person who can speak with authority concerning

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[1] No clear definition is available or possible to define the difference between postmodernism and poststructuralism. Lather defines the term postmodern as "... the larger cultural shifts of a post-industrial, post-colonial era and *poststructural* to mean the working out of those shifts within the arenas of academic theory" (1991, p. 4)(original emphasis). Lather (1993) and Edwards (1997b) both identify that poststructuralism and postmodernism are often used as mutually reinforcing terms. An important understanding is that the term 'post' does not mean an opposition to "... what has gone before or that it supersedes it; there may be some continuity with, dependence on, or (partial) revolt or disjuncture from what has preceded it" (McWilliam, Lather & Morgan 1997, p. 9).

child rearing and mothering issues. Through this New Mother study I risk unsettling my secure position as I trouble the entrenched régimes of truth in regard to mothering and parent education. The questioning that happens, as I tease apart the women's stories, may be read by some as a criticism of the clinical practice of my colleagues and myself. However, rather than criticism, the central intention of the research is to identify the conditions of the production of these entrenched régimes of truth about mothering and parent education.

This chapter has been divided into two main sections. The first section will explore the relationship between motherhood and essentialist understandings as the current dominant discourses of motherhood within western knowledge systems. This section argues that the act of mothering is described in many instances as a 'natural' process, based on the linking of a woman's physiological abilities and social practices of mothering. In this section, I suggest that a troubling of essentialist understandings of the construction of motherhood is required, as these essentialist understandings frequently result in restrictive understandings about motherhood.

The second section of the chapter will introduce the concepts and understandings that are offered by poststructural approaches and which have been used to inform this New Mother study. A discussion of poststructural understandings and the important concepts that encourage other ways of thinking about maternal learning will be discussed, in particular: subjectivity; language and discourse and the régimes of truth which are developed to enable the separation of what can count as 'within the true' and often used to guide and judge maternal behaviour; and the interplay between power and knowledge. Within the section on subjectivity the post-humanist notion of 'habitus' is discussed as a way of understanding the reproduction of the social

behaviours of mothering.[2] The final concept to be introduced is bio-power and its connection as an integral component for the production of the new mother through methods of surveillance and normalisation. The two main poles of bio-power — population regulation and the discipline of the body will be described.

2.1 Motherhood and essentialist understandings

I start this chapter by discussing essentialist understandings about women and motherhood, not to promote these understandings but to draw to the reader's attention the way in which these understandings often unknowingly influence the construction of stories concerning women and mothering. These stories then act to constrain, discipline and produce new mothers who conform to the current social practices and discourses of motherhood. As Simone de Beauvoir so elegantly describes the situation:

> it is in maternity that woman fulfils her physiological destiny; it is her natural 'calling', since her whole organic structure is adapted for the perpetuation of the species. But we have seen already that human society is never abandoned wholly to nature (1972, p. 501).

The decision to have a baby is frequently based on beliefs of mothering being a 'natural' state; fulfilment of a woman's ultimate 'role' in life of being a mother; and

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[2] The concept, 'humanism' (in the discipline of psychology) is defined by Reber (1995, p. 343) using the work of Maslow as "... higher human motives, self-development, knowledge, understanding and esthetics". A certain type of subject is constructed through humanist understandings, a subject who is able to exercise individual agency and who has an inherent potential to be self-directing and self-motivating (Usher & Edwards 1994). Humanism is identified by Foucault (1994), as a set of themes that are always connected to a variety of changing value judgements that can reappear over time. In the words of Foucault (1994, p. 314), "... 'humanism' has always been obliged to lean on certain conceptions of man borrowed from religion, science, or politics. Humanism serves to colour and to justify the conceptions of man to which it is, after all, obliged to take recourse". In this quote Foucault signals a problematic with the understandings gained from humanism, that they can be altered to comply with the latest value judgement. Post-humanist is described as a distancing from humanism and the Enlightenment project (Sim 1998). See footnote 7 for a definition of the concept of the Enlightenment period.

that 'maternal instinct' will guide the new mother innately in the care of her baby, as it *is said* to be a woman's physiological destiny. de Beauvoir provides an opportunity by her statement about a women's psychological destiny to raise at this early stage such questions as: who has constructed this belief that for all women, child bearing and mothering are our 'physiological destiny', our 'natural calling'? Ortner proposes that there are three main reasons which are based on physiological fact for the close linking of woman to nature:

> (1) *woman's body and its functions*, more involved more of the time with 'species life,' seem to place her closer to nature, in contrast to man's physiology, which frees him more completely to take up the projects of culture; (2) woman's body and its functions place her in *social roles* that in turn are considered to be a lower order of the cultural process than man's and (3) woman's traditional social roles, imposed because of her body and its functions, in turn give her a different *psychic structure*, which, like her physiological nature and her social roles, is seen as being closer to nature (1974, pp. 73-74) (emphasis original).[3]

Ortner does not accept these three reasons uncritically for women's close linking with nature. Instead, she carefully unpacks each of the reasons and provides other ways of thinking about women's physiological ability to give birth and how these physiological 'facts' are used to enmesh women into the daily social practices of the culture in which they live. For example:

> Mothers and their children, according to cultural reasoning, belong together. Further, children beyond infancy are not strong enough to engage in major work, yet are mobile and unruly and not capable of understanding various dangers; they thus

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3 The work of Ortner is now 26 years old, but it remains a key text, as Ortner clearly established the problematic between nature and culture. It is valuable for two reasons. The first reason is the identification of the link between essentialist thinking and the burden of the often mundane tasks of child rearing relegated to women on the pretext it is a woman's 'natural' duty. The second reason is to demonstrate that this debate about the responsibility for child rearing is not new and is well established. Nevertheless, this debate continues to focus on maternal responsibility and the lack of maternal commitment. For example, a recent article by Arndt (2000) in the *Sydney Morning Herald* discusses the cartoons drawn by Leunig about infants left in childcare. These cartoons seem to imply that women who use child care services are uncaring and selfish mothers. This article highlights the need to shift the debate from the quantity of maternal care because it is identified as 'natural' for mothers to care for their infants, to exploring the importance of providing quality child care, regardless of who is the carer.

> require supervision and constant care. Mother is the obvious person for the task, as an extension of her natural nursing bond with the children, or because she has a new infant and is already involved with child-orientated activities. Her own activities are thus circumscribed by the limitations and low levels of her children's strengths and skills: she is confined to the domestic family group; 'women's place is in the home' (Ortner 1974, p. 77).

Within the passage above, Ortner identifies how a domestic/public domain binary is set in place within social practice, as an extension of a woman's physiological ability to give birth and lactate. This domestic/public binary is still perpetuated within much of the literature of infant-maternal attachment which has occurred since the Second World War when a considerable amount of research has been completed resulting in theories about the psychological development and the wellbeing of children, and the contribution of the mother.[4] It is only in recent times that the role of the father is starting to be investigated and acknowledged, with the interesting outcome that many men are now seeking to find an acknowledgement of their 'natural' child rearing function.[5]

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4 See for example, the work of researchers such as Bowlby (1965), Winnicott (1960), and Klaus and Kennel (1976) who made important contributions to the way mother-infant relationships are currently understood by health professionals. The mother-infant relationship theories have been the catalyst for many dramatic reforms in medical and hospital practices; for example, changes have been made to the access parents have to their children when in hospital, and there are now expectations that a newborn baby will room-in with their mother in maternity units (Billings 1995; Mullan 1987). However, another way of viewing the mother-infant relationship theories is through a feminist critique which proposes that the research is a subtle form of oppression aimed at keeping women tied to the home and their children (Forna 1998; Mullan 1987). This oppression is seen to be through 'experts', usually male doctors who discredit women's traditional knowledge, thereby making women dependent on them as experts who churn out huge volumes of child rearing advice (Nakano Glen 1994).

5 For example, Nichols (1993) research into paternal perspectives of the childbirth experience; the prediction of role competence for experienced and inexperienced fathers by Ferketch & Mercer (1995); the work of Biddulph (1995) on raising boys and father son relationships; Lupton and Barclay's (1997) work on the discourses and experiences of fatherhood; and a recent report commissioned for the Commonwealth Department of Family Community Services about men and fatherhood in contemporary Australia (Russell, Barclay, Edgecombe, Donovan, Habib, Callaghan & Pawson 1999).

I propose that stories about mothering being a woman's physiological destiny or 'natural calling' — are just that — stories which have been passed from generation to generation, resulting in a "... biologized social construction" (Bourdieu & Wacquant 1992, p. 172) which is imposed on women. These stories become enmeshed with the physiological ability of the woman's body to become pregnant and give birth, enabling essentialist terms to be used to describe women as mothers.

Essentialism is described by Stanley and Wise as "... the existence of fixed and essential properties which invoke 'biology' or more loosely 'human nature' as the supposed basis of these" (1993, p. 208).[6] In particular, women are attributed with essences which are often unquestionably spoken of as universal, and as residing in and identified with a woman's natural and biological characteristics (Grosz 1995).

Essentialist understandings about women and their relationship to mothering are frequently used as statements of fact and, therefore, beyond question as to their validity. The acceptance of a natural account of mothering provides a limited and fixed essential approach to understanding the 'self', and perpetuates a belief that women will and should mother, by mothering their own child or assuming a mothering role in other aspects of life, as a woman's 'essences' are connected to her body and ability to give birth. This acceptance creates an understanding and expectation that all women will know how to nurture and care for an infant as an essential quality or 'true role', as the work of mothering is based on a problematic concept of 'maternal instinct'. These essentialist understandings and discourses provide a sense of stability and security, that lull us into a state of unquestioning dogmatism (Falzon 1998) which allows the perpetuation of these mothering discourses often in hidden ways.

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[6] Reber (1995, p. 343) describes 'human nature' as "an absolutely undefinable term... The term's most common use seems to be as an apology for human behaviour' based on innateness".

During the Enlightenment period, essentialist understandings were used to perpetuate the definition of knowledge as based on "... 'man,' the subject, and espouses an epistemology that is radically homocentric" (Hekman 1990, p. 2).[7] This definition of knowledge within western thought establishes a male criterion from which to measure women, such as the underlying early beliefs and assertions of Aristotle of the incomplete and inferior male, with male sexual organs which had been turned inside out or Galen's fully formed physical being possessed of a single organ the uterus, the source of motherhood and hysteria (Thompson 1999; Zemon Davis & Farge 1993). Certainly these assumptions about women would be rejected in the common rhetoric of the nineties. However, they remain as insidious beliefs and comments in the commonsense knowledge of subjects — 'women can't do that job, it's man's work'; 'mothers should stay at home with their young children'; and 'pregnancy and motherhood make you lose your intelligence'. Unfortunately, the potential to add to this list of comments appears limitless.

Western thought constructs women and nature in two complementary ways (Thurer 1994; Hekman 1990). The first is an Aristotelian sense that women have an essential nature or universal essence (Hekman 1990). The second approach is as Plato defined it by using a binary between culture and nature which has been articulated as a masculine/feminine dictomy (Lloyd 1993; Hekman 1990; Ortner 1974). Plato was of the view that the reflection of order and reason is much clearer in the souls of men than women, hence women's souls consisted of the fallen souls of men who lacked reason, resulting in women having more turbulent and non-rational souls (Lloyd

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[7] The Enlightenment period refers to the movement which emerged in Europe during the eighteenth century (McNeil 1993; Sarup 1993). Foucault (1994) defines the 'Enlightenment' as an event or a period in time. Drawing on Foucault's understanding of the Enlightenment period, it is described by Danaher, Schirato & Webb (2000) as encompassing a collection of ideas and a series of political events that began with the French Revolution. A replacement of absolute sovereignty, ignorance, fear and superstition with an understanding of how, what and why things are or occur in a specific manner; a dispelling of darkness (Sim 1998). This understanding is underpinned by a self-referential approach to oneself (Danaher et. al. 2000; Sim 1998) which cling to humanistic discourses of the autonomous natural subject (Usher & Edwards 1994).

1993). Hekman (1990) proposes that this second approach is more about identifying and defining the relationship women have to nature and men have to culture, resulting in an essential polarity and forms the basis for the development of dualism between nature and culture.

This dualism reappears in many other oppositions which are central to western thinking and knowledge, and that identify masculinity with culture and femininity with nature: the mind versus the body and other physical matter; objectivity versus subjectivity; reason versus emotions and passions; public versus private; concrete versus abstract; truth versus veil; theory versus practice; and activity versus passivity (Harding 1992; Orner 1992). These dualisms are dangerous and inadequate as they are historically presented by an essentialising of both terms, with the first term privileged over the second term (Orner 1992).[8] The difficulty which is often confronted with the use of dualisms is the effortlessness of dismissing them in theory, but not in practice (Bordo 1993a) as they have become so enmeshed within commonsense meaning systems as a mechanism to describe and govern women's and men's ways of thinking and behaving.

The commonsense meaning systems of essential qualities used to talk and think about the body conceals the desires, customs and multiple practices of the culture and societies in which we live. These essential qualities are identified as coming from the body of the woman and are frequently linked to emotion rather than to the rational thought of man (Hekman 1990). The need to challenge these dualisms is of crucial importance to enable the identification of "... how the terms interrelate, how they have been historically constructed as opposites, and how they have been used to justify and naturalize power relations" (Orner 1992).

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[8] For example, men are naturally more intelligent, rational and cultured, women are more emotional, irrational and nurturing.

Using an essentialist approach to understanding mothering has the effect of diminishing the value placed on the mothering function and limiting the possibilities for women who also have the responsibility for the care of an infant. Rather than unquestioningly accepting that essences exist, a constant questioning and incredulity is required to unsettle mothering discourses based on essentialist thinking. Poststructural approaches provide such a framework for questioning and unsettling these essentialist constructions and discourses, and encouraging other ways of thinking about motherhood.

2.2 Poststructuralist approach

> The poststructural move is to foreground the difficulties involved in representing the social rather than repressing them in pursuit of an unrealized ideal (Lather 1993, p. 677).

In this second section a discussion of poststructural approaches and the main concepts which are used to gain understanding within this thesis will be highlighted. These main concepts include particular conceptualisations of the subject, subjectivity and the post-humanist concept of habitus[9]; language and discourses; and power and knowledge. Through the act of writing about poststructural approaches (in an attempt to clarify the meanings) a dilemma constantly occurs of setting up a polarity between essentialist and poststructural thinking. The intention of this chapter is not to achieve a clear distinction between essentialist and poststructural thinking but to trouble the established essentialist thinking and discourses about motherhood, by providing a poststructural framework to assist in the reading of the stories provided by the women within this New Mother study.

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9 As identified earlier in this chapter, 'habitus' is located as a post-humanist concept, rather than a poststructuralist concept. Nevertheless, Bourdieu's concept of habitus is very useful for supplementing the understandings gained from the poststructural concept of subjectivity with practices of the body.

Poststructural concepts and understandings provide a way of thinking and a mechanism to acknowledge and explore the complexity of women's lives. Poststructuralism, according to Usher and Edwards (1994), is best comprehended as a theoretical position, a tool for analysis and a way of thinking. Weedon adds to this description by calling poststructuralism "... a useful, productive framework for understanding the mechanisms of power in our society and the possibilities of change" (1997 p. 10). Poststructural approaches provide an opportunity to unsettle the circulating discourses based on essentialist and dualistic thinking that have informed understandings about motherhood.

Discourses based on essentialist thinking frequently create a dilemma for women and health professionals as they can contribute to the development of a dichotomy of 'good' and 'bad' mothering. These mothering positions do not provide for cultural difference and the complexity of mothering (Forna 1998; Woolett & Phoenix 1997), so a woman can be easily labelled as a 'bad' mother when she is unable to self-regulate or at least disguise her feelings or actions which do not conform to the current social norms for mothering.

For women from other cultures the discourses of the 'good' or 'bad' mother may have different meanings. Gabrielle Carey (1996), an Australian, tells a story of infringing the 'good mother' discourse about her experience of the early days of mothering her first child in a small village in Mexico. Carey was so proud of her new infant that, within days of the birth, she went for a walk with her infant in the main street of the village. This walk was an infringement of the forty day confinement rule which was put in place to ensure women had time to regain their strength before returning to their family responsibilities. Carey had infringed the local 'good mother' rules and possibly put at risk, for the other women of the village, the ritual of caring for themselves. This ritual was the closest many of these women would ever get to being allowed a holiday. So the practices that are accepted and expected in one

culture may be alien in another culture.

Usher, Bryant & Johnston (1997) propose that essentalism offers only certain accepted moral stances and accounts of knowledge. For example, an expression of this accepted moral stance is through the use of the 'good mother' discourse which works on an implicit understanding that a mother's needs are secondary to those of her infant. This understanding is taken-for-granted and difficult to argue against, given the dependence and vulnerability of an infant. So a woman who looks after her needs and desires before those of her infant can be identified as a 'bad' or 'uncaring' mother as she is in most probability positioned by others as lacking in 'maternal instinct'. This essentialist approach to mothering results in the development of tensions in the way in which women are positioned as mothers. It can now be argued that each of these essentialist approaches has set in place a means of judging notions of 'right' and 'wrong' mothering, by setting in place a binary based on a woman's physiological functioning. Usher argues that "instead, a postmodern approach seeks to subvert this dichotomy and suggest alternatives which radically challenge and critique the dominant epistemological discourse in all its various forms" (1996a, p. 26).

The following discussion will provide an overview of the poststructural terms that contribute to a framework for analysis within this thesis.

2.2.1 The subject and subjectivity

The first concepts of the subject, and of subjectivity, if explored through the use of a poststructuralist reading, require a shift from thinking about the 'individual' of humanism to the multiple subject positions of poststructuralism. An understanding of the term 'individual' is provided by Sarup as:

> ...[dating] from the Renaissance and presupposes that man is a free, intellectual agent and that thinking processes are not coerced by historical or cultural circumstances. This view of reason is expressed in Descartes's philosophical work. Consider this phrase: 'I think, therefore I am.' Descartes's 'I' assumes itself to be fully conscious, and hence self-knowable. It is not only autonomous but coherent; the notion of another psychic territory, in contradiction to consciousness, is unimaginable. In his work Descartes offers us a narrator who imagines that he speaks without simultaneously being spoken (1993, p. 1).

The necessary shift which is required from thinking about the individual of humanism is to take a counter view of the subject as active and dynamic, with multiple subject positions which are constantly in motion and developing, the narrator who speaks as well as being spoken. This understanding of subjectivity is expanded by Hollway (1998), as a person's practices and the power through which they can position themselves in relation to others. These activities of subjectivity development refer to conscious and unconscious thoughts and emotions (Weedon 1997). Rather than being pre-determined by our biology, a person's "... subjectivity is made possible through the discourses s/he has access to, through a life history of being in the world" (Davies 1994, p. 3).

A poststructuralist approach acknowledges that we take on subject positions by positioning ourselves and being positioned by others, moment by moment, through the discourses that are mobilised. Davies describes this process as:

> while not negating the power of the conscious and unconscious minds to store and use the multiple layers of knowing that accumulate in any one life, each person is, nevertheless, also in an important sense constituted afresh in each new context, each new set of relations and positionings within the discourses and storylines (1994, p. 4).

The complexity involved in the development of a person's subjectivity is supported by Henriques, Hollway, Urwin, Venn and Walkerdine's statement that it is "...necessary to theorize subjectivity as multiple, not purely rational, and as potentially contradictory" (1998, p. 203). This understanding of subjectivity is contrary to the essentialist discourses of identity which presuppose an individual with a fixed,

coherent and unique essence (Henriques et. al. 1998; Weedon 1997; Usher & Edwards 1994). These subject positions which are constantly being produced are positioned in relation to particular practices and historical contexts, which are also dynamic and multiple (Henriques et. al. 1998).

The concept of subjectivity as contradictory, multiple and not purely rational becomes very 'real' for many women as they try to acknowledge previous subject positions or take up new subject positions as mothers. Within this New Mother study the multiple subject positions taken up by the women were often in conflict with the dominant social practices and expectations of motherhood. For example, a conflict with social practices and expectations occurred for one participant, Victoria, because she had returned to her studies within weeks after her baby was born. During a visit by a domiciliary nurse who saw her pile of academic books, Victoria was told that she would have to forego these activities now she was a mother. Victoria constructed this comment as a judgement of her commitment to motherhood and as an infringement of the 'good mother' discourse of the domiciliary nurse. Victoria's construction and the resulting subject positions which she can occupy as a woman are based on meanings drawn from social practices and current available discourses about mothering and infant psychological well being.

However, dynamic, multiple and highly complex qualities of subject positions enabled Victoria to construct alternative subject positions through a counter discourse, which she did, to justify her desire to return to her studies as assisting her to enjoy mothering to a greater extent as she was being intellectually stimulated. Victoria in constructing a new subject position has re-configured the power relations between herself and the nurse. This new configuration of the power relations allows her to dismiss the nurse's comments. Subjectivity is not a natural given. Rather, it is influenced by a particular historical period and the resulting social or cultural constructs which govern our lives. A social construct, as defined by Phoenix and

Woollett, is "... concerned with the ways in which ideas, and hence our experiences of the world are dynamic, multiple and highly complex. Furthermore, they are specific to the period of history and the society in which they are produced" (1996, pp. 13-14). These understandings connect with the concept of habitus. This concept provides an understanding of the importance of social practices and how they contribute to the development of subjectivity.

2.2.1.1 Habitus

The post-humanist concept of habitus as formulated by Bourdieu will be discussed as one that describes how certain subject positions are embodied. Habitus is "... an internalized set of general and long-lasting dispositions that organise human subjectivity" (Meisenhelder 1997, p. 165), resulting in a practical sense for behaviour which occurs in any particular situation — "... a 'feel' for the game, that is, the art of *anticipating* the future of the game, which is inscribed in the present state of play" (Bourdieu 1998, p. 25) (original emphasis).[10]

The notion of habitus is not a 'natural' ability to behave or function (Meisenhelder 1997), such as the concept of 'maternal instinct' which implies a 'natural' ability to mother. Through the use of the concept of habitus a tool is provided to trouble many of the unexplained but widely held commonsense understandings or doxa of everyday life.[11] These concepts will be discussed further in Chapter 4 when the discourses of 'maternal instinct' will be unsettled.

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10 A disposition is described by Bourdieu (1977) as a term to express what is encompassed by habitus (a system of dispositions). It includes: the result of organised actions, with a meaning similar to structure; a way of being — a habitual state, in particular, of the body; and a tendency, propensity, predisposition or inclination. The acquiring of dispositions is a gradual process which identifies early childhood experiences of particular importance (Thompson 1991).

11 Doxa is used by Bourdieu to describe "... the world of tradition experienced as the 'natural world' and taken for granted" (1977, p. 165); or as "... a particular point of view of the dominant, which presents and imposes itself as a universal point of view" (1998, p. 58).

Bourdieu provides a complex description of habitus which implies that a whole set of behaviours have become habitual and are embodied by the subject. A habitus is frequently enacted unconsciously and acts to position a subject. Bourdieu describes habitus as:

> ... systems of durable, transposable *dispositions*, structured structures predisposed to function as structuring structures, that is, as principles of the generation and structuring of practices and representations which can be objectively 'regulated' and 'regular' without in any way being the product of obedience to rules, objectively adapted to their goals without presupposing a conscious aiming at ends or an express mastery of the operations necessary to attain them and, being all this, collectively orchestrated without being the product of the orchestrating action of a conductor (1977, p. 73)

The concept of habitus has been simplified by Butler as the "... embodied rituals of everydayness by which a given culture produces and sustains belief in its own 'obviousness'" (1996, p.30); or using the words of Bourdieu & Wacquant (1992) a "... socialized subjectivity". Habitus has also been described as an "... embodied history, internalized as a second nature and so forgotten as history – [it] is the active presence of the whole past of which it is the product" (Bourdieu 1990 p, 56).

According to Bourdieu (1998), habitus is the development of classification principles and schemes, different tastes, and principles of vision and division. Habitus provides distinctions of what is good or bad, right or wrong, and distinguished and vulgar behaviour. These distinctions are not taken as 'given' or transferable to all people or even all subject positions. For example, behaviours identified as appropriate by one person may be cheap, showy or pretentious if displayed by another person (Bourdieu 1977).

The ability to take on multiple subject positions is often reliant on fulfilling the anticipated and accepted behaviour of the specific position (Bourdieu 1977). Bourdieu (1993) proposes that habitus is about reproduction rather than production (of course the debates around the relationship between these things still rage no final

position has been reached). Habitus is identified as a past that survives in the present and has the ability to perpetuate itself into the future as a form of cultural reproduction (Bourdieu 1977). There are two components of habitus which are important to this New Mother study: the ability to 'know the rules' and bodily hexis. The first is the ability to tacitly know the rules or, in Foucault's terms, régimes of truth which are linked to the subject position through the discourses of the 'good' mother. Bourdieu proposes that the "... 'customary rules' preserved by the group memory are themselves the product of a small batch of schemes enabling agents to generate an infinity of practices adapted to endlessly changing situations" (1977, p. 16). These rules are important as they are embedded within the discourses of motherhood and hence guide women as they learn to mother.

The second component of habitus, bodily hexis, is the organisation of the body and how the body is deployed in the world (Thompson 1991). It is "...a durable way of standing, speaking, walking and thereby of feeling and thinking" (Bourdieu 1990, pp. 69-70). Bodily hexis is identified by Bourdieu & Wacquant (1992) to be both gendered and gendering; it is theorised as a

> ...*socially informed body*, with its tastes and distastes, its compulsions and repulsions, with, in a word, all its *senses*, that is to say, not only the traditional five senses – which never escape the structuring action of social determinisms ... (Bourdieu 1977, p. 124).

The senses Bourdieu (1977, p. 124) is talking about include a sense of direction, duty, commonsense, humour, morality, absurdity, responsibility and practicality. These senses are connected with the earlier notion of a 'feel for the game' in response to the demands of a field (Bourdieu 1990). A field is "... a set of objectives, historical relations between positions anchored in certain forms of power (or capital)" (Wacquant 1992, p. 16). For instance, a 'feel for the game' may result from the taking on of a gendered habitus of a female, and therefore the bodily hexis of that habitus which may be reflected in the ability to hold an infant in a 'motherly' manner.

A 'feel for the game' is the ability to use everyday rituals and rules which are identified by Bourdieu (1977, p. 17), as behaviours that "... everyone is able, not so much to cite and recite them from memory, as to reproduce them (fairly accurately)". The ability of habitus to take on the everyday rituals as part of the unconscious has implications for the earlier discussion about incidental learning (in Chapter 1) and memory (to be discussed in Chapter 4). These three concepts of habitus, incidental learning and memory have commonalities in their descriptions and suggest an interplay between the three concepts.

A habitus is not a static entity but it constantly changes and shifts in response to the shifting subjectivities of the woman. "It is precisely because it can be adjusted with (often unconscious) regard to the success or failure of various practical projects that the tradition embodied in the habitus can be supple enough to change with other aspects of a society" (Calhoun 1993, p. 78). The habitus allows for changes to occur because it provides subjects with an orientation for their actions and inclinations, without strictly determining these actions (Thompson 1991), allowing it to be adapted to the changing social practices and expectation.

The concept of habitus adapted from Bourdieu's work is useful for this New Mother study through the provision of alternative ways to construct and think about the characteristics which have been attributed to women. For instance, the concept of 'maternal instinct' can be unsettled rather than being automatically accepted as the commonsense belief of a 'natural' essence. Using the understanding of habitus and subjectivity, 'maternal instinct' can be thought about as rituals of everydayness which are embodied through a process of cultural reproduction. Habitus will be used within this thesis to provide a meaning structure from which to think about, and allow a troubling of, the commonsense understandings and discourses of motherhood.

This section has provided a brief introduction to the main concepts of the subject and subjectivity using a poststructural approach. This introduction has been extended to include Bourdieu's concept of habitus which will be used to trouble commonsense thinking embedded within the discourses of motherhood. As this thesis progresses, these concepts will be developed and used extensively. The following section will add to these understandings about subjectivity by discussing how subjectivity is brought into existence through language and particularly through the Foucauldian notion of discourses.

2.2.2 Language and discourse

The second concepts of importance are language and discourse, and their function in the development of subjectivity, since "to speak is inevitably to situate one's self in the world, to take up a position, to engage with others in a process of production and exchange, to occupy a social space" (Hanks 1993, p. 139). In the following section, the relationship between language, discourse and their implications for subjectivity will be explored and how these concepts are underpinned by Foucault's notion of 'régimes of truth'.

Language, according to poststructural theorising, has two main functions. The first, "... is the place where actual and possible forms of social organisation and their likely social and political consequences are defined and contested" (Weedon 1997, p. 21). The second function identifies language as playing a central part in the development of subjectivity and the way we position ourselves and are positioned as subjects (Weedon 1997; Usher & Edwards 1994). Lyotard argues that "... language games are the minimum relation required for society to exist: even before he [sic] is born, if only by virtue of the name he is given, the human child is already positioned as referent in the story recounted by those around him ..." (1984 p. 15).

The relationship between language and discourse is often unclear as to which is the 'larger concept' — do discourses operate within language; or do discourses determine language? (Pennycook 1994). For the purposes of this New Mother study, discourses will be identified as a regulating system or a patterned way of thinking. This understanding of discourses locates itself as supporting the concept of discourses determining language. This concept of discourse is identified by Usher, Bryant and Johnston (1997 p. 103) to be every social practice, including those which are attributed to the essential 'self', and are formed and mediated through language.

Poststructural understandings reject the essentialist concept of language as a transparent tool used by individuals to describe or analyse the 'real' world (Weedon 1997). Instead, they identify social practices as being encapsulated in and legitimised by discourses (Foucault 1972), allowing the concept of discourse to be expanded as more than ideas, collections of statements or propositions, but includes practices and ways of producing knowledge and the shaping of our world according to that knowledge (Schatzki 1996; Crowley & Himmelweit 1992).

Discourses are described by Foucault as "... a series of discontinuous segments whose tactical function is neither uniform or stable" (1978, p. 100). Although a "discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it" (Foucault 1978, p. 101). In particular, a Foucauldian notion of discourse is described as:

> ... ways of organising meaning that are often, though not exclusively, realized through language. Discourses are about the creation and limitation of possibilities, they are systems of power/knowledge (*pouvoir/savoir*) within which we take up subject positions (Pennycook 1994, p. 128).

In using this Foucauldian sense of discourse, a framework is provided for locating a discourse, the rules which govern the discourse and the inner logic of the discourse, thereby allowing the discourse to be spoken or used with authority. This authority

comes with additional conditions being put in place to enable the subject to be counted as 'within' a discourse. The added condition requires that speaking, acting and believing must be in accordance with others belonging within the discourse, and therefore allow subject positions to be taken up within the discourse (Lankshear, Peters & Knobel 1996).[12]

These poststructural concepts of discourse challenge the notion that there is a unitary, universal essential self. Instead these concepts offer an understanding of subjectivity being constructed and negotiated through discourses. Fairclough (1992) advances these concepts further by identifying that the function of discourses are to construct, represent and reflect social entities and relations; and to position people in different ways as social subjects. He also applies the concept of discourse to the structuring of areas of social practice and knowledge, raising the notion of discourse as having the potential to act upon and be acted upon by subjects.

The notion that discourses can be acted upon provides the understanding that they are not a closed system with a universal fixed meaning. According to Foucault (1978) discourses are a multitude of discursive elements that cannot be separated into accepted and excluded discourses. These understandings about discourses highlight their potential to change in response to the demands of current social or cultural practices. By acknowledging that discourses are not unified or stable, then it can be accepted that discourses are open to change and can be read in many ways.

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[12] For example, within institutional discourses such as medicine greater authority is accorded if these discourses are spoken by a doctor than a nurse.

2.2.2.1 Régimes of truth

> Each society has its régime of truth, its 'general politics' of truth: that is, the types of discourses which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true (Foucault 1980a, p. 131).

Régimes of truth construct the measures for the way in which people should act, feel and understand their world, which are usually reflected in the discourses which are used. Foucault in the above quote identifies the important function of régimes of truth in maintaining social order. According to Foucault the production of a discourse is

> ... at once controlled, selected, organised and redistributed according to a certain number of procedures, whose role is to avert its powers and its dangers, to cope with chance events, to evade its ponderous, awesome materiality... we all know the rules of exclusion. The most obvious and familiar of these concerns what is prohibited ... We know perfectly well that we are not free to say just anything, that we cannot simply speak of anything, when we like or where we like; not just anyone, finally, may speak of just anything (1972, p. 216).

Foucault has highlighted the rules of behaviour which we learn as part of our socialisation into the families and communities in which we live, the need to abide by the 'rules', and providing the ability to function within a particular habitus of a subject position. Régimes of truth are an assembly of rules set up to enable the separation of what is true and false. This assembly of rules allows the attachment of truth to a system of power which then sustains this truth (Foucault 1980b). Régimes of truth have been usefully named by Walkerdine as "... fictions which function in truth ..." (1990, p. 109).

These régimes of truth are not static but are linked with systems of power which produce and sustain truth (Foucault 1980b). Hence this truth increases the ability and ease to judge others, by identifying and measuring their supposedly abnormal and non-conforming behaviours against a criterion of 'normal' behaviours, which have

been constructed by communities in which people live.

For example, within this New Mother study, the 'good mother' discourses function through régimes of truth that contend a good mother will have specific attributions in that she will, first, readily meet the needs and demands of her infant; second, love and nurture her infant; third, avoid getting angry at her infant; and fourth, breastfeed her infant.[13] The régimes of truth about the 'good mother' are perpetuated through child rearing and mothering advice offered by health professionals, friends, relatives, the popular media and within child rearing texts (Thurer 1994).

It is important to note, here, that within this New Mother study I am not arguing for the discarding of current child rearing techniques, as I do not want to replace one régime of truth with another.[14] Instead, this research study has identified a need to expose the conditions which support the production of these régimes of truth that act in an essentialising, totalising and decontextualised manner, and which can result in distress and anxiety for many new mothers.

In this section I have argued that women can occupy different and multiple positions in language, and therefore, the notion of an essential self becomes problematic. Within this New Mother study there are several recurring discourses of motherhood which will be foregrounded during the analysis process used in the subsequent chapters of this thesis. These discourses all have their own set of rules and act as régimes of truth which contribute to the production of the new mother.

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13 Specific maternal attributes contained in the 'good mother' discourse are often denounced as myths in many texts about mothering (for examples see, LeBlanc 1999; Forna 1998; Maushart 1997; and Villani 1997).

14 For many women the child rearing advice which has been developed and established over decades, is often sought after, used and valued.

2.2.3 Power and knowledge

The third group of concepts which will be woven through this thesis are power and its relationship with knowledge, especially the concepts of privileged and subjugated knowledges. Foucault has been instrumental in providing alternative ways of understanding power through his historical studies of the practices of human sciences. While studying the discourses of the human sciences, it is claimed that Foucault was not positioned as an insider trying to prove their truth or falsity. Instead, he traced their discursive practices to understand on what basis these disciplines operated through their network of power relations (Rabinow 1984).

Power is frequently discussed within the literature as a commodity which is oppressive and requiring resistance, such as in liberal-Marxist notions of power — a form of sovereign power (Armstrong 1994). Within a liberal-Marxist formulation of power "... it is possible to liberate people and give them back their true identities, which have been removed through the process of alienation, by removing power entirely" (Armstrong 1994, p. 23).

In his critique of current notions of power, Foucault (1977) identifies power as a commodity that is administered from the top down as a binary between ruler and subject (sovereign power). Sovereign power is based on sovereign (legal) judgements which acts by: standing outside or above conflicts, acting to resolve competing claims; resolving conflicts in terms of legitimacy through identifying the actions deemed to be lawful; and being put into action only when rights or laws have been violated, through acting to restrain or punish a violation (Rouse 1994). Sovereign power is basically a right of seizure: of bodies, time and life — "... it culminated in the privilege to seize [a] hold over life in order to suppress it" (Foucault 1977, p. 136). The body is removed from the field of power and disappears rather than being liberated (Armstrong 1994).

Foucault (1980a) challenges the notion that power is always repressive and about saying 'no'. He asks the question: if power was always repressive then would anyone ever be made to obey it? Foucault proposes that power is made acceptable because it "... doesn't only weigh on us as a force that says no, but that it transverses and produces things, it induces pleasure, forms knowledge and produces discourse" (1980a, p. 119); therefore power can be constructed as productive and necessary for the adequate functioning of communities.

Rather than sovereign power being the only way in which to understand the existence of power, Foucault offers an understanding of power as:

> ... something which circulates, or rather as something which only functions in the form of a chain. It is never localised here or there, never in anybody's hands, never appropriated as a commodity or piece of wealth. Power is employed and exercised through a net-like organisation. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power. They are not its inert or consenting target; they are always also the elements of its articulation. In other words, individuals are the vehicles of power, not its points of application (1980b, p. 98).

Foucault identifies power as elusive and dynamic, with no central point from which power is located or administered. Power is not held by the dominant group, but is ever present and distributed through a complex productive network which infiltrates the whole social body. In providing a Foucauldian overview of power Bordo (1993b), proposes that power is not authoritarian, conspiratorial or orchestrated; nevertheless bodies are produced and normalised to serve the prevailing dominant and subordinate relations. Power is therefore enacted through the disciplined and productive body.

According to Foucault (1980b) subjects are simultaneously exercising power and undergoing the effects of power, which works through the organisation of networks. In identifying power as not being from one identifiable source but present everywhere, as part of the practices of everyday life, Foucault proposes that power has an

omnipresence:

> ... not because it has the privilege of consolidating everything under its invincible unity, but because it is produced from one moment to the next, at every point, or rather in every relation from one point to another. Power is everywhere; not because it embraces everything, but because it comes from everywhere ... power is not an institution, and not a structure; neither is it a certain strength we are endowed with; it is the name that one attributes to a complex strategical situation in a particular society (1978, p.93).

Power is not just outside of relationships, but indwelling within relationships. Hence, "the exercise of power is not simply a relationship between partners, individual or collective; it is a way in which certain actions modify others" (Foucault 1983, p. 219). So only when power is put into action does it exist (Foucault 1983). In providing this observation of power, Foucault (1978) implicitly links power into everyday life as a tool which is used by everyone through the discourses subjects use, rather than a tool wielded only by the dominant. In other words, we are all implicated and actively participate in the use of power (Taylor 1986).

Foucault (1980b) identifies an analysis of power as needing to commence from the infinitesimal mechanisms which have their own techniques, trajectory and tactics. This approach enables the mechanism of power which have existed to be made transparent and encourages the development of an understanding of how a mechanism of power continues to be used or to function. An analysis of power relations and how these relations function will provide a tool within this New Mother study to assist in the reading of the women's stories and how the women are positioned in relation to others.

Throughout his work Foucault provides connections between the interplay of knowledge and power. An explanation is offered by Foucault that "the exercise of power perpetually creates knowledge and, conversely, knowledge constantly induces effects of power" (1980c, p. 52). This explanation assists in understanding the relationship between power and knowledge, although it does not explain or capture

the complexity of the relationship or the privileging of certain knowledges and subject positions which occurs within knowledge/power relationships.

Knowledge is defined by Lyotard as more than "... a set of denotative statements, far from it. It also includes such notions as 'know-how,' 'knowing how to live,' 'how to listen', ..." (1984, p.18). Using Lyotard's definition of knowledge opens opportunities to trouble beliefs of what counts as knowledge, and to credit knowledge as a much broader and more complex entity than the usual narrow commonsense understandings of knowledge based on an ability to recall 'important' information and perform specific highly valued skills which encourages the privileging of certain knowledges above others. This privileging of knowledges is usually through claims of scientific objectivity and method, although, as Haraway suggests, "just as for the rest of us what scientists believe or say they do and what they really do has a very loose fit" (1991, p. 184).

Foucault identifies less privileged knowledges as subjugated: "... a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated: naive knowledges located low down on the hierarchy, beneath the required level of cognition or scientificity" (1980b, p. 82). These subjugated knowledges are popular knowledges which are a particular, local or regional knowledge (Foucault 1980b). In discussing subjugated knowledges, Haraway cautions that there is a danger in the romanticising or appropriation of subjugated knowledges, as "to see from below is neither easily learned nor unproblematic, even if 'we' 'naturally' inhabit the great underground terrain of subjugated knowledges ... [as] the standpoints of the subjugated are not 'innocent' positions" (1991, p. 191). Haraway is acknowledging the presence of power and knowledge, and the potential ease at which a supposedly subjugated knowledge can become privileged. The concepts of privileged (or dominant) knowledge and subjugated knowledge are an essential part of understanding the production of knowledge and meaning making and,

therefore, of this New Mother study.

This lack of innocence is exposed, in that subjugated standpoints can act as a possibility for "... the production of alternative forms of knowledge, or, where such alternatives already exist, of winning individuals over to these discourses and gradually increasing their social power" (Weedon 1997, pp. 107-108). Subjugated knowledges have the capacity to resist and shift through the discourses used to construct these knowledges and the subject positions taken up by the speakers of the discourse.

This section has presented a Foucauldian construction of power and its relationship with knowledge. Shifting our understandings of power and knowledge to those offered by Foucault assists in identifying the tensions and contradictions which can occur in taking up multiple subject positions. These understandings will be elaborated as this thesis progresses.

2.2.3.1 Bio-power

In this section the concept of bio-power will be introduced by providing an overview of: the two poles of bio-power which are, first, population regulation and the discipline of the body; second the productive and disciplining aspects of bio-power; third technologies of the self; and finally resistance to bio-power. The concept of bio-power is important for this New Mother study as a useful way to examine how mothers are produced through surveillance and normalisation practices.

Foucault explains the concept of bio-power as human lives being brought "... into the realm of explicit calculations and [which] made knowledge-power an agent of transformation of human life" (Foucault 1978, p. 143); resulting in a "... power over life ..." (Foucault 1978, p. 139). This concept of bio-power has emerged from a

seemingly benevolent, but effective social control which is peculiarly invasive (Sawicki 1991). The notion that bio-power is invasive may be due to the widespread networks of surveillance which develops through the person and groups such as the government, professionals, community members and the family. The techniques used to maintain bio-power are frequently invisible and silent, increasing the ease which they entangle and discipline the subject and populations.

The disciplinary techniques of bio-power treat the body individually "... exercising upon it a subtle coercion, of obtaining holds upon it at the level of mechanism itself — movements, gestures, attitudes, rapidity; an infinitesimal power over the active body" (Foucault 1977, p. 136-137). These disciplinary techniques are identified as changing the way the body is treated resulting in a "... supervision of the smallest fragment of life and of the body ..." (Foucault 1977, p. 140).[15]

In his discussions about bio-power, Foucault, divides it into two main poles which are needed to control and maintain subjects and the social body.[16] The two poles of bio-power have been described by Foucault (1978) as population regulation and the discipline of the body. These two poles can also be interpreted as power relations that work in and through the human body to ensure subjects are secure, healthy and productive.

The first pole is described by Foucault (1978) as population regulation and it has a specific focus on the body through the mechanisms of life such as birth, life

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15 According to Foucault (1978), this supervision of the body and life signalled a shift for western countries from the seemingly repressive approach of sovereign power to a more constructive approach towards the social body which worked to promote life. This shift is assumed to have occurred during the Enlightenment, which has been identified as a period of profound change occurring within Western countries in the second half of the eighteenth century.

16 For example, see the paper by Armstrong (1939) for a discussion of the beginnings of the infant welfare movement within Australia and the activities used to reduce infant mortality through public health strategies and education.

expectancy and levels of health. Population regulation is exercised through the body politic by the use of surveillance practices and disciplinary power and entails a 'bio-politics' of populations. This change in the focus of power to invest in life results in people being measured, examined in various ways, and thus made easier to control (Foucault 1978).

The second pole of bio-power, the discipline of the body, relates to the body as a machine, which requires disciplining: the body's capabilities need to be optimised; its forces need to be extorted; its usefulness needs to be increased in parallel with its docility; and finally the body needs to be integrated into systems of efficiency and economy (Foucault 1978). Foucault (1977) calls the body that has been disciplined the 'docile body'. This disciplined body changes from the unorganised and incoherent subject into an efficiently functioning structure (Foucault 1977). The body has been "... manipulated, shaped, trained, ... [it now] obeys, responds, becomes skilful and increases its forces" (Foucault 1977, p. 136).

This docile body is now constantly held in juxtaposition to other bodies through the dense web of surveillance between and around bodies (Armstrong 1983). So, even though Foucault has divided bio-power into two poles, they are interdependent. Surveillance requires a docile body to gaze upon and the body requires the norms developed by surveillance practices to use as a measure of how to behave, and thereby, become self-disciplined. This ability to be self-disciplined is an important component of what Foucault calls the technologies of the self.[17] According to Foucault technologies of the self:

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[17] Foucault (1988) states that there are four major technologies: 1) technologies of production which allows us to transform, manipulate and produce things; 2) technologies of sign systems enables us to use signs, symbols, signification and meanings; 3) technologies of power this assists the determination of the conduct of subjects and allows an objectification of the subject; 4) technologies of self. These technologies rarely function in isolation and they all imply certain modes of training and modification of the subject to acquire skills and attitudes.

> ... permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immorality (1988, p. 18)

The importance of technologies of the self for this New Mother study is the shift that Foucault has identified from 'taking care of oneself' to 'know yourself'. This ability to know yourself is frequently encouraged through the use of confessional practices, which act as an important strategy for the maintenance of surveillance and discipline of the self.

Foucault proposes that a significant factor in the success of bio-power has been the continued and rapid development of professions and disciplines, with the function of identifying population norms and disciplinary practices to regulate the social body through techniques of surveillance, observation and recording. One of the outcomes of these practices has been an increasing focus on health promotion and education (Gastaldo 1997) to set and enforce norms, and to inform about such things as the 'right' way to mother, and to encourage compliance with public health practices. The development of norms and the ability to assess if they have been achieved requires subjects with accepted knowledge and therefore authority to judge. Nevertheless, Foucault, when referring to subjects who are deemed to have authority through their knowledge or position, is not describing doctors and others as figures of domination:

> ... but rather ... describe[s] people through whom power passed or who are important in the fields of power relations ... an important link in a set of power relations (1984, p. 247).

Foucault's understandings of the subjects as the link in power relations is demonstrated by the current public health requirements for the identification of targets and goals to maximise health outcomes (Lupton 1998), with a consequence that governments and health professionals actively collect and rely on data to demonstrate

that identified health targets and goals have been achieved. According to Hacking (1982), a result of disciplinary practices is the accumulation of huge quantities of data of all kinds for use in controlling and altering populations. However, it has rarely been successful in achieving the desired outcomes for governments or professionals. Many of the categories we currently use are the products of statistics and counting, collected as part of the population regulation activities of bio-power (Hacking 1982).

On first reading, the existence of bio-power appears to be a negative apparatus with its end product being control and oppression of the population. However, bio-power is often productive and positive, as many of the activities of bio-power have resulted in the wide-ranging improvements in the health, wellbeing and public health standards of populations. These bio-power activities are often crucial in a government's ability to maintain social order. On the other hand, it is also important to note that, while many of the public health measures have been positive in the short term, there is the possibility of negative long term outcomes. For example: the removal of sewage from the home has resulted in a safer home environment, but some sewage disposal methods have caused long term environmental damage; the use of antibiotics has decreased mortality due to infection, but now infections are becoming antibiotic resistant and many bacteria have become difficult or impossible to treat; and access to education is only positive if the content is relevant to the needs of the child. So, as with Foucault's (1980b) theorisation of power, bio-power is part of a network which is never localised and subjects are always in the position of undergoing and exercising power.

Although bio-power is described as often using invisible techniques to control and discipline populations to conform to social 'norms', resistance is also present. Foucault raises a critical point about resistance of subjects to bio-power: "it is not that life has been totally integrated into techniques that govern and administer it; [as] it constantly escapes them" (1978, p. 143), such as: the inability of governments to

create a population of people who unquestionably accept the practices of medicine. Instead, subjects seek alternative therapies; or women who demand homebirths, even when medical opinion has relegated these women into 'high risk' categories for childbirth.

This resistance of populations can also be identified in the trend to try to identify and quantify health outcomes, which ensnares health professionals within the web of government surveillance. A conflict results between the demands for health reforms and professionalism, as health professionals identify a loss of professional autonomy, due to the increasing requirement to evaluate and justify their clinical practices to others outside their profession (Southon & Braithwaite, 1998). An increasing reluctance to place themselves under the normalising gaze of government bureaucracies is one of the possible outcomes of these reforms to ensure accountability within professional practice.

In this section I have described Foucault's concept of bio-power as a disciplinary practice which is used to bring populations into the realm of social control, through the use of population regulation and the disciplining of the body to make it a 'docile', 'productive' body. A negative critique can be used to discuss bio-power which positions subjects as being brought under the gaze of government and being unable to resist. Bio-power can also be discussed using a critique which identifies it as a productive and valuable practice to improve the health and quality of life of subjects. This critique I am proposing does not unconditionally accept that bio-power is appropriate or acceptable for all subjects but, by using Foucault's understandings of power, subjects are positioned as being able to resist many of the practices of bio-power. The concept of bio-power will be explored further as this thesis progress, as I argue that bio-power is an integral part of the production of the new mother through surveillance and normalisation practices.

2.3 Conclusion

An introduction has been provided of the poststructural concepts which will form the foundation of this thesis and which are used as tools to work with the data that has been collected during this New Mother study. The importance of poststructural approaches, and in particular, Foucauldian approaches, is highlighted by McCallum as the ability to use "... new approaches to old questions ... So rather than providing 'schemas' and closures, the implied intellectual invitation is to take up his methods of enquiry as a way of charting new territories and formulating questions in different sorts of ways" (1997 p. 54).

Criticism and arguments against poststructural approaches are often raised with allegations that they are too critical, undermining, disruptive and potentially everything is left 'up for grabs' (Usher & Edwards 1994). These allegations are disputed by Usher and Edwards as they argue

> ... that the postmodern is very much *of* this world precisely because it does not present itself as ahistorical and apolitical. Certainly, it teaches us to be sceptical of foundationalism in all its forms, of totalising and definitive explanations and theories and thus of dominant taken-for-granted paradigms ... (1994, p.26).

In particular, for this New Mother study, this means the taken-for-granted dominant essentialist theories of motherhood as demonstrated in the prevailing literature on mothering and parent education.

The very least that is provided by poststructural approaches is a questioning and an alternative discourse that allows other ways of speaking, thinking and acting, as well as providing a useful analytic tool to examine theory and practice (Usher & Edwards 1994). The poststructuralist concepts discussed within this chapter will form an integral part of the analysis process used in this thesis.

Chapter 3

Methodology

A poststructural construction of research, is one of research being constructed as a social practice, a partial and situated activity which even when the researcher's understandings become fixed in text, they remain open to other interpretations by the readers of the text or as noted by Usher (1996b, p. 34-35):

> ... if research is a social practice, a practice of producing certain kinds of knowledge that are socially validated, then as such it is a set of activities that constructs a world to be researched. When we delineate what we intend to study, when we adopt a particular theoretical position, when we ask certain kinds of questions rather than others, when we analyse and make sense of findings in one way rather than another, when we present our findings in a particular kind of text: all this is part of constructing a researchable world. In other words, research is not simply a matter of representing, reflecting or reporting the world but of 'creating' it through a representation.[1]

Usher has provided a poststructural reading of the concept of research, though he does acknowledge that his representation can be thought of as an extreme understanding of research or as a 'wild' example, which he has supported by the notion that research is a textual practice which is also about "... the business of 'creating' worlds" (1996b, p. 35).

This chapter constructs a story about the methodology used to undertake this New Mother study. The first section of the chapter describes my attempts to include several poststructural and feminist research practices within this study and some of the difficulties encountered in choosing this type of research approach.

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1 Usher provides a description of research as "... a social practice carried out by research communities and what constitutes 'knowledge', 'truth', 'objectivity' and 'correct method' is defined by the community and through the paradigm of normal science which shapes its work" (1996a, p. 17).

The second section of this chapter provides an account of the research approach. This account includes, first the recruitment process and a brief profile of the women who participated in this New Mother study; second the technical details of how the data was collected; and third, a discussion of the ethical concerns which required consideration, and in particular, the importance of constructing a position as a researcher which met my professional responsibilities and desires as a nurse. The names of the women who participated within this New Mother study and others who have been referred to by the women have been changed to maintain confidentiality within the research process.

The final section describes the analysis process which included the transcribing of the tapes; the sorting of the stories into themes; and the method used to work with the stories, which is a form of Foucauldian discourse analysis. The analysis process commenced with the transcribing of the interview tapes. This transcribing process caused unexpected physical and emotional demands that are rarely discussed within the research literature. These demands included the time required to transcribe the tapes and my emotional reaction to the stories told by the women. The sorting of stories is described and the necessity of completing multiple readings of the transcripts. Finally, an extension of the discussion about discourse, which started in Chapter 2, introduces the use of discourse analysis.

3.1 Research practices

The first section of this chapter will review several combined feminist and poststructural (postmodern) research practices. In Chapter 2, a lack of a clear definition to assist in differentiating between postmodernism and poststructuralism was identified. However, Lather (1991) suggests that there is a possibility of an interchange between the terms; so for the purpose of the following discussion the terms poststructuralism and postmodernism will be used as having complementary meanings.

The combination of feminist and poststructural research practices, at times can be difficult, as these research practices are not always in harmony, and different aspects of feminist practices are often identified as having a contested relationship (Glass & Davis 1998; Fahy 1997; McNay 1992; Flax 1990; Hekman 1990) or at best an ambivalent relationship (Peters & Lankshear 1996; McNay 1992) to poststructuralism. A reason for this contested or ambivalent relationship between feminism and poststructuralism is suggested by Sarup as that:

> postmodernists offer sophisticated criticisms of foundationalism and essentialism but their conceptions of social criticism tend to be anaemic. Feminists offer robust conceptions of social criticism, but they tend to lapse into foundationalism and essentialism (1993, p. 156).

In providing this critique of feminism and postmodernism, Sarup has identified the potential strengths and weaknesses of each frame. In the following quote, Ransom, using Foucauldian understandings, provides further insight into the reason for this contested relationship and the possible tensions which can occur between feminism and poststructuralism:

> postmodernism may appear to account for, and potentially to subsume, feminism itself; but the relationship between Foucault's postmodernism and feminism can also be seen as part of an ongoing, complex and sometimes fraught dialogue between feminism and the mainstream or (more problematically) malestream production of ideas (1993, p. 124).

This contested relationship can also be constructed as partially due to poststructural understandings and the developing scepticism towards claims of knowledge, truth and the essential universal self (Peters & Lankshear 1996). Two main issues have been proposed for this contestation: first, an unwillingness to work at dissolving the existing dualisms; instead, some feminists want to switch the dualism from the privileging of males, to the privileging of females; and second, the postmodern rejection of absolutism (Hekman 1990). The postmodern rejection of one final truth and of an essential or innate 'female nature' pose critical problems for feminism which

are not easily resolved, politically or theoretically (Hekman 1990).[2] The outcome of this relationship between poststructuralism and feminism is a fracturing of feminism's ability to 'speak and know for women' without due regard for the complexity and diversity of women (McNeil 1993). This inability to speak and know for 'women' as a general category has political implications as the differences between women within and between cultures are acknowledged. According to bell hooks, it is crucial that this inability does not end in the reinscribing of "...conventional oppressive hierarchies" (1994, p. 77).

Fraser and Nicholson, on the other hand, highlight the shift from speaking and knowing for women in positive terms. They propose that poststructuralism and feminism do have points where they merge and result in mutual benefit. An underlying benefit of this alliance resulting in an interlacing of commonalities and difference, so that:

> ... while some women share some common interests and face some common enemies, such commonalities are by no means universal; rather they are interlaced with differences, even conflicts. This, then, is a practice made up of a patchwork of overlapping alliances, not one circumscribable by an essential definition (Fraser & Nicholson 1990, p. 35).

The importance of the alliance can be identified in the ability of poststructuralism, especially using the work of Foucault, to assist in complicating the discourses about the female body and providing an understanding of the creative power of bodies to resist the grip of systematic power on the body, which has often acted to make women's presence invisible (Bordo 1993b). Poststructuralism troubles essentialist constructs of the body, thereby encouraging other ways of constructing discourses about and for women.

Sarup's (1993) response to the contested relationship between feminism and postmodernism is in terms of identifying the similarities between them. These

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[2] According to Hekman (1990) this rejection of the essential 'female nature' is particularly difficult for radical feminists, who talk about the 'essentially feminine'.

similarities are: firstly, a willingness to try new approaches to social critique which are not reliant on the traditional philosophical theories; and secondly, far-reaching and deep criticisms of philosophy and its relationship to culture. At the same time, reassurance is provided by Lather that this combination of feminist and poststructural research approaches does not diminish the potential of feminist research practices to correct "... both the *invisibility* and *distortion* of female experience in ways relevant to ending women's unequal social position" (1991, p. 71) (original emphasis); as poststructural research practices do not advocate similarity, but explicitly acknowledge difference.

In attempting to foreground the women's constructions of motherhood within this New Mother study, I wish to position the women who participated in this study as 'subjects', rather than 'objects' of knowledge (Grosz 1995). As subjects of knowledge the women are positioned by me as actively engaged in constructing knowledge in partnership with the researcher, rather than being "... passive *vessels of answers* ..." (Holstein & Gubrium 1997, p. 116)(original emphasis) which positions participants as not being engaged in the production of knowledge. For example, consider Victoria's response during the third interview to my questioning:

Cathrine:	So how would you describe being a mother?
Victoria:	(laugh) ... you always ask these really difficult questions and I think what am I going to say on the spur of the moment. I have to go back and think ... think about what to say ... Say that again.

Victoria is actively constructing a thoughtful response to my question about being a mother. This desire to provide a situation in which women were able to actively engage in constructing knowledge is problematic as issues of power are constantly present and influence the way in which subject positions are constructed by and for the participants and the researcher. To position the women as objects of knowledge would limit this research to a descriptive study of the women during this period of

their lives and as the researcher I would be positioned as a passive observer.[3]

According to Reinharz (1992) and Lather (1991) there is no one research methodology which is identified as feminist; rather, what distinguishes feminist research is the way a methodology is used and the relationship that develops with the women who participate in the research. This understanding of feminist research can be proposed as trying "... to produce nonhierarchial, non-manipulative research relationships which have the potential to overcome the separation between researcher and the researched" (Cotterill 1992, p. 594). In taking this approach suggested by Cotterill, my presence is being acknowledged and explicitly used within the research, rather than constructing a position as the 'objective' researcher. This position I am constructing for myself, according to Jones (1992, p. 18), conflicts with the "... tradition of objectivity in the social sciences - and elsewhere - [as it] has insisted that the 'I' who writes the text is not welcome; for the 'I' represents subjectivity and bias, the enemies of truth".

The research practices of using a dialogue within the interviewing process provided the possibility of positioning the women as actively engaged in constructing knowledge. This approach encouraged the women to question, answer and make comments about the research. These opportunities were extended to provide an additional opportunity at the end of each interview when I explicitly invited the women, first to tell me things which they thought were important and which had not been discussed in the interview so far; and, second, to ask questions. Frequently these questions were about the progress of this New Mother study, my experiences as a mother, about their health or the health of their infants, and child rearing practices.

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3 For example, Scott (1997) provides a discussion of the importance of acknowledging the subjective experience of the researcher. Scott proposes that "while guarding against the dangers of a narcissistic preoccupation with the self, granting researchers permission to put the self into the story provides an exciting opportunity to tell it how it is and, in the process of doing so, to better understand the complexity of the research process" (1997, p. 134).

When talking with the women about their mothering, as a nurse and as a more experienced mother, it was impossible to maintain a static position as an objective researcher. The stories which have been produced are influenced by the way I am positioned by the women as the researcher and the questions which were asked within the interview. For example, an instance of a subject position being constructed for me occurred when Jane was asked in the third interview why she had so willingly told me the stories about her mothering experience; she replied:

> Jane: I suppose it was more that you were a professional ... I think ... yeah I guess I look at ... you wouldn't sort of judge me ... you know what's sort of going on ... just you know the mother up the street I wouldn't just come out and say 'I've got postnatal depression' (Tim now 7 months old).

Other women positioned me as another mother, as a nurse and even as someone who cared about them. These positions were often constantly shifting and in response to such things as a comment made, a facial expression or a question asked. Because of the specific power relations which existed during each interview, the women provided information about their experiences of mothering which may not have otherwise been revealed to a researcher without the ability to take up similar subject positions. These understandings of the dynamics of multiple and shifting subjectivity does not place me in a privileged position as a nurse or mother, as other researchers would probably raise different issues or feelings within an interview. Rather, these understandings of multiple subject positions within research assist in demonstrating that knowledge is always partial and situated, and is a "... view from somewhere" (Haraway 1991, p. 196).

The influence of my shifting subject positions did not end at the completion of the interview phase but continued throughout the development of this New Mother study as I worked with the data: making decisions about what to use and what to discard from the analysis; and in the way the data was read and the resulting stories which were constructed from these readings. This acknowledgement explicitly positions me within this study.

This research approach I have constructed does not release me from concerns about issues of power or taken-for-granted assumptions about my presence as an acknowledged part of the research process. Rather, the responsibility remains to develop research mechanisms and understandings which acknowledge the influence my presence as the researcher has on the research participants through power/knowledge relationships. In this following section I will discuss the tensions resulting from trying to incorporate reciprocity within this New Mother study and the difficulties encountered.

3.1.1 Reciprocity

When commencing this New Mother study, I undertook a commitment to try to achieve reciprocity within the research process. A process of "... give and take, a mutual negotiation of meaning and power" (Lather 1991, p. 57) between the participants and the researcher would be used to try to achieve reciprocity. The implications of reciprocity within the research process and the resulting tensions will be discussed in this following section.

A Foucauldian understanding of power locates the research participants and the researcher within a web of power, with each capable of exercising power within the research process. This understanding of power disrupts the notion that the researcher is all-powerful within the research process. Power can be used by either the research participants or the researcher; for example, these power relations are always contextual and influenced by the requirements and on-going surveillance of ethics committees.

As the research progressed it became more and more problematic to think about issues of reciprocity and my desire to minimise any negative impact caused by participation within this New Mother study. This commitment to reciprocity was, in part, due to the concerns I had as a nurse and my understandings of the potential

difficulties women encounter during the first year of mothering, for example, the understandings of sleep deprivation new mothers experience and the added imposition of having a stranger come into their home, resulting in additional pressure being caused by these interview visits. In particular, as the women when I visited their homes may have been trying to make 'a good impression' that they were coping with motherhood and were competent mothers.

It is an impossibility to identify the extent to which reciprocity was achieved within this New Mother study. Even if I concluded reciprocity was present, the women may not come to the same conclusion. So, rather than proposing that I was able to achieve even partial reciprocity within this study, a more appropriate commitment was made to generate spaces for engagement with the women, which was achieved through several activities. These activities included a dialogue as a part of the interviewing process; the provision of the finished transcripts to the women; a willingness to discuss the progress of the New Mother study; providing answers to questions about child rearing and other health related concerns; and disclosure of personal information about my experiences as a mother when questioned by the women.

The issue of generating spaces for engagement will be discussed in greater detail later within this chapter. The following section addresses the practical aspects of the research.

3.2 Conducting the research study: 'collecting' the women's accounts

In this second section I provide a description of the research approach used to manage this New Mother study. This description will include gaining ethics approval to conduct this research; an overview of the recruitment process; a brief profile of the women who acted as subjects within this New Mother study; the technical details of the data collection, in particular, how the interviews were conducted and the types of questions asked at each interview; and the transcription and management of the data

analysis and the difficulties which were encountered.

3.2.1 Ethics approval

This section provides a discussion of the ethics approval process and difficulties which occurred prior to commencing the interview process. The proposal for this study was submitted to two research and ethics committees, the University of Technology (UTS) Human Research Ethics Committee and an Area Health Service (AHS) Ethics Review Committee. The UTS Human Research Ethics Committee accepted the proposal without alteration with the statement in the approval letter of 'the committee commented that the proposal was very thorough and professional'.

The response of the AHS Ethics Review Committee was not as favourable. I had been warned by other nurses of the difficulties they faced gaining permission for their 'qualitative' studies from Area Health Service and Hospital Ethics Committees. Speculation has occurred that these difficulties may be due to the desire of doctors to define medicine as a technical rather than a social discipline (Oakley 1992). The increasing focus on evidence-based practice may also have compounded this reluctance to acknowledge the legitimacy of qualitative research.[4]

Gaining approval from the AHS Ethics Review Committee for this study to progress took four months. A different minor issue was raised each time the research proposal went to the AHS Ethics Review Committee for approval.

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[4] According to White (1997) evidence-based practice is grounded in a search for relevant research literature and the evaluation of that research literature using a rating scale. The resulting clinical interventions, are then able to be identified as based on the available 'scientific' research. The Australian National Health and Medical Research Council (NHMRC) have adapted the 'Quality of Evidence Rating Scale' from the United States Prevention Services Task Force to rate the quality of research evidence (Wallace, Shorten & Russell 1997).

First submission of proposal	Requested to gain a letter of support from Tresillian Family Care Centres[5] to allow me to directly refer women or infants who I thought were 'at risk'.[6]
Second submission of proposal	Requested to gain a letter of approval from the Director of Nursing at the hospital in which I had arranged for the research information sheets to be distributed during childbirth classes. I had only submitted a letter of approval from the manager of the parenting education unit.
Third submission of proposal	Requested to change the language on the research information sheets.

Approval was gained the fourth time the research proposal was sent to the AHS Ethics Review Committee after the language had been changed on the research information sheet from writing to the women as researcher in the first person to the third person. For example, from 'I would like to talk to you about your experiences ...' to 'the researcher would like to talk to you about your experiences ...'. It became apparent from this response to the participant information sheet that the AHS Ethics Review Committee may have wanted to erase my presence from the research by objectifying me as a researcher.

Why were these minor changes requested each time the proposal went back to the AHS Ethics Review Committee, and in particular, the third request for an amendment? The first two issues were issues about the safety of the women and their infants. In particular, the identification of women or infants 'at risk' had been raised within the research proposal and an outline of my actions was provided, which

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5 Tresillian Family Care Centres is a health service which provides a range of services for parents of children 0-5 years old experiencing parenting difficulties e.g. 24 parent help-line; outreach, day stay and residential services; and parent and community education. Tresillian acts as a major child and family health referral service for NSW. The staffing profile consists of child and family health nurses, social workers, psychologists, paediatricians and psychiatrists. I have been employed by Tresillian as a child and family health nurse and educator for the past 19 years.

6 For example, if I thought the mother had abused the infant or that she had suicidal ideations.

included accessing Tresillian. So the two letters of support which were requested were administrative concerns.

The final issue was of writing style and the resulting explicit naming of myself as the researcher, which, if of concern should, have been raised in the initial review of the proposal. No justification for the request to change the language used from the first to the third person was given within the request letter or during a subsequent telephone conversation.

An assumption can be made that the research approach I was attempting to use was unfamiliar and did not fit within a medical model of 'scientific' research. It could be proposed that poststructural and feminist research approaches are looked on with scepticism as they unsettle the desire for research data that is objectified and uncontaminated by the social context. This belief of the necessity for a researcher to discard their personal values to avoid contamination of the research has been challenged by Oakley through her statement that:

> mainstream knowledge pretends that personal values are left behind in intellectual work; feminist knowledge knows that they are not, and that an awareness and articulation of what these are and how they may be represented in knowledge as a product is essential, not to prevent the shaping of knowledge by personal perspective, but to understand, to know, when and how this happens (1993, p.214).

Scientific approaches to research have as their aim the 'truth'. However, many post positivist theorists, including both Stivers (1993) and Lather (1991), argue that the most we can hope for in research is agreement, as final knowledge and truth are not possible. To achieve this scientific approach and be taken seriously, Stanley and Wise state that if " 'scholarly detachment' ... [is expected] we must present our research in such a way that we strip 'ourselves' from descriptions, or describe our involvements in particular kinds of ways – as somehow 'removed' rather than full-blown members of the events and processes we describe" (1993, p. 155).

3.2.2 Recruiting

Fifteen women were recruited through two sources — the first and most successful recruiting method was by word of mouth through my social network. The second was through the childbirth classes at a hospital, in Sydney, Australia. I provide here a brief overview of the recruitment process.

After approval was gained from the AHS Ethics Review Committee, women were contacted by the distribution of the research information sheets during the 'childbirth classes' at a Sydney Hospital. The women were given written information, then requested to contact me if they wished to participate in this New Mother study. Five women contacted me and, after being provided with verbal information during a telephone conversation, they agreed to participate in this New Mother study.

Ten women were recruited by word of mouth through my social network. Seven of these women were unknown to me, but were friends of friends or acquaintances. For example, one of the women was a friend of my hairdresser, another was a friend of a work colleague and one woman was told about my research at a party. It still remains a mystery as to who told her about the research and the need for participants.

I knew three of the ten women as nursing colleagues. Prior to commencing the interviews, we discussed our relationship and the implications which may arise for that relationship during and at the completion of the interview process. These three women were insistent they wanted to participate within the research, even though I had reservations about their inclusion. These concerns were related to issues of power and confidentiality, as I anticipated that the interview questioning would facilitate the disclosure of information they may later regret. I am now pleased they were willing to participate, as the three women were nurses. Through their insights, knowledge and experience, I believe they have enhanced the research by the stories they told and the shifting positions they assumed during the construction of these stories.

3.2.3 Description of the research subjects

In this thesis, claims are not being made that the research participates represent the diversity of mothering experiences, styles or ways of learning which exist in Australia or that the results can be generalised to other women. Nevertheless, the results have the potential for transferability to a variety of practice fields such as nursing, midwifery and parent education. This New Mother study constructs a sense of the complexity and specificity through the multiple and contradictory subject positions of the women.

The women who accepted the invitation to participate within this New Mother study were a relatively homogeneous group in that they did not represent the diversity of the Australian population of new mothers, though the characteristics of the group of women are of interest and add to the richness of the research. Therefore, an overview of these characteristics will be explored within this section. The one characteristic the women had in common was their eagerness to participate within this New Mother study, a factor of research interest in itself.

The fifteen women lived within the Sydney metropolitan area — four in the southern suburbs, one in south western Sydney, seven in the inner west, one in a northern suburb, one in a north western suburb and one woman lived in a semi-rural area on the fringe of Sydney. One of the women lived next door to her parents-in-law on the semi-rural property and another lived in a flat attached to her parents' house. The age range of the women was from twenty seven to forty two years of age; twelve of the women were thirty years of age or older.

Twelve of the women were born in Australia, with only three women born overseas — one in a Central European country and two in New Zealand. One of the woman

was first generation Australian, whose parents came from Germany. Three of the women had partners who were born overseas — one came from Canada and two from Greece. All the women were in heterosexual partnerships and thirteen were married. During the interviews I met only three of the partners.

Twelve of the women had tertiary qualifications; one woman was a student completing a higher research degree, while another woman had completed a doctoral degree and worked as a university academic; four women were registered nurses and midwives (one of these women was also an experienced child and family health nurse); one woman was a child care worker; three of the women were school teachers and one woman came from a large family of ten children. The other six women had limited contact with children of two years of age and under (see Appendix 1. for a short profile of each woman).

Of significance for this New Mother study are the life experiences of several of the women as they foreground differences between the women and the way in which subject positions as mothers are constructed by them and for them. For example: one woman had a home birth; one had experienced father-daughter rape; one had been physically and emotionally abused as a child; two women developed postnatal depression — one of these women required psychiatric intervention; four of the women had difficult relationships with their mothers — one woman had no contact at all with her mother; several women returned to work within the first nine months — two within three months of the birth. This list could easily be extended to demonstrate the difference among the women, even when at first glance these women appear to be from similar socio/economic and cultural backgrounds.

Even though this group does not attempt to represent the diversity of mothering in Australia, an assumption that the group of women is relatively homogeneous can be troubled. At a superficial level the statement could be justified. However, at a deeper level, the women had extremely diverse life experiences, pregnancies, childbirth, and mothering experiences; they often had contradictory expectations and desires, and the

ease at which they learnt and accepted their function of mothering varied greatly.

In defence of the seemingly homogeneous research group, Mishler (1986) in his discussion of sampling, concluded that the allocation of research subjects into different subgroups is potentially artificial and has no direct representation of social institutions, families or subjects. This notion is supported by Usher in his discussion about generalisation of research results he raises two possible conclusions:

> the first is that generalisations are possible but they tend either to be truisms or to be much too general. The second is that the search for generalisations is probably doomed to failure since it is questionable whether generalisable and predictive knowledge is possible in the social domain (1996a, p. 14).

Through this statement Usher accentuates the impossibility of generalising results and therefore women's experiences, in any 'universal sense'. So, regardless of the heterogeneity of the research group, the ability to generalise or universalise research findings remains questionable, as the findings will always remain partial and situated. However, this inability to generalise does not stop professionals from making assumptions about and connections to their work, thereby enabling a transfer of research results and understandings to inform and hopefully improve clinical practice.

3.2.4 Generating spaces of engagement

The term 'generating spaces of engagement' is employed to describe the intent behind the interviewing style used within this New Mother study. A series of three interviews was completed with fifteen women (who are first-time mothers). These interviews occurred, first, during the last three months of their pregnancy (third trimester); second, at approximately thirty days after the birth of their baby; and third, between six-to-nine months after the birth of their baby. Finally, a group gathering of the research participants was convened after the third interviews were completed. This section will describe the interviewing style, the general content of the interviews and the issues that occurred.

The interviewing style used was based on a dialogue or conversation with the women, rather than an 'interrogation' using a scripted interview schedule. The use of a dialogue as an appropriate interviewing technique is supported by Cotterill's statement that the "... best way to find out about women's lives is to make interviewing an interactive experience" (1992, p. 294). In her discussion of the 'realities' of interviewing, Oakley (1993) also advocates a relationship between the participant and researcher as non-hierarchial; and that the researcher invests their own 'personal identity' in the relationship. During Oakley's discussion of interviewing women, she raises the issue of the women's reaction of friendship to her obvious desire to develop a relatively intimate and non-hierarchial relationship which considered and responded to the needs of the women and their infants. It is implied by Oakley that this intimate and non-hierarchial relationship was achieved by behaviours such as ensuring confidentiality of the interview data by being the only person to listen to the interview tapes; answering all questions about her personal life and the research as fully as required; and being prepared to interrupt an interview to answer a question, or respond to a baby.

A similar interactive interviewing experience was generated within this New Mother study by using a semi-structured dialogue with the women, which facilitated an exploration of the women's learning and experiences of pregnancy, childbirth and the first months of mothering. A series of questions and themes had been identified and used to guide the interview process and acted as a check-list to ensure that potentially important issues in terms of other researchers' findings, and my own professional and personal experiences were investigated. The women readily responded to a conversational style of interview which frequently consisted of a question to the woman, an answer and then a question back from the woman seeking confirmation of her answer, reassurance or the sharing of my experience of a similar mothering situation. This semi-structured dialogue was chosen, on the grounds that a reliance on a highly structured question/answer model of interviewing has the effect of a greater decontextualising of the response meanings, which possibly results in concealing the

interrelated issues of discourse, context and meaning (Mishler 1986). This concealment potentially occurs because of the requirement to maintain the predetermined boundaries of the structured interview.

Difficulties with the use of a dialogue occurred during the sorting and analysis process, as there is no explicit grouping of themes which is possible if a structured interview schedule is followed. The transcripts are not contained within carefully designated parameters that provide markers for grouping responses. This lack of structure in an interview incorporating a dialogue could cause major difficulties if the researcher required a matching of participant responses.

In using a dialogue with the women, disclosure of information about my life was anticipated and indeed occurred during the interviews. The amount of disclosure was frequently directed by the women through the questions they asked or their apparent need for affirmation of their experience at times being similar to mine as a mother. During the interviews, the women asked questions about their babies or about the meaning of different medical terms. An example, of this type of questioning was during the second interview, Heather was describing her delivery and the physical state of her body:

Heather: .... I did notice on my notes that I had ragged membranes, so I don't know still to this day what that means?

Cathrine: (laugh) Oh right, I can fix that, well when the placenta comes out and the membranes are the bag that the baby's in.

Heather: oh all right...

I continue the explanation about ragged membranes and why it is recorded in her notes. Heather had read her hospital notes, but had not asked for an explanation. This may have been due to a sense of infringing her subject position as a patient and feeling guilty about not gaining permission to read these notes. In providing her with an answer to a medical term, some of the mystique and the institutional power that health

professionals have can be diminished by increasing her understanding of what happened to her body during childbirth.

An additional opportunity was provided at the end of the interview for the women to ask questions. This section of the interviewing process became very important. The women responded to my answers frequently with additional information that they had forgotten or did not feel ready to share in the main part of the interview.

To address some of the women's questions about feedback from the research, a copy of their interviews was given to the women. These transcripts provide a particular kind of record of how the women constructed their experiences of learning to mother. The women's responses to the transcripts were mixed: several of the women had already read the transcripts with their partners, others had decided not to show anyone else; some of the women were going to give them to their daughters when they were old enough, and one woman was concerned that her son might interpret the transcript as demonstrating her lack of love for him as a baby.[7]

In documenting this interviewing process, it appears reasonably organised and managed. However, it is important to foreground the disjointed and chaotic unstructured approach, which was frequently caused by the inclusion of the baby at the second and third interview. Rather than being a disadvantage, the chaos often enhanced the process and the richness of the data. This enhancement occurred as the women attended to their babies, which allowed alternative spaces of engagement to occur where they made additional comments, asked questions, showed how clever or beautiful their babies were and demonstrated their growing confidence in mothering. These distractions frequently extended the interviews, but provided interesting observations of the interaction between the women and their babies. During the third interview many of the babies became very interested in the recording equipment which

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7 Jane had experienced postnatal depression for many months and at times had constructed extremely negative stories about her experiences of motherhood.

provided an additional challenge to place the equipment in a position which still picked up the interview but did not provide enticement to an inquisitive baby.

Each of the interviews occurred in the women's homes or at a mutually agreed place, at a time which was suitable for the women, with each interview taking between one to two hours. There is in excess of sixty hours of interview data which has been collected from the fifteen women. In most instances the women were alone at the time of interview (except for the presence of the baby).

However, on several occasions either the woman's partner or mother were in the house, which tended to cause tensions during the interview. The women appeared more guarded in their responses to the interview questions and I seemed more reticent in the questions I asked, often changing the order of the themes we discussed. This changed order allowed the women to discuss more sensitive issues about relationships without their partner or mother being in the room.

Only one woman requested to be interviewed in her office for the first and third interview; the second interview was conducted at her home. Most of the women were interviewed in their lounge rooms, especially when their babies were present. The third interviews were often completed sitting on the floor with the baby exploring the surrounding environment and us.

At the instigation of the women, they were invited to meet as a group to share their experiences of participating in this study after the completion of the series of three interviews. The group meeting also provided an opportunity to feedback initial findings of the research.

The interviews were recorded and then transcribed after each session with the women. The completed transcripts were then returned to the women as a record of their experience. The comments from the women who have started to receive the transcripts were of pleasure and a growing sense of involvement in the research.

A major positive aspect of this research method was the increasing friendship with the women. I anticipated each follow-up interview with pleasure and a great deal of interest to find out how they were managing with their task of learning to mother. It was with a great deal of sadness that I said farewell at the completion of the third interview. Since the completion of the interviews I have had unexpected meetings in the street with several of the women and their infants. This contact, for me, has been of two friends meeting who have shared an important event; are pleased to see each other; and have a continued interest in each other's progress.

The following section will provide an overview of the four interviews completed with the women.

3.2.4.1 First interview

The first interview occurred during the last three months of the woman's pregnancy (third trimester). This interview had several aims these included the following series of themes: investigating the woman's pregnancy history; her experience of being mothered; and documenting her initial construction of herself as a mother, her expectations of mothering, what she would like to occur, how she viewed the baby growing within her and her impressions of the support that would be provided by significant family members or peers. During this interview the woman's understandings were recorded of the information she had received to prepare for the experience of childbirth and motherhood; her understanding of what would happen and how it would feel, physically and emotionally; and an identification of the educational process she had been involved in to prepare for motherhood.

This interview, in most instances, started in a very formal manner with offers of cups of tea, and several of the women had prepared morning or afternoon tea. By the middle of the interview the women had began to relax and were very talkative, raising issues and themes which had been anticipated but not actively sought. The majority of the women had never participated in a research study before and had been unsure of

what would occur during the interview.

3.2.4.2 Second interview

The second interview, at approximately four to six weeks after the birth of the woman's baby, provided an opportunity to investigate the woman's experiences of childbirth, the early days of learning to mother, her perceptions and the experience of mothering.[8] The timing of this interview was chosen because an intense period of learning about their baby and themselves as mothers, is usually occurring for the women when the baby is between four and six weeks.

During this interview the women often asked questions about the following kinds of issues: medical terms; practical child care such as breastfeeding, bowel motions, vomiting and their baby's unsettled behaviour; and the physical and emotional changes they were undergoing such as sleep deprivation, mood swings and urinary problems. Throughout, this second interview the women often sought reassurance about their mothering skills and feelings about motherhood.

3.2.4.3 Third interview

The opportunity to interview the women again between six to nine months after the birth was arranged in the belief that the women would have distanced themselves from the earlier raw experience of childbirth and the intense period of early motherhood. The aim of this interview was to engage the women in reflection about their experiences of maternal learning. During this period of reflection the issues explored

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[8] From my experience as a child and family health nurse, this is a period for many women of labile emotions, extreme tiredness and of trying to develop a relationship with their baby. This understanding is reinforced by the reluctance of health professionals to diagnose postnatal mood disorders before six weeks as this remains within the postnatal period (Riley 1995); six weeks is one of the recommended times to use quantitative measures for the identification of postnatal depression (Holden 1994); and six weeks postpartum is the time used as an interview period in other similar research studies about mothering (Oakley 1992).

included: the significant learning that has occurred; identification of knowledge and skills that would have or had been of value during this learning process; inhibitors to learning; the use of their prior experience for learning; connection with other women through this process; and identification of the woman's unanswered questions about learning to mother.

Several of the women rang prior to this interview to remind me that it was time for the third interview. All of the fifteen women who agreed to participate within this New Mother study completed the three interviews. The commitment of the women to this study possibly reflected the productivity of the research process for the women. This productivity may have been in terms of social support or as proposed by Oakley (1993) access to a 'therapeutic listener' which meets for the woman a general need for support which was not available from family or friends. Many of the women had identified that their participation within the New Mother study was an activity that was for 'them'.

3.2.4.4 Group gathering of the research participants

Due to the developing interest of the women in this New Mother study and the understandings I was developing, a fourth occasion of contact with the women was arranged. The women were invited to meet as a group. This group provided an opportunity for feedback about the initial research findings and also to discuss how they felt about participating in the research process and their final reaction to reading their transcripts.

An invitation was sent to the women requesting them to contact me if they wanted to attend the group. The women had the transcripts of their three interviews prior to being invited to the gathering. I anticipated that these transcripts would assist the women refresh their memories of their experiences. For several of the women, their babies were nearly two years old at the time of the group meeting.

The group was held at my home on a Saturday afternoon. For numerous reasons only four women attended. Several of the women expressed disappointment that the group conflicted with other social engagements which they had already committed to such as a wedding, a Buddhist religious ceremony and a church weekend retreat. One of the women had moved to the country and another was unwell. The four women who attended were Zoe, Rebecca, Meredith and Jane.

The group lasted for about two and a half hours with a great deal of lively discussion about their experiences of motherhood, what it had been like to be part of this New Mother study and their plans for the future. Even though questions were prepared, the women directed the conversation, frequently challenging one another, asking questions, probing, reassuring, supporting and encouraging each other to share their experiences. On listening to the tapes of this group, my voice is 'there', but not as the only interviewer. The group was clearly deciding the direction of the discussion through their interactions and the subject positions they were assuming. These shifting subject positions included: sympathetic listener; willing storyteller; 'good', 'bad' and ambivalent mother; experienced and 'knowing' mother; and the experienced research subject.[9]

The group gathering allowed me to address what had become an important issue in the earlier stages of the research, the question of language. The women had been unable to adequately capture descriptions and meanings of 'what mothering meant for them', so an activity was identified which might assist in rectifying this perceived deficit in my research. After the four women had arrived they were asked to draw 'what mothering meant to them'. A range of coloured felt pens and white paper were supplied. Jane and Rebecca at first were reluctant to draw. Reassurance was provided by Zoe and Meredith that they would not be critical of their drawings. No guidelines were offered as to what they should draw apart from 'what mothering their own child

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[9] On several occasions they simultaneously stopped talking when the tape recorder clicked off, all laughing and making comments about how well trained they now were.

meant for them'?[10] When the women had finished they were asked to describe their drawings. These drawings will be discussed in greater depth in Chapter 7.

The sequence and timing of these interviews was important to enable the women to develop a rapport with me as the researcher, especially beginning the interviews during the women's pregnancy, as this allowed me to focus on the women without the distraction of their babies.[11] This limited longitudinal approach to the interviews provides a snapshot of the complexity of mothering and opportunities to reflect on their experiences of learning to mother. The knowledge and meaning making that comes out of this New Mother study is not meant to be generalised to all mothers, but to be used as a mechanism to start to understand the discourses and social practices which assist in the production of new mothers.

3.2.5 Ethical considerations

This final section will focus on the ethical considerations related to this New Mother study. Prior to commencing the interviewing phase of this study I had many doubts about the ethical aspects of the research, in particular, how I would deal with my shifting positions of nurse and researcher. A constant unsettling notion occurred of assuming a subject position of researcher where I was requesting assistance from women, rather than the reverse in the much more familiar positioning of a nurse where women came to me to ask for assistance with a parenting problem. Contradictions were occurring which caused tensions, as potential problems and issues that could develop during the interviewing process were identified.

These concerns as a researcher were overlaid with my responsibilities as a registered

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[10] While the women were drawing, which took approximately 10 minutes, I made afternoon tea. This food preparation was a planned strategy to ensure I was busy and away from the kitchen table while the women did their drawings.

[11] It needs to be acknowledged that even during the first interview the baby was present as a quietly intrusive subject, who would regularly remind the women of their presence through movements, discomfort and the occasional kick.

nurse and the requirement to maintain a 'duty of care' by ensuring any situations which arose were managed in an appropriate and safe manner.[12] The main ethical concerns were related to the identification of a woman or baby 'at risk'; and the use of women's experiences for research, particularly in the disclosure of sensitive issues.

3.2.5.1 Identification of a woman and baby 'at risk'

The first major concern was the potential to identify a woman or baby 'at risk'. This concern was based on my clinical experience and the published literature about perinatal mental health disorders and child abuse. Maternal distress, anxiety and depression have the potential to place women and their young children 'at risk' of physical and emotional injury, which may result in the development of postnatal mood disorders and/or child abuse. Both of these outcomes can have profound and long-term effects on the functioning and wellbeing of the infant, woman and family (Kowalenko, Barnett, Fowler & Matthey 2000; Maughan & McCarthy 1997).

The first concern of the development of maternal distress or depression, which is of clinical significance, can compromise a woman's capacity to safely care for herself and her baby (Kowalenko et. al. 2000; Riley 1995).[13] A key factor in preventing or ameliorating the mental health problems experienced by women during the perinatal period has been identified as the provision of social support through contact with a person prepared to listen to the woman's experiences and concerns (Kowalenko et. al. 2000; Thorpe & Elliott 1998; Riley 1995; Holden 1994; Oakley 1992; Oakley 1986a).

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12 Rogero-Anaya, Carpintero-Avellaneda & Vila-Blasco state that "... beneficence (helping and caring for the sick) and nonmaleficence (not doing harm) ..." (1994, p. 217) are the guiding principles of health care which must also be a part of health research.

13 Maternal distress after childbirth is not being identified as a psychiatric disorder but, if left unresolved, can develop into a mental health disorder such as depression. Nevertheless, maternal distress can severely inhibit a woman's enjoyment in and ability to mother her infant (Thorpe & Elliott 1998; Barnett & Fowler 1995; Riley 1995).

The second concern is that in Australia, during the 1994/95 period, there were 30,615 substantiated cases of child and youth abuse (NSW Health 1997, p. 16). As with perinatal mental health disorders, a major factor in the prevention of abuse of infants and young children is the provision of physical and emotional support for women (parents) experiencing difficulties in their care giving functions (SCSI 1998; Tomison 1998).

The use of social support, especially providing an opportunity to focus on and talk about a woman's needs and concerns, is constructed as an effective strategy to minimise risk (Riley 1995; Holden 1994). The process of research interviewing, in particular, a semi-structured dialogue within the interview, can be identified as providing this opportunity for women to talk about their experiences and concerns with an attentive and interested listener, with resulting feelings of social support being gained (Oakley 1992).[14] So it can be argued that research interviewing is unlikely to have any detrimental effects for the women, as it has been demonstrated that providing an opportunity for women to talk about their maternal experiences is therapeutic in minimising and in many instances preventing the onset of postnatal mood disorders (Holden 1994; Holden 1987; Handford 1985) and child abuse (NSW Health 1997). For the women within this New Mother study, the interviews seem to be an anticipated and pleasurable experience. This understanding is constructed due to the welcome I received at each interview, in particular, at the second and third interview and of all subjects willingness to complete the series of three interviews.

However, I remained concerned about the implications for this New Mother study if intervention was required, resulting in the potential for the breaking of confidentiality promises which were made to the women. These concerns about the researcher's responsibility were also raised by Oakley (1992), about her research study on social

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[14] From the positive response of the women within this New Mother study the opportunity to discuss their experiences of learning to mother has be consistent with Oakley's (1992) research experience. For example, I refer back to the discussion on 'generating spaces of engagement' within the earlier sections of this chapter.

support, where research midwives had identified potential 'at risk' situations. Oakley acknowledges that the definition of the midwife's research role prohibits her from actively intervening, although in the instances cited by Oakley, it was acknowledged that the midwife did identify 'at risk' situations and took action. The outcome of this research situation may have been significantly altered because of the intervention, thereby resulting in a potential 'contamination' of the research outcome in scientific research terms. However, rather than a concern about contamination if intervention was required, a foregrounding would occur of the complexity of learning to mother and care for an infant, and the potential difficulties involved in this type of research study.

As a nurse, the safety of the mother and baby is of paramount importance so, as a part of the research plan, the issues were explored and a strategy was identified to manage these potentially difficult situations. The strategy identified was already used within my clinical practice as a nurse — if intervention became necessary, my concerns would be raised with the woman and assistance would be offered in accessing the type of support or intervention she may require. If a child abuse notification was required the woman would have full knowledge that I was taking this notification action.

Fortunately, I did not encounter a situation where I believed a child or mother was in an immediate 'at risk' situation requiring intervention. In making this statement I need to acknowledge that several of the women appeared anxious about their mothering ability and were experiencing sleep deprivation, which resulted in angry comments about motherhood and their infants. However, these women had already taken steps to alter the situation by the time I came for their second or third interview. The types of actions which the women instigated included commencement of treatment for postnatal depression; another woman had arranged for her mother to come and stay for a couple of weeks; and another woman was having regular home visits from a child and family health nurse.

Two strategies were used to assist me fulfil my duty of care. Firstly, as a safeguard, a referral protocol was developed to satisfy the AHS Ethics Review Committee. This protocol ensured that I was able to use Tresillian Family Care Centres as a direct referral source if the need arose. For example, I could directly refer a woman to Tresillian if she required child rearing advice or education; additional psycho-social counselling support; assistance with infant feeding difficulties; support to ameliorate sleep deprived; or intervention to manage the woman's experience of a postnatal mood disorder.

As described within the earlier section of this chapter about 'generating spaces of engagement', the second strategy was the use of a dialogue within the interviewing process and the acknowledgement of the multiple subject positions I occupied during the interview process. This strategy provided opportunities for the women to direct the interviews and discuss issues of concern about their mothering, ask advice about child rearing and psycho-social aspects of mothering. The decision to acknowledge the different subject positions I occupied during the interviews allowed me to explicitly position myself as a nurse if necessary to assist the women with their concerns.

3.2.5.2 The use of women's experiences for research

The use of women's experiences of pregnancy, childbirth and motherhood, and the implications of encouraging women to disclose information about their lives and to construct stories about their mothering experiences will be discussed in this section. This disclosure of information links research interviewing with confessional practices, of placing women in a position where they willingly construct stories which often disclose intimate aspects of their lives.[15]

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[15] The notion of interviewing as having links to confessional practice is constructed from Foucault's (1978) concept of the production of truth through the validation function of the confession. According to Foucault (1978) the confessor provides the truth and the listener validates the truth. Confessional practices will be discussed in greater detail in Chapter 5.

Consenting to be interviewed for a research study results in an agreement to disclose aspects about a woman's life which may otherwise not be thought or spoken about by the participant. Three issues of concern were identified that related to disclosure during the research interview. The first issue related to the participants' feelings of vulnerability and safety during the interview. The second issue was that the information the women disclosed might not be related to the interview and disrupt the collection of data. The third issue was my concern that an expectation may exist, because of my nursing background, that I would provide some type of advice or intervention for the women. These disclosure issues are issues of power, because of the relationship between the researcher and research participant.

A comparison can be made between essentialist and poststructural thinking about power and its positioning within research. Mishler proposes that "in the mainstream tradition the interviewee-interviewer relationship is marked by a striking asymmetry of power; this is the central structuring feature of interviewees as research contexts" (1986, p. 117). However, according to Lather a poststructural view of the relationship between interviewee and the interviewer results in research which is constructed as "... an enactment of power relations; the focus is on the development of a mutual, dialogic production of a multi-voice, multi-centred discourse" (1991, p. 112).

In discussing power, I am not trying to propose that power is always equal during the interviewing process, but constantly shifting and beyond a contained binary of domination and resistance. Scheurich (1997, p. 71) supports this notion through an example of his own research experiences:

> interviewees do not simply go along with the researcher's program, even if it is a structured rather than open one. I find that interviewees carve out space of their own, that they can often control some or part of the interview, that they push against or resist my goals, my intentions, my questions, my meanings. Many times I have asked a question which the respondent has turned into a different question that she or he wants to answer. While sometimes this may be an effect of misunderstanding, other times it is the interviewee asserting her/his own control over the interview. In other words, interviewees are not passive subjects; they are active participants in

> the interaction. They, in fact, often use the interviewer as much as the interviewer is using them.

The interaction within an interview situation is one of constantly shifting subject positions and power relations. These understandings exposed by Scheurich trouble the notion of a safe space for the women, as it unsettles the belief that the researcher is in total control of the research process and can ensure a safe space. A similarity can be drawn with the desire to 'empower' women through the research process. Scheurich highlights the difficulty with the concept of empowering others as this desire functions as a kind of paternalism which "... implies that the researcher can give power to the interviewee. The researcher is the superordinate who has the power to give, and the interviewee is the subordinate who needs the power that can be given by the researcher" (1997, p. 70).

An example of a situation in which the disclosure of information could have left a woman with feelings of vulnerability occurred during the first interview with Meredith, who disclosed that her father had raped her. I believe knowing she had been raped was important in providing a context for investigating her learning. This situation was managed by not probing further during this part of the interview, as the intimate details of the incident were not crucial to my research. I tried to allow Meredith to be in control of what she wanted to tell me about her experience. Before continuing with the next question I asked Meredith if she was ready to move on or if she wanted to talk further about what had happened to her as a teenager. Meredith chose to move on to the next area of questioning. As a way of protecting her confidentiality, Meredith asked that the occupations of her parents be withheld as this information may increase the ease with which she and her parents could be identified.[16]

When reflecting on this incident I realised the power relations within the situation were dramatically shifting. I have read my reluctance to probe further into Meredith's

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[16] Meredith no longer has contact with either of her parents.

experience as allowing her to have control over the situation, to provide a space for her to either disclose intimate details of the experience or to move onto the next topic of discussion. However, it may also be read as not wanting to be placed in a position in which I was concerned I would not have the skill to manage the interview safely.

Meredith's disclosure occurred during the middle of the first interview. If this issue had been raised for the first time during the second or third interview, the management of the situation and the type of information provided may have been different as the power relations would have possibly altered as my relationship had become well established by the second or third interview. More importance may also have been attributed to the information in relationship to Meredith's learning which was being provided, and an increased probing of the incest experiences may have occurred.

The choice made not to actively probe into Meredith's experience of incest could also reflect my social values and positioning as a researcher who has been invited into her home. These choices do have effects on the research which need to be foregrounded and problematised. The notion of value-free scientific research is challenged by Usher through his statement that:

> the need to take account of the dimension of power challenges the possibility of 'disinterested' research and value-free knowledge. Science is both constituted by a particular set of values and itself is value-constituting, yet the scientific attitude is one that continually attempts to suppress the place of values and conceals the workings of power (1996a, p. 29).

The use of a dialogue as part of the interviewing process explicitly positions this New Mother study outside of the criteria often attributed to scientific research. It allows a less constrained and 'naturalistic' approach to gaining information which acknowledges the shifting power relations between the research participants and the researcher.

This section has identified and discussed the two major research considerations and their implications for this New Mother study. The first is the inability to identify if strategies for reciprocity have been achievable. This inability resulted in a more achievable expectation to be identified of trying to generate spaces for engagement with the women participating within this New Mother study. The other consideration was the use of women's experiences for research and the related concern of disclosure of sensitive information; in particular, of importance within this discussion was the issues of power between the research participants and the researcher.

3.3 The analysis process

A major part of the research process has, of course, been working with the data. Several strategies and different activities have contributed to the analysis and formed the basis of this thesis. The analysis process often began during the drive home from an interview, as the events of the interview were reviewed by identifying stories and themes which may be of importance. These initial feelings about the interview were recorded on tape. The third section of this chapter will describe the process of transcribing the taped interviews; the sorting of the collected data; and the use of discourse analysis to work with the interview texts.

The first formal analysis activity was the process of transcribing each interview, as the women's stories were transcribed into written text. Each interview text tells a multifaceted story about the experience of learning to mother. The series of three interview transcripts (one for each interview) can also be identified as coming together to form one story, or alternatively three different stories which are connected as they trace the shifting subject positions of the woman. These series of three interviews, when read in conjunction with the transcripts of the other fourteen women, produce the corpus of the research.

The second analysis activity incorporates working with the corpus to distinguish story lines (Davies 1994) and patterns within the transcripts. This sorting process identified a major theme which is the production of the new mother as a social practice and three sub-themes of surveillance, normalisation of motherhood, and maternal learning.

The final component of the analysis was the use of discourse analysis. Discourse analysis was chosen as the method of analysis because of its potential to provide new and alternate readings of the selected interview data. Discourse analysis will be discussed in the final section of this chapter.

3.3.1 Transcription of the data

In the following section I will describe the transcription of the tapes which proved to be an important stage of the analysis. The hours of listening and re-listening provided an opportunity to develop a closeness with the data, which otherwise may not have occurred. This closeness to the data could be constructed as an important strategy for stimulating reflexivity within this New Mother study.

As valuable as this transcription process was in terms of developing a closeness to the data, it was also extremely demanding physically and emotionally. Mishler also identified the difficulty of this process and his words provide a description which reflects my experience of the transcribing process as being "... complex, tedious, and time-consuming work that demands careful listening and relistening ..." (1986, p. 47). At the completion of the interviewing phase of this New Mother study there were in excess of sixty hours of interviews and it took approximately eighteen hours of transcription time for each hour of interview.

The decision to transcribe the interview tapes myself was made because of concerns about two main issues; firstly, the sensitive nature of the information being provided by the women during the interviews. This information included physical and emotional

issues; relationship problems; feelings of anger towards their infants; physical and sexual abuse. The second issue arose because of the stories I had heard from other researchers and read within the literature about censorship of the information by the typist, which resulted in additional unexpected work for the researchers.[17]

The process also involved decisions about how to represent the women's stories in text. A decision was made not to include nonverbal communication and vocal quality in the transcripts. The tapes have been preserved to maintain the ability to check, if necessary, specific comments and the context in which they were spoken.[18] After each interview I recorded my impressions of how the session had proceeded, significant behaviours of the women and any concerns which had been raised to provide insight into what had occurred to enable clarification as the interview process became distanced by time. These interview notes include the following comments:

> When Meredith told me she had experienced father daughter rape, I thought my worst fears were about to eventuate, as I had been worried about such a disclosure. Thankfully, I think I managed the situation well (first interview: researcher notes).
>
> Victoria was looking very tired and was sleep deprived (second interview: researcher notes).
>
> Lisa's mother was visiting from New Zealand for a few weeks and planned to return after the baby was born. Having her mother in the house I felt inhibited me when asking questions (second interview: researcher notes).
>
> Heather looked and acted very confidently with Carolyn (third interview: researcher notes).

The transcribing process proved to be both physically and emotionally demanding. The physical demand of concentrating to capture the words accurately with often unclear tape quality necessitating repeated listening before a particular phrase or word

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17 Lane (1996) has noted that typists can become unexpected participants in the research process as validators, commentators, normalisers and analysts of the research data.

18 The interview tapes will be kept for five years from the date this thesis is published.

was deciphered.

During the transcribing process there were unexpected emotional demands related to listening to the distressing stories of disappointment, pain, anxiety and distress. The women's stories often made connections to my own experiences and stories of mothering, causing a reflective process to occur and unresolved issues to be raised. This reflexivity raised questions about my shifting positioning within this New Mother study; and how these subject positions would influence the questions asked and the readings and interpretation of the research data. Some of these issues were connected with the discourses of motherhood which I had also infringed and the resulting unknown of 'would my children be different if I had adhered to the régimes of truth within these discourses of motherhood'? The subject positions I assumed while transcribing the data frequently had the effect of influencing what I remembered or identified as important during and after this second hearing of the content of the women's interviews.

Stories about the women's mothers had the greatest effects on my emotions. Firstly, the stories which caused me the greatest sadness were those of the disappointment felt when the women's own mothers did not fulfil their expectations for the provision of assistance and support during the early days of mothering. Secondly, the stories told of mothers who were there for their daughters, being supportive, telling stories and just being available for the women refreshed memories of missed experiences with my own mother, as she had died prior to the birth of my first child.

I was frequently surprised by these reactions to the stories, because I had not had the same reaction during the interviews. Possibly this was due to positioning myself as a nurse during each interview and maintaining the social practices of that position. These practices included focusing on what the woman was saying rather than allowing my thoughts to reflect on my own concerns about mothering. During the transcribing process the same constraints were not there and a process of reflexivity started to occur which frequently focused on my maternal experiences.

Acknowledging the ease with which I made connections with the women's stories became an important understanding for the later analysis process. As I worked through the analysis process an attempt was made to check what subject position was influencing the reading that was occurring. This checking process became part of the reflexivity deployed within this New Mother study. The implementation of a checking process was not done to eliminate speaking from my mothering positions, but to understand the influence these reading had on the analysis of the data and the way the stories are presented within this thesis.

This section has identified issues related to transcribing the interview tapes. On reflection this process was extremely important to enable a connection with the data. However, it did impose an additional physical constraint and extended the time frame of this New Mother study.

3.3.2 Sorting

The completed transcripts resulted in a large and complex amount of data. The process of how the data was sorted and the difficulty of identifying consistent themes will be discussed within this section. This process started informally during the transcribing of the data when interesting or significant segments and themes started to emerge. The sorting process and the tensions that developed will be discussed in the following section.

Because of the relative newness of discourse analysis (Lee & Poynton 2000) which will be the analysis approach used to work with the data, there have been minimal guidelines in how the data should be managed or sorted. Though before the data sorting commenced it was already 'prejudiced' by the initial projection of the meanings which come for my multiple subject positions within culture, society and history, and pre-knowledge of what may be considered worthwhile (Usher 1996a).

Understanding that the sorting process is already prejudiced dispels any notion of objectivity within the sorting process, as the reading of the text and the resulting meanings are mediated through my subjectivity.

An initial stage of working with the transcripts was to complete a familiarisation reading with marginal notes made to assist in the later sorting process. Several phases of sorting through the transcripts have occurred to identify categories and themes — physical aspects of mothering, pregnancy, childbirth, breastfeeding, infant care, sleep deprivation; not knowing; knowing through experience; formal, informal and incidental knowledge; learning about the maternal body; social construction of mothering; disjunctures between professional and maternal knowledge and experience; surveillance and normalisation; and being disciplined by the infant. From this sorting of the data, one major theme and three sub-themes were identified. The major theme is the recognition of the production of the new mother as a social practice, the sub-themes are maternal surveillance, normalisation of motherhood and maternal learning.

The sorting processes have resulted in various outcomes, including a tendency to produce meanings that fit with the mainstream essentialist approach to maternal research; or as Lather (1991) describes these interpretations as 'realist tales'. This approach to research is frequently descriptive and raises few challenges for the dominant maternal and parenting discourses. This production of an essentialist approach to maternal research was a form of slippage back to past meaning systems which had informed my prior education as a nurse and adult educator. When this descriptive approach started to overwhelm the analysis, a process of reflexivity or 'stepping back' from the text was implemented and asking questions such as: what subject positions am I inhabiting when I read the data in this way; how are the women positioning themselves as subjects; who are the main characters in this data; are there contradictions and tensions; and what are the discourses being spoken?

At times the outcomes and the general approach of trying to identify consistent themes have raised tensions. These tensions in part have been due to two issues. The first is that the sorting process is not a clear-cut activity which is achieved by following a neat process, but a process of meaning-making which is often messy, contradictory and problematic. This sorting process locates the decontextualised text as being influenced by the conscious and unconscious orientation and assumptions of the subject position I construct as a researcher, which plays a significant part within the meaning-making process (Scheurich 1997).

The second is a recognition of this approach of making comparisons and generalisations which is inconsistent with a poststructural understanding of a decentred subject and multiple shifting subject positions. Using such structured approaches to organising the transcript data is consistent with universalising and normalising approaches to research which propose that there is a world which is predetermined and explainable (Usher 1996a). This concern which was raised during the sorting process is addressed in part by poststructural approaches to research, which encourage multiple readings of the text (Foucault 1980a), dismisses the construction of experience as an authentic representation and acknowledges the position of the researcher within the research process.

The results of the sorting was a beginning rather than an ending to this process of finding themes; as frequent returns to the transcripts were necessary to check the selected portion of text within the larger context of the transcript. The interrogation and unravelling of the text continued through the use of discourse analysis which assisted in providing a poststructural reading of the transcript data.

3.3.3 Discourse Analysis

Discourse analysis is relatively new as a research method within nursing (Powers 1996) and the wider medical community. Discourse analysis drawing on Foucauldian, poststructural, feminist and educational work has the potential to unsettle the very foundations on which medicine and nursing have developed as disciplines by challenging assumptions which have been uncritically accepted as part of a commonsense and natural world (Crowe 1998). The potential effect of discourse analysis is to call into question the belief of being able to participate in, and produce objective and value-free research resulting in revealing of the 'truth' or 'reality' of a situation. Within this section the features of discourse analysis will be explored and will expand on the understandings of language and discourse provided in Chapter 2.

Discourse analysis is about disrupting the complacency that surrounds knowledge/power systems and the development of spaces for other realities and truths (Lupton 1995). It also rejects and troubles thinking about a text as a site of the essential self, waiting to be released (Fox 1993). Instead, discourse analysis considers texts as sites which form social practices through discourses and their implicit régimes of truth which act to govern these discourses (Foucault 1980b); a calling into question the conditions which produce discourses.

The choice of discourse analysis as the method of analysis used within this New Mother study occurred because it provides the opportunity for "... a counter-reading of historical and social conditions and offers possibilities for social critique and renewal" (McHoul & Grace 1993, p. 27) by developing "... an account of the intricate relationship between text, talk, social cognition, power, society and culture" (van Dijik, 1993, p. 253), which demonstrates the many-sides of meaning, resulting in a reading "... against the grain..." (Bordo 1993b, p. 193). The use of discourse analysis allows this study to go beyond the provision of a description which is said to represent the 'truth', 'reality' or 'lived experience' of a woman and opens potential

possibilities to understand motherhood, maternal learning and knowledge in alternative and possibly more productive ways.[19] Or as offered by Foucault his principle of exteriority:

> ... we are not to burrow to the hidden core of discourse, to the heart of the thought or meaning manifested in it; instead, taking the discourse itself, its appearance and its regularity, that we should look for its external conditions of existence, for that, which gives rise to the chance series of these events and fixes its limits (1971 p. 22).[20]

Drawing on this principle of exteriority, Threadgold provides several questions which can be used to unsettle a discourse; "just how is it possible to know that, to think that, to say that—these are the questions we should be asking" (2000, p. 49). These questions provide a significant point of departure for many nursing research studies and the investigation of the experiences of people.

Discourse analysis, in particular, when it draws on Foucauldian understandings, provides the tools to go beyond interpreting discourses at a descriptive level which often results in a 'realist tale' of 'truth' and 'reality'. This 'realist tale' has the effect of positioning the author of the text as the knowing subject. As Foucault states:

> ... I would like to show that 'discourses', in the form in which they can be heard or read, are not, as one might expect, a mere intersection of things and words; I would like to show that discourse is not a slender surface of contact, or confrontation, between a reality and a language (*langue*), the intrication of a lexicon and an experience; I would like to show with precise examples that in analysing discourses themselves, one sees the loosening of the embrace, apparently so tight, of words and things, and the emergence of a group of rules proper to discursive practice. These rules define not the dumb existence of reality, nor the canonical use of a vocabulary, but the ordering of objects... A task that consists of not – of no longer – treating discourses as groups of signs (signifying elements referring to content or representations) but as practices that systematically form the objects of which they speak (1972, pp. 48-49).

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19 Nevertheless, there is still a phenomenological flavour to this study; the existence of this phenomenological flavour is hardly surprising, as phenomenology is one of the dominant qualitative research approaches used by nurses and was therefore a significant part of my initial nursing research understanding and training.

20 Foucault (1971) offers three other principles that governed his work. These principles were reversal, discontinuity and specificity.

Foucault rejects the use of discourse as a purely interpretative mechanism or group of signs. According to Foucault it is more complex as resulting discourses actively constitute objects; these objects are spoken into existence; and language is not transparent. Fairclough (1995) also argues that we need to go beyond this 'natural attitude' to language to reveal the work of social practices within language — the producing, reproducing or transformation of social structures, identities and relations which are routinely overlooked.

According to Fairclough (1995) the use of Foucauldian approaches to discourse analysis focus on how social 'realities' and 'truth' are produced through discourses, rather than how social 'realities' and 'truth' are reflected in discourses. This discursive production of truth does not purport to be a 'truth' to be exposed, but permits us to identify how the meaning is produced by discursive regimes (Fairclough 1995).

Discourse analysis encompasses a variety of methodologies which focus on language structure, meaning and interaction within the social context of everyday activities (Mullavey-O'Byrne 1998; Fairclough 1992). Parker (1997a) proposes that discourse analysis accentuates the variability occurring within language instead of trying to uncover some consistent underlying truth; it uncovers the purpose of language in different settings; and it investigates the construction of texts and how these draw on symbolic resources rather than being made anew each time.

Discourse analysis provides a framework to work with and interrogate discourses by identifying what is said and the possibility for what has been concealed by the women within this New Mother study. This analysis includes investigating how the 'said' and the 'not-said' constitute the storylines through which the women live and understand their lives; how they are subjected to power relations within discourses; and how they are 'subjectified', or formed as subjects. This method enables the uncovering of the production and transmission of power through discourses, allowing an illustration of how discourses reinforce as well as expose and undermine power (Foucault 1978).

The series of interviews which have been collected can be identified as women speaking and being spoken into existence as mothers — a historical chronicle of the women's experiences of pregnancy, childbirth and the early months of motherhood. Nevertheless, the connections and knowledge which form are not the "... smooth, continuist schemas of development which are normally accepted" (Foucault 1980a, p. 112) as a historical chronical, which are frequently described in essentialist research approaches as phases or stages of 'becoming' a mother.[21] These chronicles of becoming a mother are frequently read as representing a process which is linear and with the possibility of these generalisations being extended to all mothers. The contradictions and discontinuities are rarely foregrounded, when discussing this type of research and the resulting knowledge claims.

So the issue in discourse analysis is not only to work with the obvious, but to understand why specific things are said in certain places and at specific times (Pennycook 1994) which result in attending to one part of an experience rather than another (Davies 1989). Foucault (1980d) warns of a need for vigilance to avoid collapsing back into the safe structures which have been set in place by the dominant discourses, resulting in a belief in a universal, stable and rational subject.

Using the advice of Foucault when analysing events requires a constant re-reading and questioning of the stories. From these re-readings and repeated questioning of the text, an analysis starts to emerge with understandings about what is being privileged or marginalised; what are the power relations between the positions which are being taken up; who are the 'cast of characters' in the stories; how are they made to talk and act; how are they made to work in the person's account; how do the spaces get negotiated between myself and the women; and how are meanings and knowledges being constructed.

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[21] See the research of Barclay, Everitt, Rogan, Schmeid & Wyllie 1997; Barclay & Lloyd 1996; Rubin 1984, for examples of generalisations being extended to all mothers through the development of a framework for understanding the phases women go through to 'become' mothers.

Discourse analysis using a Foucauldian approach enables a shift from a descriptive approach, which interprets the interview data as a transparent and frequently essentialist representation of language and experience, to an understanding of the data as constructed by social practices. The resulting analysis is mediated through the research participants, researcher and subsequent reader's meaning systems.

3.4 Conclusion

This chapter provided an account of the research approach which has been used to collect and work with the stories of the fifteen women who have participated in this New Mother study. The women are not purported to represent the diversity of the Australian population of women learning to mother for the first time, nor does the analysis attempt to provide a final truth that can be generalised to all new mothers. Instead, the most that can be expected is a transferability of ideas and concepts to draw on when working with women learning to mother for the first time and for a troubling to occur of the established and dominant discourses of motherhood and parent education.

Chapter 4

'Maternal Instinct', Memory and Habitus

> 'That is a mother,' said Hook, and he pointed to the Never-Bird sitting on her floating nest. 'That nest must have fallen into the water, but would the mother desert her eggs? No.' 'If she is a mother,' said Starkey, 'perhaps she is sticking about here to help Peter.' Hook said that was just what he was afraid of. Smee and Starkey then understood that Peter and the Boys were quite safe, and could come to no harm from wicked Pirate plots, because they had a mother to take care of them. A mother was stronger then the wickedest Pirate. Whatever could be done? (Barrie 1959, p. 86).

'Maternal instinct' is a discourse which promotes a belief in the innate ability of women to mother their infants.[1] The discourse of 'maternal instinct' circulates with and intersects the many other discourses of motherhood. Acceptance of this 'maternal instinct' discourse, and therefore the innate ability of women to mother, has been through an implicit acknowledgement of its existence by such activities as: the creation of stories and myths; 'scientific' links being made to the mothering behaviour of other animals; and the inexplicable emotions of women towards their infants and others.[2] This discourse of 'maternal instinct' frequently proposes that women 'should' be mothers, or at the very least, display the characteristics of a 'good' mother (Woollett & Nicolson 1998; Nakano Glenn 1994; Oakley 1993; Phillips 1991; Badinter 1981; Oakley 1974). A result of these discourses about 'maternal instinct' is a mechanism that explains and frequently discounts the taken-for-granted or inexplicable aspects of mothering. As in the description by Hook, the Pirate Captain in

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1 In naming 'maternal instinct' as a discourse it is important to say that I am not trying to provide the reader with an impression of a neat package which contains the elements that contribute or make up the components of a quantifiable product. The lack of containment of discursive elements is identified by Foucault when he states that "it would be quite wrong to see discourse as a place where previously established objects are laid one after another like words on a page" (1972 pp. 42-43).

2 These discourses perpetuating 'maternal instinct' highlight a striking omission within the literature and everyday conversation of any corresponding reference to 'paternal instinct', which link men to fatherhood or acknowledge any innate nurturing behaviour (Thurer 1994; Whitbeck 1983). This omission results in support for the continued positioning of women as the main carers of children.

the story about *Peter Pan*, mothers are often given mystical and omnipresent status. This status is presented and reinforced within childhood literature and stories encouraging these beliefs and understandings to begin in the early childhood period.

The universalising of the expectations of maternal behaviour, to all women within all cultures through the use of 'maternal instinct' discourses, results in tensions and inconsistencies as they imply a consistency between cultures and therefore cultural practices. As discussed in Chapter 2 this essentialist approach to understanding motherhood acts to universalise motherhood; and these discourses are usually put in place to control the maternal behaviours and responsibilities of women.

Attempts have been made by some feminist authors, with minimal success, to discount the commonsense links that are used to connect mothering with nature by using the concept of 'maternal instinct'.[3] In the following statement Badinter offers an understanding of how entrenched the belief in 'maternal instinct' remains:

> ... though the word may have been officially discarded, there remains a tenaciously resistant idea of motherhood that is near enough to the traditional image to be easily mistaken for it. It is pointless to maintain that maternal behaviour is not grounded in instinct as long as people persist in regarding a mother's love for her child as so strong and seemingly universal that it must somehow owe something to nature. Despite the change in vocabulary, the old notion endures, and it all becomes a question of semantics (1981, p. xxii).

The destabilisation of 'maternal instinct' as a concept within the discourses of motherhood, even if not commonly spoken about within medical discourses, is a difficult task as it is pervasive and enmeshed within the socially constructed belief systems about motherhood.

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3 For example, refer to Chapter 2 of this thesis and the work of Blaffer Hrdy (1999), Forna (1998), Hekman (1990) and Ortner (1974) for a discussion of the relationship between motherhood and essentialist understandings.

The discourse of 'maternal instinct' is constructed through the interplay of rules, and of greatest interest and concern to this New Mother study are the prohibitions contained within these rules, and therefore what women can and cannot say or do as mothers. These prohibitions, as identified in Chapter 2, Foucault notes allow subjects to know "... that we are not free to say just anything, when we like or where we like; not just anyone, finally, may speak of just anything" (1972, p. 216). Rules and the resulting prohibitions are used to explain the taken-for-granted or inexplicable in an attempt to account for a domain of maternal experience. The resulting explanations of maternal experience set in place the potential for a form of discursive 'maternal determinism', which provide the mothering values, beliefs and behaviours that a culture encourages women to reproduce. Maternal determinism works discursively to delimit maternal choices and possibilities through the discourses of motherhood, and often the resulting understandings from these discourses that women bring to their mothering experiences.

However, in trying to account for the experiences of mothering, within the professional and parenting literature, using 'maternal instinct' as a foundation, multiple spots of instability start to occur, allowing leakages within the account through the development of contradictions and tensions. These contradictions and tensions frequently occur because of the ongoing shift in cultural and social belief systems, often in response to economic, political and environmental necessity. The resulting shifts can cause a disjuncture between a woman's maternal experiences, her feelings and beliefs about motherhood, and the socio-cultural constructions of motherhood.

Within this discourse of 'maternal instinct', a commonsense belief is promoted that maternal knowledge is provided from an innate source. This commonsense belief does not provide for the existence or even co-existence of a theory of maternal learning. However, a discourse of maternal learning is available and therefore potential exists to compete with the discourse of 'maternal instinct'. Nevertheless, 'maternal instinct' as

a commonsense belief is frequently accepted without question, as something which encourages and allows 'maternal instinct' to be constructed as a fixed entity. Contradictions and tensions that result from this discourse of 'maternal instinct' are more easily dismissed as being beyond the control of the subject. The opposing often co-existing notion of maternal learning is then constructed as being controllable, less effective and ancillary to the dominant, if implicit, discourse of instinct.

Other co-existing discourses of motherhood which frequently support and perpetuate the discourse of 'maternal instinct' are identified within this thesis as important constraints to acknowledging the complexity of learning and the ongoing and everyday experiences which contribute to maternal learning. A powerful function, which can be related to the concept of 'maternal instinct' and the supporting discourses, is the controlling and disciplining of women to conform to the expected norms of the communities in which they live and mother. These understandings and the problematisation of the discourses of 'maternal instinct' contained within this chapter will contribute to a context for the subsequent thesis chapters.

This chapter will start to expand the introductory discussion about Bourdieu's concept of habitus and the educational discourse of incidental learning already commenced in earlier chapters of this thesis. The first concept, habitus, is used to explain how certain subject positions are embodied through a practical sense of behaviour that occurs in any particular situation (Bourdieu 1990; 1977). Habitus in the context of this study can be described as the behaviours and characteristics of a mother within a specific community or culture. The concept of habitus does not imply a natural ability to function or behave, but refers to learned behaviours which are frequently embodied behaviours. The second concept of incidental learning can be discursively constructed in a similar way as habitus, as learning that occurs tacitly (Foley 2000) and is frequently displayed as somatic (body) knowledge.

A new concept is introduced and explained within the final section of this chapter, of the medical discourses of a particular understanding of memory functioning referred to as declarative and non-declarative memory. This construction of memory provides a framework for making meaning about the way in which a specific habitus is embodied and how incidental learning can occur in a seemingly unknowing and unexpected way as somatic knowledge.

This chapter is presented in three main sections: the first section focuses on the characteristics of a mother; the second section troubles the concept of 'maternal instinct'; and the third section discusses the use of a medical discourse of memory as a possibility for explaining the seemingly inexplicable ability to mother. This medical discourse of memory allows a link to be made with habitus and the educational discourse of incidental learning.

4.1 Characteristics of a mother

The constructions of motherhood produced by the societies in which women live can be problematic because of the frequent mismatch between the discourses of motherhood which often promote the concept of 'maternal instinct' and a woman's experiences of being mothered or of mothering her own infant. Within these discourses of motherhood the definition of a 'mother' can be simply stated as a woman who has a child (by birth or adoption) — although, with the event of new technologies of conception, the definition of a 'mother' has become increasingly unstable, socially and legally (Ross 1995; Scutt 1988). The resulting instability in the use of the term 'mother' has caused the subject of motherhood to become problematic for feminist thinking (Forna 1998; Turkel 1996; Joeres & Laslett 1995). This instability starts to cause an unsettling of the potential for 'maternal determinism' to occur providing opportunities for women, in particular, feminists to challenge the dominant and essentialist constructs of motherhood which link it to nature, as

identified in Chapter 2.

This section will explore how the women within this New Mother study construct the characteristics of a mother. The discourses used by the women are not new or radical, but are some of the available discourses which are commonly mobilised to describe motherhood and mothers. Through these discourses the women provide insights into their learning about the characteristics of a mother and their preferred practices of mothering. A perpetuation of the disciplining of the mother to act in a controlled manner is frequently implicitly and explicitly constructed in and through these discourses. Tensions occur in relation to these discourses when women experience ambivalent feelings about motherhood as they clash with the anticipated and accepted belief in the ability of a mother to provide unconditional love and care for her infant.

The women within this New Mother study all expressed the desire to be the best possible mothers for their infants. In the following three transcript extracts, which were in response to a question about the characteristics of a mother during the first interview, three different discursive positionings were constructed: as a facilitator and protector of the baby's needs by Zoe; of 'primary maternal preoccupation' by Heather; and of 'self-denial' or 'self-discipline' by Emma.[4] The maternal characteristics, which were provided, related to: infant care; assisting the baby's 'self' to develop; behavioural and emotional traits; and the difficulties of mothering. A fourth extract is used to discuss maternal ambivalence.

The first positionings of facilitator and protector of the baby's needs are articulated by Zoe.

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[4] 'Primary maternal preoccupation' is a term used by Winnicott (1987) to describe a period of adaption to an infant's needs women are supposed to go through when they 'become a mother'. This term will be discussed in greater detail within this chapter.

Zoe: ..... I think someone that .... is able to help that ... baby feel, well, as a baby feel secure and ..... sort of looked after ..... And that after, you know, is able to sort of ... help ... or assist in the process of ... that ... person becoming an individual of their own ... self ..... (first interview).

The two positions of facilitator and protector are represented as co-existing within this extract about the characteristics of a mother. The first position as facilitator is frequently acknowledged as a desirable characteristic for mothers within the psychological literature and discourses. The mother who uses a facilitation approach is said to adapt to her baby's needs (Raphael-Leff 1991).[5] Through this facilitator function the mother becomes the infant's first educator — tutor par excellence (Badinter 1981). This position is often represented as the facilitation of their infant's development of a sense of self.[6] Zoe highlights several behaviours in her statement using a combination of words related to actions and feelings — *help, feel secure, assist in the process, becoming*. This combination of behaviours is identified as *the process of ... that ... person becoming an individual of their own ... self .....* However, by the use of the words *able to help* and *assist in*, Zoe does not give the impression that as a mother she is totally responsible for her baby's feelings and the process of *becoming an individual.*

The second position as protector is implicit in the mothering characteristic of being able to make the infant feel *looked after*; and the actions that will make a baby *feel secure.* These two positions start to provide an interesting insight into the complexity of the power relations mothers negotiate with their infants. As the protector the

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5 According to Raphael-Leff (1991) the opposite of a maternal facilitator approach is a regulator approach, resulting in the mother expecting the infant to adapt to her. Raphael-Leff does conclude that most mothers oscillate between these two approaches, often making compromises in regard to their preferred style of mothering.

6 There are multiple characteristics ascribed to the development of the self within the literature: for example, self-worth, self-esteem, self-reliance or the false self (Karen 1994; Bowlby 1988; Kagan 1984). These multiple characteristics relate back to the notion of the unitary essential subject discussed in Chapter 2.

mother is positioned as being powerful. This power comes from the expectation that she will know 'what is best for her baby' and that she will protect the infant from the dangers of everyday life. On the other hand, the facilitator is a position where she is encouraged to allow her baby to explore, experiment and not to be 'overly protective' of the infant; to guide but 'not to get in the way' of the baby's attempts to try new things.

Within these two functions of facilitator and protector, Zoe is possibly providing teaching of significance. This teaching has the potential to assist her baby to develop the habitus that will form the basis of her baby's ability to function within the culture in which the baby lives. During these early stages of an infant's life the teaching and learning occurring is closely linked to bodily sensations, as a newborn infant has not developed a meaning system for words. According to Bourdieu (1990), the earlier a child enters into the culture the less they will be aware of the associated tacit learning that is occurring. This tacit learning can be identified as incidental to the everyday actions of the infant's daily life.

According to Zoe the ultimate goal of the characteristics of a mother is for the baby to become *an individual of their own ... self .....* This understanding positions the baby as not yet separate or as an *individual*, though they are progressing towards the ultimate goal of being a subject. This subject appears to resemble the unitary subject that reflects the dominant beliefs and psychological discourses that have been critiqued by using poststructural understandings. These beliefs and discourses propose that an internal essential structure of the self can and should be achieved as the desired norm of healthy personhood (Venn 1998). The mother is therefore expected to guide this newborn infant from a seemingly prehuman state to a rational human state of the individual or self (Henriques et. al. 1998). A taken-for-granted assumption is being made that the baby as yet has not transformed to being a *self*, and that this *self* is a desirable and possible outcome that must be worked towards as an end point.

As discussed in Chapter 2, the concept of the individual is a person who "... is a free, intellectual agent and that [their] thinking processes are not coerced by historical or cultural circumstances..." (Sarup 1993, p.1). An individual is also theorised as a fully conscious and self-knowing subject who speaks but is not simultaneously spoken (Sarup 1993). The concept of the individual as a unitary subject is problematic as it is reliant on nature to form the subjectivity of the baby and resists the functions of learning and guidance which are being highlighted by Zoe as an important function of the mother as facilitator.

In the second story Heather constructs a mothering position which is not inclusive of others in taking responsibility for the baby — this mothering position is constructed through the use of a concept similar to 'primary maternal preoccupation' as its defining characteristic.

Heather: ..... it's a nurturing role, it's a ..... you're responsible for the child's food ..... its comfort, you know. It's a caring role its ..... yeah it is nurturing, I think that it is the key word, because that encompasses everything that ... that child needs .....

In this extract Heather highlights the importance of nurturing in her statement about the characteristics of a mother. *Nurturing* is identified as a key word that encompasses responsibility for the *child's food, its comfort,* and *caring*. The outcome of Heather's definition is a positioning of a mother as being responsible *for everything that ... that child needs*. A potential tension occurs with this belief as it places the mother in an omnipresent position, who is reluctant or unable to relinquish her responsibilities to anyone else, thereby effectively excluding and/or marginalising others from sharing responsibility for the infant's needs.

This understanding is consistent with the normative effects of the influential work of the object relation theorists who theorise a mother's function as "... providing the first

experiences of satisfaction through feeding, which provides the foundation for meeting the baby's needs" (Henriques et. al. 1998, p. 211). Of particular relevance here is the work of Donald Winnicott as he proposes that women go through a period of adaptation called 'primary maternal preoccupation', which he describes thus:

> in this state mothers become able to put themselves into the infant's shoes, so to speak. That is to say, they develop an amazing capacity for identification with the baby, and this makes them able to meet the basic needs of the infant in a way no machine can imitate, and no teaching can reach (1987, pp. 36-37).[7]

Winnicott's statement assumes a universal ability of women to accurately translate the experiences of the infant. Winnicott restricts the potential for trial and error or learning from the infant's responses occurring, as he promotes an understanding of an inability to teach maternal behaviours that meet the basic needs of an infant. Rather, these behaviours are implied as coming from within as an essential maternal ability. This notion of an essential ability to mother is reinforced by his statement that "mothers who do not have it in them to provide good enough care cannot be made good enough by mere instruction" (Winnicott 1960, p. 591). Through these statements Winnicott takes up an essentialist stance by his reference to the inability of teaching to rectify problems of mothering. This alignment results in a commonsense belief in 'maternal instinct' as the ultimate determinant of the ability of women to provide appropriate mothering. Winnicott's statement appears to offer a limited understanding of learning as possibly being restricted to overt activities of formal instruction.

The concept of primary maternal preoccupation can place an enormous burden on the mother as Winnicott (1960) argues that the failure to provide appropriate maternal behaviours and responses can result in psychosis or schizophrenia. In Henriques et. al.'s words, Winnicott identified the failure of primary maternal preoccupation as

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[7] I have used the work of Winnicott as he remains an important influence in Australia on the way health professionals think about and construct the mechanisms for promoting infant mental health.

resulting in "... deleterious consequences for the baby's psychic development" (1998, p. 211). Winnicott's interpretation of the importance of the contribution of maternal behaviours to the health of the infant may in many instances be significant. However, Winnicott's concept of primary maternal preoccupation requires women to position themselves as the omnipresent mother, unable and unwilling to relinquish her responsibilities to anyone else.

In the third extract, Emma starts by relating a story about her mother illustrating the commonly espoused maternal discourses of women who mother in the sixties[8] and which are still widespread in the nineties[9] — that of self-denial and self-discipline.

Emma: My mother would say that, a good mother puts her children first, and .... would be able to manage house and husband and children and job all at the same time ... And not lose their patience too often ..... But I guess a mother is a woman first ..... who has a greater sense of awareness of other ... little person's needs perhaps than she had in the past (first interview).

Emma's initial response is to provide her mother's definition of a *good mother*. It could be argued that this definition remains powerful and persuasive as a possible basis for learning to reproduce or incorporate these behaviours at an unconscious level, through incidental learning, as the ideal or dominant subject positions that

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8 For example, see Friedan (1963) who identified a frequently promoted subject position for women as happy housewife heroines in the fifties and sixties. These positions have women happily renouncing their careers and discovering that what they really wanted to be was housewives looking after their husbands and children.

9 For example, the current policies of the Australian government have restricted financial support provided for childcare services. This situation has effectively reduced women's ability to participate in the paid workforce, continue to study or participate in many community activities because of access to affordable and suitable child care services (Brennan 1998a). Families are now forced to subject their children to "... a patchwork of arrangements involving family care, informal care, and limited formal provision; and some parents, as a last resort, have withdrawn from paid employment" (Brennan 1998a, p. 5). The impact of this change in government policy in most instances affects women, particularly those women on low incomes who cannot afford the additional childcare costs and are forced to withdraw from the paid workforce.

Emma may assume as a mother. These characteristics provided by Emma's mother reinforce the discourses of motherhood that a mother 'must be all things to all people' and that mothers should be self-disciplined; or the 'super mum' of the mid twentieth century (Phillips 1991). Nevertheless, this discursive construction of the 'good' and 'bad' mother binary provides for women a position which they can judge themselves or be judged by others. The previous reference to the 'good enough' mother by Winnicott in the discussion about Heather's characteristics of a mother, provides a half-way point — a Mother needs only be 'good enough'. Unfortunately, tensions remain as to what is meant by 'good enough'; and who decides if a mother is 'good enough'? A constant reminder is needed that judgements of mothering quality are based on the current historical, social and cultural constructions of the characteristic of a mother.

As Emma continues to articulate her understandings of the characteristics of a mother, she acknowledges the multiple subject positions which a woman is expected to manage and accept as a *good mother — puts her children first* or the unselfish mother; is *able to manage house and husband and children and job all at the same time* or the competent mother and homemaker; and does *not lose their patience too often* or the mother who is always patient. Even though Emma is only posing these mothering characteristics as a possibility, a problematic is set in place through her mother's beliefs about mothering, resulting in enormous tensions for the woman trying to create and maintain these mothering positions. This is especially the case for Emma, as this statement about her mother's *good mother* poses a contradiction for her, since she reports that her mother physically and emotionally abused her as a child. Her words thereby raise questions about the concealment of the unhappiness of motherhood and the resulting tensions and inability of women to position themselves constantly within these 'good' mother discourses.

The inability of women to successfully fulfil the discursive positioning of the 'good' mother becomes problematic for many women and their families. Rather than acknowledging the difficulties they are experiencing as mothers, women may start to conceal these behaviours and thoughts. An increasing tension can start to occur within the family, which potentially results in feelings of guilt and anger.

Emma has attempted to make sense of the 'good' mother discourses by mobilising a new discourse about mothers. This new discourse provides an opportunity for Emma to challenge her mother's construction so that she can position herself as *a woman first*. This understanding acknowledges the inability of women to deny or lose these multiple subjectivities or subject positions when they have a child. The construction of a new mothering position *as a woman first,* may reflect Emma's desire to mother in a different way to her own mother.

The other quality Emma has identified is *a greater sense of awareness of other ... little person's needs*. The use of *other,* followed by a pause possibly indicates a shifting of thought to focusing on her unborn baby. Her greater awareness of another's needs than in the *past,* signals a possible understanding by Emma for the need to shift or increase her range of possible subject positions after the birth of her baby. The difficulty for Emma is that the characteristics of her mother's *good mother* may remain an insidious and dominant part of her learning about mothering, regardless of how hard she tries to reject this discourse of the *good mother* who is constantly there for her family.

These 'good' mother discourses construct normative positions which act to constrain the way in which women behave so they conform to the maternal behaviour expected by the people living within their communities. For example, mothers are not supposed to show emotions of hate or anger (LeBlanc 1999; Parker 1997b). A result of these behavioural constraints is the potential for many women to limit their exploration of

maternal emotions or interactions of love, hate or anger. These feelings of hate or anger, if spoken, are capable of infringing the 'good' mother discourses. Parker (1997b) articulates this mothering ideal by proposing that women are expected to experience motherhood unambivalently. The guilt that can be stimulated by ambivalent feelings of love, hate and anger may result in an overwhelming guilt and immobilisation (Featherstone 1997). On a positive note, Parker proposes that emotions of love and hate act as a creative force in maternal development and that "... the often painful conflict between love and hate can in itself provoke and strengthen the mother's desire to know and answer the baby's needs. Instead of acting upon violent impulses, mothers may start to create solutions such as singing lullabies, rocking or feeding" (1997b, p. 28).

Unfortunately, Parker's statement establishes a dichotomy of love and hate as two separate and discrete emotions, which has the effect of providing stable, bounded binaries and hence contained understandings of these emotions. However, the tensions between these emotions needs to be foregrounded as I would propose they are far more subtle and complex and shift constantly in intensity. The isolation of love and hate as discrete emotions easily allows the assignment of love to the 'good' mother discourses and accordingly hate remains an unrecognised emotion of motherhood. According to Parker (1995) love is the taken-for-granted emotion of motherhood while hate is often acknowledged as a disaster and gives rise to guilt.

During the interviews that were completed within this New Mother study, the contradiction of love and hate or a dislike of mothering occurred often as contradictory positions within the one story. Drawing on poststructural understandings, the construction of these positions as contradictory or negative is a response to the current historical or cultural context in which they are spoken, and how a woman discursively positions herself and is being discursively positioned by others during the discussion of these feelings. During the third interview, Jane

provided an example of these positions of love and hate through the comments she made and her physical behaviour towards seven month old Timothy:

Cathrine: What's it like being a mother?

Jane: (Laughing) Oh ... I don't know whether I can talk freely in front of him (moves Timothy to other side of the room) ..... Oh I'd say ..... okay. I wouldn't say good ....

Cathrine: It's been pretty tough has it?

Jane: Yeah, it has actually.

Jane moved Tim to the other side of the room before she would discuss her negative and angry feelings about motherhood. Later in the interview Jane responses to a question about the positive aspects of motherhood:

Jane: .... yeah ... I mean yeah, him .. in himself I guess ..... Yeah, I suppose just the love and the happiness he does bring me now and then ... But apart from that .... no I wouldn't ..... lifestyle wise ... I wouldn't say everything ... you know, not as good as it was ...in other respects ... Stop listening (talks to Timothy) .... It takes you by surprise at times ... But I guess that's hard to talk to people about ... how horrible you find it, and then you say 'but I do love them', which always sounds so phoney.....

On the way home from the interview, I recorded my feelings about what had occurred during the interview.

Diary Notes: I am feeling really sad for Jane after this interview; her attitude to motherhood has changed so much since the first interview. In the first interview she loved being pregnant and was really excited about having a baby and planned on having other children. When I asked 'what it was like being a mother' she sounded so sad and disappointed about her experience of mothering. Timothy seemed really responsive to her but her smile was like a veil had been drawn over her face. Jane has decided she cannot face the prospect of having any more children.

This diary note has been provided, as my initial reaction to the interview was different to reading the transcript two years later as an experience captured in text. Jane's answer does not evoke the same emotional response as I experienced on the morning of the interview. However, when I read my interview notes, bodily sensations of sadness returned as a reconstruction of the experience started to occur. Unfortunately, these sensations cannot be shared with the reader as they elude language.[10]

According to the 'good' mother discourses of psychology and the taken-for-granted everyday discourses, mothers are meant to provide unconditional and continuous love (Henriques et. al. 1998). This 'mother love' consists of some of the following elements: a type of mysterious nourishment that is secreted by a mother; a behaviour that, according to many accounts, originated as a biological instinct; and results in total maternal fulfilment when all the needs of her infant are successfully met (Phillips 1991). Unfortunately, this unconditional and continuous love does not allow for the coexistence of anger and hate. Indeed, these emotions of anger and hate appear to have the potential to undermine the institution of motherhood (Rich 1976) as they challenge cultural expectations that mothers always love their infants. 'Mother love', instead of being constructed as an instinct, is possibly better explained as a strong emotion that has to be learned, and is often fragile, uncertain, imperfect and can be withdrawn (Badinter 1981). According to Badinter, at the very least "mother love cannot be taken-for-granted. When it exists, it is an additional advantage, an extra, something thrown into the bargain struck by the lucky ones among us" (1981, p. 327).

The women's stories have started to highlight the complexity and elusiveness of trying to construct an understanding of the characteristics of a mother. The ways in which the characteristics of motherhood and mothering are defined by societies in which

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[10] The effects of the women's accounts on me have been briefly discussed in Chapter 2.

women live can have profound effects on their ability to construct a position for themselves within the circulating discourses of motherhood. The following extended story, which was gained over three interviews, illustrates the problematic relationship between the accepted discourses of motherhood which promote unconditional love and an enduring commitment to the infant (child) by their mother and the sometimes traumatic experiences of being mothered which can often be literally unspeakable.

4.1.1 Living with the contradictions of motherhood: Meredith's story

Major difficulties can be encountered by women when they have had traumatic experiences of being mothered which potentially limits their willingness to embrace a construction of a mother as a loving and nurturing person. The following extended story demonstrates Meredith's struggle to contend with the contradictions inherent in the discourses of motherhood, the lack of a speakable discourse about her experience of being mothered and how she discursively constructs a maternal position, with new maternal characteristics, which enables her to be called and use the term 'mother'.

A challenge was posed for Meredith as she attempted to position herself as a mother due to her experience as a teenager when she had been a victim of father-daughter rape which left her with memories of her mother as other than the nurturing, protective mother.[11] Meredith had stopped all contact with her parents and did not anticipate seeing them again. Making the decision to become pregnant was difficult and was further complicated because she had found out her baby would be a boy. Meredith had desired a daughter and had used techniques related to timing in her menstrual cycle to try to conceive a girl.

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[11] deMause (1974) provides an alternative view to the constantly protective mother within his work on the evolution of childhood. Instead of being protective, deMause portrays many mothers in past centuries as frequently being complicit in sexual and physical abuse practices being performed on their infants and that the needs of the mother (father) frequently placed an enormous burden on the growing child.

In this series of transcript extracts collected over a nine month period, Meredith rejects the accepted response to motherhood of joyful anticipation. Instead, she constructs a story of initially rejecting the use of the term 'mother'; then, through the next nine months, she starts to make sense of, and gradually reconstructs, the term 'mother'. Half way through the first interview I asked Meredith if she could imagine herself as a mother. Meredith's response identifies the difficulty she is experiencing discursively constructing a subject position using the term 'mother':

Meredith: I suppose, first of all, I should say, I'm not sure that I really like the word mother anyway. So I have ambivalent feelings about putting that label on myself anyway and so tend ... well, tend not to think in those ... those terms. ..... And so, when I think, when I think about myself having a child, I think, ... I think there'll be that I'll find there's plenty of frustrations involved. ..... As well as hopefully, lots of joys..... But that I'll have to be careful not to let my ... my nature of being well organised and ... having been a control freak, to getting, to be (giggle) a bit more realistic about life.

Her response to my question is immediate as she highlights her *ambivalent feelings*. The term 'mother' for Meredith is constructed as having negative attributes that possibly come out of her particular experiences of being 'mothered'. Meredith's rejection of the term 'mother' could be interpreted as a rejection of all the 'good' that is purported to be embedded within the term. On the other hand, this ambivalence about the term 'mother' could equally be the acknowledgement of the existence of feelings of loss, sorrow and separation (Parker 1997b) felt by Meredith about the missing relationship with her mother.

Meredith does not answer my question about imaging herself as a mother; rather, she articulates the emotions of having to care for a baby — *frustration* and *joy*. Her comments about the emotions are provided in a considered manner, which is emphasised by the pauses in her statements. In her response Meredith balances the inevitable *frustrations* of mothering with the *joy* of a baby; her words give an impression that she is trying to be positive about the prospect of caring for her baby.

Meredith positions herself in several ways in this extract: as *well organised*, as the woman aware of her tendency to be a *control freak*, and as a woman who realises the importance of being *a bit more realistic about life*. This statement may be an attempt by Meredith to anticipate the emotions and the experience of looking after a young child by identifying possible scenarios that can arise for her as a mother.

In this next section of the second interview, four weeks after the birth of her son Daniel, I asked Meredith if she felt like she was a mother now. In her response Meredith talks of how she has started to construct a mothering position through the use of a hybrid name:

Meredith: ... Ohhh .... that's a really interesting question .... Cause you know that's ... that was the tricky part from our, from our first interview about not wanting to be called a mother and not, not really wanting to own ... that, that name. I suppose ..... well we sort of .... we overcame that because Thomas [partner] came up with, Thomas came up with the name while I was still in hospital ... of calling me Merrimum, cause lots of people call me Merrie anyway. Its short and ... and I like that and that's the way I refer to myself now so I guess the distance from my own mother and the negative experiences there and what I didn't want to relate to ... and align myself with that ..... that. I can still use part of that name but it's very much just about me, about how I want to be as a mother or as a parent and differentiate that from how a lot of other people ... parent. So yes, does that answer your question?

Meredith's initial response provides an impression of welcoming the question as something that she has considered and is ready to talk about. Meredith reflects back to the first interview and recalls the discussion about her feelings towards the term 'mother'. With the support of her partner Thomas, Meredith seems to be starting to make sense of how she will discursively position herself. A solution has been provided by constructing a new name that did not have the same connotations for her that the term 'mother' held. A process is occurring of constructing new and positive understandings of the word 'mother', which no longer constrain her through her previous negative experiences and meanings. The new name *Merrimum* allows

Meredith to position herself in a way that is familiar. Rather than saying 'mother', Meredith states *I can still use part of that name* but it has now been constructed to be about her and not her mother. The development of a hybrid name of *Merrimum* could be proposed as an important step in Meredith's ability to discursively construct a mothering position and to develop her own characteristics of mothering.

During the third interview, when Meredith's son Daniel was seven and a half months old, her response to a question about whether there had been anything really difficult for her to learn as a mother was:

Meredith: ..... I think it's probably been the more the mental jump of ..... calling and naming myself as mother, is the ... has been the biggest thing for me. Rather than the physical ..... caring sort of aspects ..... that mental sort of ... yeah ... identification ... process has been ... the slowest and the biggest sort of ... hurdle ... I suppose if you want to call it that, yeah.

Cathrine: Did you maintain that name you were going to call yourself, Merrimum?

Meredith: Yeah ... yeah, I still do yeah ... yeah. So I'm ..... yeah I'm still really happy if he'd rather call me Meredith or Merri than mum, but I don't find it offensive any more when other people call me a mum or a mother or whatever. Which ... which I did find difficult ..... to begin with ..... I suppose now that I've super imposed ... my positive image of what it is to be a mother for me on ... to that — you know. When I read it on forms and all those kind of things, well I have that image to put in my mind now. Rather than a bit more negative one that I had, I had before he was born.

Meredith acknowledges the difficulty of *calling and naming myself mother*, that this process requires a *mental jump*. She differentiates between *calling and naming* as if there is a subtle difference, possibly, *calling* does not have a sense of permanency and acceptance, whereas *naming* indicates a considered act of acceptance, legitimacy and finality. Meredith talks about the process of *calling and naming* using words which denote a physical effort — *jump, slowest, biggest, hurdle*. These words offer some

insight into the struggle faced by Meredith, in naming herself as a mother, as being a difficult act. She compares this struggle with learning to manage the physical aspects of caring for her baby which contributes an understanding that this physical care was much easier to learn.

My question about maintaining the name *Merrimum*, is answered in a seemly more relaxed manner than in previous interviews. There is also acknowledgement of her acceptance when others position her as a mother. The use of *offensive* to describe her reaction offers an understanding of the difficulty of the task Meredith had faced in taking up the positions of mother. Meredith highlights the used of positive images which has helped her to get to the stage of accepting her various mothering positions. A new understanding of what it means to be a mother has emerged for Meredith, which could be posed as being a significant learning experience for her. This learning seems to have come incidentally through mothering her son and without explicit acknowledgement that what has been occurring can be identified as learning. In Chapter 6 the concept of incidental learning will be explored in greater detail.

The frequent mismatch between the discourses of motherhood and a woman's experiences of motherhood can be problematic, resulting in tensions and contradictions. For example, mothers have been constructed as willingly 'laying down their lives' to protect their children (Oakley 1981). However, this is not a consistent behaviour for all mothers; as Meredith's experience demonstrates, her mother was unable to protect her from her father or even to believe that the father was perpetrating such an act as rape on their daughter. Using the understandings gained from Meredith, it can be proposed that for some women a major learning task of motherhood is to develop alternative understandings and constructions to the often literally unspeakable constructions they have developed through their past traumatic experiences. These discourses are unspeakable for at least two reasons: firstly, the experience of incest does not provide a discourse that can be used to construct a

nurturing mothering position. The second is that talking about incest, in most instances, remains a taboo within western society.

4.2 The 'nature' of motherhood — 'maternal instinct'

> Irrespective of the mother's upbringing, it is always assumed that 'maternal instinct' will come to the fore and will perform miracles (Welldon 1988, p. 18).

'Maternal instinct' is a common theme within the discourses of motherhood and in particular, the everyday language of women, their families and others within the communities in which they live. 'Maternal instinct' as a concept, as suggested in the above quote, is frequently attributed the power to automatically prepare women for the care and nurturing of their infants; or as a safety net which naturally provides women with the ability to mother. Commonly accepted understandings of 'maternal instinct' are identified, in some feminist, medical and everyday literature, as "... a natural manifestation of an innate female characteristic ..." (Smart 1996, p. 37); or "... the tendency of the female of the species to engage in the so-called maternal behaviours of feeding, sheltering and protecting the young" (Reber 1995, p. 437). The concept of 'maternal instinct', regardless of the place or time in which women live, has come to be identified as inherent within the very nature of women (Weaver & Ussher 1997; Badinter 1981).

Nevertheless, inconsistencies frequently occur within the discourses of motherhood which call into question and challenge the existence of the concept of 'maternal instinct'. For example, Karen identified a problem with the use of concepts drawn from understandings about animal instincts to support research into infant-maternal attachment:

> ... as it came to be used by many biologists, is that it implied a rigid, inherited behaviour, performed identically by every member of the species. Those that believed that animals were governed strictly by instincts reduced them essentially to machines that were programmed to behave in certain ways from birth (1994 p. 29).

Within this statement Karen identifies the tendency to generalise and universalise understandings about animal instinct to humans without consideration of the complexity of both human and animal behaviour. Eyer supports these concerns and questions the ability of researchers to equate the behaviour of rats and other animals to the behaviour of human mothers:

> ... who read, write, and speak in thousands of complex languages, perform microsurgery and psychotherapy, compose symphonies and make movies ... the thinking mother should feel just a little wave of skepticism coming on as she contemplates her likeness to rats and monkeys (1996, p. 87).

Eyer's statement, in highlighting the complexity of women's achievements, clearly draws into question approaches to research that links women's maternal behaviour to animal behaviour.

As already discussed in Chapter 2, child rearing is an expected and accepted natural function of woman due to the link frequently made between the physiological ability of women to conceive, give birth and lactate, and the everyday social and cultural practices of child rearing. Mullan also notes that the view of motherhood as a 'natural given' is problematic as it is a "... most insidious perspective ...which bases its arguments on the pernicious notion of maternal instinct" (1987, p. 114). Mullan (1987) argues that, if 'maternal instinct' existed, then all women would want to be mothers, and this belief is not supported by the many women who have no desire to mother. The concept of 'maternal instinct' is troubled further by Badinter (1981) through her historical study of French motherhood and the indifference and tendency of many mothers in the seventeenth and eighteenth century to abandon their infants. Badinter proposes that issues of survival may get the better of 'maternal instinct' or "at the very least, 'maternal instinct' must be considered malleable, able to be shaped and molded and modified, and perhaps even subject to sudden disappearances, retreats into civilization's shadows" (1981, p. xxi).

This section will explore the concept of 'maternal instinct'; how it is frequently enmeshed within the discourses of motherhood; the difficulty of trying to describe or identify examples of 'maternal instinct' will be exposed; and the possible consequences these understandings about 'maternal instinct' have for maternal learning.

Discourses of motherhood frequently include references to 'maternal instinct' as an explicit statement or involving implicit taken-for-granted concepts that draw on the essentialist characterisations of women as discussed in Chapter 2. For example, within some of the feminist and psychological literature, there are implicit taken-for-granted as well as explicitly stated concepts of 'maternal instinct'. An implicit, taken-for-granted acceptance of 'maternal instinct' is achieved through Ruddick's (1989) notion of 'maternal thinking' which implies through the collocation of the two concepts 'maternal' and 'thinking' that all mothers naturally think differently from others. An explicit example is provided by Brazelton's statement that many of a mother's "... instinctual reactions to her baby are frowned upon by one authority or another" (1983, p. xviii). Or LeBlanc's statement "if you feel the need to nurture and protect your baby upwelling inside you, do not allow your instinct to be diminished by those who would dismiss it as merely another skill which anyone can learn as though it were nothing special" (1999, p. 84). These two references to 'maternal instinct' reinforce the notion of 'maternal instinct' acting to inform a mother about the way she should respond to her baby.

The use of the concept of 'maternal instinct' to underpin discourses of motherhood links understandings of women's abilities to mother as a natural given or bodily function of women. These discourses of motherhood which draw on nature and the abilities of a woman's body have the potential to diminish the value attributed to the mothering function and the difficulty encountered by some women as they learn about and develop maternal skills. This diminished value is due to the privileged position

rational thought has in most instances over bodily functions, instincts and emotions within western thought (Hekman 1990; Orner 1992). The privileging of rational thought occurs possibly because it can be quantified or named, whereas maternal knowledge and skills consistently resist attempts to be fully or comprehensively quantified or named, as demonstrated within this thesis.

Rather than unquestioningly accepting that women have a 'maternal instinct' which readies them for the natural function of mothering, a troubling of the concept of 'maternal instinct' is needed. By troubling the concept of 'maternal instinct', possibilities start to develop for alternative ways of thinking about mothering and the way in which maternal learning can be constructed.

'Maternal instinct' was a topic of discussion within each of the three interviews and the group gathering, where it was clear that the term 'maternal instinct' had varying levels of legitimacy for the women and their understanding of the development of maternal knowledge and skills. The three extracts used within this section explore some of the contradictions and tensions that can occur when discussing 'maternal instinct'. The extracts foreground three possible positions: a rejecting of 'maternal instinct', while still maintaining the possibility of its existence; an initial acceptance of 'maternal instinct', but an inability to sustain this position; and a total rejection of 'maternal instinct'.

In this first extract Julia provides an account which positions her largely outside the discourse of 'maternal instinct', in response to my asking her if she thought mothering was an instinctual or learned activity. Julia's daughter is now eight months old.

Julia: ..... oh that's a curly one ..... I don't know, I think a lot of it is guesswork ... But I suppose I've learnt ... I mean, it's pretty easy to know when she's cranky (laughing) [yes] ..... Probably just from being around her, a lot of it would be learning ... A lot of it is too sort of you suddenly think to yourself ... 'oh she's probably hungry'. You know [yes] ..... So I'd say mostly learnt, I ... I think in the long

> run ..... I don't really see myself as having this incredibly strong maternal ..... I'm not an earth mother ... you know, I'm not ..... one of these women that totally devotes their lives to their children and starts cooking totally organic food ... and all that sort of thing (third interview).

Julia acknowledges the difficulty of the question, as she considers whether mothering is a learned or instinctual activity by her hesitation and then exclamation of *oh that's a curly one.* The use of *I don't know* indicates Julia may not have thought about this question prior to the interview or that the question does not have an answer.

Her response of *I think a lot of it is guesswork* starts to immediately refuse the concept of 'maternal instinct'. Julia justifies her answer with comments of *I mean its pretty easy to know when she's cranky (laughing).* This justification and the laughter seem to be offered as a taken-for-granted fact of the clear messages that her baby provides about her needs. Two examples are provided of how Julia learned to read her baby's behaviour: *probably just from being around her a lot* and of problem solving: *you suddenly think to yourself... 'Oh she's probably hungry'.* The comment of: *probably just from being around her a lot* indicates that incidental learning is a possibility for the way in which knowledge of a baby's needs is gained.

Julia starts to construct a position through the rejection of a specific maternal attribute — *I don't see myself as having this incredibly strong maternal....* The clarification of the strength of the emotions signals a possibility that there are degrees of being *maternal.* The identification of degrees of being *maternal* thus enables the setting of a criterion to judge a woman's maternal attributes.

Julia continues to position herself through her next statement as not being an *earth mother.* This statement allows a connection to be made between maternal attributes and nature. These connections between mothers and nature occur periodically throughout history in legends, poems, paintings and novels (Thurer 1994). In more

recent times, the notion of the *earth mother* regained prominence in the 1960s resulting in a trend to reject medical intervention in childbirth and mothering practices (Umansky 1996). In the 1970s ecofeminists cited women's nurturing abilities of both the earth and their infants as a potential protection against male destructiveness (Umansky 1996). The connection with nature was strengthened further by the work of researchers such as Klaus and Kennell (1976) whose theory about maternal-infant bonding, which in part developed from observations of the behaviour of animals, was readily embraced by the medical and popular mothering discourses.

Definitions of the *earth mother* are consistent with the fantasies that allow the mother to escape and be untainted by the conflicts of the external world (Parker 1995). The notion that women can totally devote their lives to their children or cook totally organic foods provides the impression of women who are insulated from the legal, social and economic activities of life.[12] This escape, it can be argued, is an impossibility for most women if not all women to maintain, as the boundaries which are set to contain the definition of mother through the notion of an 'earth mother' are too narrow and restrictive.

An essentialist view of women necessitates a belief that all women have the same common characteristics, regardless of time or place in which they live. Variations and any possibility for change are therefore clearly restricted (Grosz 1995). The belief that women's physiological ability to bear children and lactate results in women's interests being defined as main carers of children and others within and outside the family (Wearing 1996) becomes possible. This belief can act to reinforce statements that direct women, men and children as to the way in which mother should behave, which, if accepted without question or modification, can result in a form of 'maternal determinism' being put in place.

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12 The legal requirements for children include regular participation within an accredited schooling program; minimal standards of health care and nutrition; and compliance with child safety regulation.

In the following two extracts, Rebecca and Meredith positioned themselves in very different but shifting ways, during the group discussion, as they discussed their understandings of and positions in relationship to 'maternal instinct'. Rebecca did not hesitate in answering my question about whether 'maternal instinct' existed. At this stage her son Marcus was thirteen months old and she was four months pregnant with her second child.

Rebecca: Its absolutely amazing ... I think ... yeah ... I really do, its ..... something [maternal instinct] I never really thought of prior to having Marcus .. But its ..... I don't know its just .....

Cathrine: What is it to you?

Rebecca: ... Oh gee ..... I don't know, just ... It it just spins me out knowing that I know what to do when he is upset about something .... and ..... just being there for him ... and protecting him ..... The bond is unbelievable, I never ever thought I could feel this way .... Cause I mean, you love babies and you love children and things like that ... but like anyone no-one can love them as much as you love your own and things like that ... And umm with family and friends as well ... but ... I just think it's a very strong thing, but you know.

Cathrine: What I am hearing is it's a bond, rather than always a knowing of what to do?

Rebecca: Well, I think its probably a bit of both .....Yeah ... Yeah, but it's you know, like especially when you come from someone where I haven't had a great deal to do with babies and things like that ... And then I just think well you know ... I know what to do with Marcus ... Not only in the first stages I had to ask a lot of questions to get around it. But just knowing that ... you you get to know their cries because I used to think 'oh what do you mean?' You get to know their cries, they cry, they cry ... (all group laughing) ... They cry, they cry .... but later on, like a lot of girls used to say to me 'oh that's mine crying up in the the nursery', when we were in the hospital. And I thought ... God, I could never work out which cry ... I couldn't for the life of me ... I could never know if that was Marcus crying in the nursery or he wasn't ... And I was starting to think ... well may be you know ... I'm not picking up on things, that I should be picking up on and I was starting to get a little bit upset about that. But I think, ... yeah maternal instincts it's very ... strong.

Rebecca takes an immediate stance about the existence of 'maternal instinct', though she is not able to describe it. Rebecca becomes caught up in maternal emotion and the bond between mother and child. In an attempt to clarify her meaning, I questioned her by asking if *it's a bond rather than always a knowing what to do,* Rebecca partially accepts this interpretation.

A contradiction has started to occur in Rebecca's statements *I haven't had a great deal to do with babies and things like that ... and then I just think well you know ... I know what to do with Marcus.* Rebecca is constructing her story from the position of a mother, thirteen months after the birth of her first child, who feels confident with his care. Rebecca follows the statements of knowing what Marcus' needs are with a story of 'not knowing' his cries during the early days of his life. From the laughter of the group this inability to differentiate the different cries of their babies was also a mystery for the other women. 'Not knowing' was highlighted by the previous comments of Rebecca *I'm not picking up on things.* This comment suggests that there is a list of things a mother should know about her infant.

Rebecca has positioned herself in relationship to the other mothers in hospital, which leaves her open to be judged as a mother who has not attached or attuned to her baby because she was unable to recognise her son's cries. If a belief in 'maternal instinct' as 'naturally knowing' certain things about her baby is perpetuated, Rebecca's lack of ability to attune to her son's cries could position her as not being particularly 'maternal'.[13]

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[13] According to Blaffer Hrdy (1999), being sensitive to an infant is mainly subliminal learning (smell and sound has been identified as more important than sight or genetic connection with the baby) for distinguishing one baby from another. This learning is thought to occur during the first few days after birth. It is not thought to be necessary for the woman to have given birth to the baby for the women to become attuned to the baby. Blaffer Hrdy (1999) provides examples of babies being mixed up at birth and given to the wrong mother. The mothers have accepted these babies and then been reluctant to exchange the baby for their own at a later stage.

Rebecca finished her story by reinforcing her original stance on the existence of 'maternal instincts'. However, the contradictions remain as the recurrent themes in this story are of learning and 'not knowing'; for example *the first stages I had to ask a lot of questions to get around it ...* or ... *you get to know their cries.* Rebecca clearly recognised her lack of knowing in the days after Marcus' birth — *I'm not picking up on things that I should be picking up on.*

Rebecca mobilises discourses of 'maternal instinct' to describe and capture the seemingly inexplicable or difficult-to-explain maternal emotions. A possible explanation for the use of 'maternal instinct' as a taken-for-granted notion to explain maternal emotions is provided by Bourdieu's proposition that "every established order tends to produce (to very different degrees and with very different means) the naturalization of its own arbitrariness" (1977, p.164). This naturalisation can be identified in the way women are cited as possessing 'maternal instinct' which is exemplified by certain taken-for-granted universal characteristics and expectations, such as the ability to nurture, having empathy with others, or having a non-competitive approach to life (Blaffer Hrdy 1999; Oakley 1995). Bourdieu (1977) accounts for this naturalisation as a form of social reproduction that makes adherence to the beliefs of that social world self-evident and undisputed. This naturalisation can also be described as a practical sense that has the ability to identify acts of social necessity as a natural occurrence (Bourdieu 1990).

A resorting to 'maternal instinct' as a seemingly taken-for-granted or commonsense understanding initially occurred in the story provided by Rebecca, but she was unable to sustain the links to 'maternal instinct' as the story progressed. After Rebecca had finished recounting her story about 'maternal instinct', Meredith, whose son was now twelve months old, tells a story which rejects the existence of 'maternal instinct'. Instead, Meredith's story constructs the ability to mother as a learning process.

Meredith: (laughing) Well when you [Rebecca] said that I thought 'bullshit' (all the group laughing). It was totally different ... for me. It was a completely learnt thing ... and there is nothing instinctual, that's not in terms of a relationship of caring ... and wanting ... the best you know ... thing that ..... I didn't know how to hold a baby, and I remember a friend coming in who was a dentist, in the first couple of days ... A really good friend and ... him saying 'you look like you don't even know how to hold the baby' and I thought, I don't and I really ... After I mean ... It made me really a bit upset with Nick, and then afterwards I thought I should have said ... 'Nick when you first picked up your dental instruments did you know what to do with them? ... no!' ... I'm buggered if I know how to turn a baby from this breast to this one, you know. And I asked my sister, who has not had kids, but ... manipulated little babies in her job, you know and she said 'oh, its a bit easier, yeah they're floppy but, you know, swing them around a bit' ... Now I've actually got, you know, got the hang of it. ... But I felt just really, you know, inept till it was, it was another skill I was going to learn and ..... and I did ... And in a sense he did me a favour because it crystallised in my mind what I thought about that ... And that it is a learning process and if anybody was going to criticise how I was doing it, I was going to say 'its cool, I've still got my 'L' plates on ... you know and I know where I am about this ... but he's not unsafe ... and I love him ... and it will be okay'.

Meredith rejects the notion of 'maternal instinct' without hesitation. Rather, she makes an important distinction between learning and a relationship of caring and wanting the best for her baby. The story of her friend's surprise at her lack of skill in handling her baby highlights his expectation that women instinctually know how to mother which is often equated to handling a baby in an expert manner. The expectation may have been even higher for Meredith as she worked as an infants/primary schoolteacher.

Difficulties arise if a woman tries to occupy the expected habitus (behaviours and characteristics of a mother within a specific community or culture) and fails, as it can result in the woman questioning if she is a failure as a mother. The potential for the friend's remarks to cause Meredith to lose confidence and result in her questioning her ability to mother was forestalled by her providing an understanding of mothering

as a learning process, rather than an innate state. Meredith has positioned herself in relation to her male friend and his skill as a novice dentist. This shifting in position, from incompetent mother to a mother who is learning, has altered the power relations between Meredith and her friend as she positions herself with similar learning needs as a novice dentist rather than a mother who is failing to adequately manage her infant.

Meredith's dismissal of 'maternal instinct' demonstrates that women are able to exercise agency through mobilising different discourses which proffer room for them to move and are not restricted by being inscribed by essentialist notions of 'maternal instinct'. Essentialism, often in reference to 'maternal instinct' (as highlighted in Rebecca's earlier story) is deployed to account for certain activities or social practices which allow for specific behaviours and responses in terms of emotion, intuitiveness, and commitment to helping others (Grosz, 1995). Norms are identified and accepted for specific female or male behaviours (which are often taken-for-granted). 'Maternal instinct' is often the basis of these female norms and if a woman does not conform she may be deemed to be lacking womanly or maternal qualities by the people she comes in contact with.

This section has highlighted the difficulty of identifying practices that are related to or identified as 'maternal instinct'. Instead, within the three extracts, the women talked about learning as a common behaviour in gaining maternal knowledge and skills to care for their infants. The essentialist discourses of motherhood which mobilise taken-for-granted beliefs about the concept of 'maternal instinct' are unable to explain what is meant by 'maternal instinct', how it functions, and why some women have minimal difficulty in positioning themselves as mothers and competently completing the tasks of mothering such as breastfeeding, infant care and nurturing practices, while others have varying degrees of difficulty managing the tasks and behaviours of mothering. These discourses of motherhood need to be troubled and if possible alternative explanations uncovered, as any evidence for the existence of 'maternal instinct' is

hard to find.[14] The presentation of 'maternal instinct', in the literature as well as in everyday discourses (such as Rebecca's story) as something that women 'possess' which allows them to be nurturing and instinctively know how to care for a baby is problematic. As an impression of women as 'lacking' can be developed if they are not able to call upon this essentialist notion of 'maternal instinct' when they have a baby. Blaffer Hrdy notes that "much lip service has been paid to 'Biology,' 'Instinct,' and 'Natural Laws' without a great deal of attention paid to how maternal behaviour unfolds in the real, everyday environments in which mothers actually live, or in those very different ancient environments in which women evolved" (1999, p. 26).[15]

A challenge to the concept of 'maternal instinct' is not a denial of the bond between the mother and her infant, as the position of mother can be a privileged and desired position for women to assume. The purpose of the challenge is to stimulate other ways of thinking about mothering that are not linked to an unproblematic version of the essentialist concepts of 'maternal instinct'; which women can find distressing and impossible to achieve. Challenging the construction of 'maternal instinct' provides an opportunity for women to consider what it means to mother and to encourage women to trouble statements, which frequently link the physical and emotional responsibility, and other mundane child rearing activities exclusively to women.[16] A possible

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14 These concerns were raised by Chodorow (1978) in her important book about the reproduction of mothering.

15 For example, see Blaffer Hrdy (1999) for a review of the biological basis for maternal behaviour.

16 In an article in the *Australian Medical Journal*, about rethinking the provision of child care for infants in Australia, Cook (1999, p. 30) argues that infants during the first year of life should "... have their mothers available to them through most of each 24 hours ..." and that they be principally cared for by their mothers until over two years of age. Throughout Cook's article there are three references to parent or parenting; four references to families; and in the final paragraph one reference to fathering, but no reference to fathers and their potentially important function or ability to care for an infant. The focus is on the importance of mothers and the responsibility she must take being constantly available to the infant. This article perpetuates the simplistic notion that women should be totally responsible for the care of children under the age of two years. The article by its silences rejects the nurturing skills and abilities of fathers who may want to take time off work to also share the caring function and the possibility of other life factors which may impede women's ability or desire to stay home with their children. It is

challenge to the concept of 'maternal instinct' is offered by the medical discourses of memory, in particular its ability to provide meaning for the way in which a specific habitus and incidental learning experiences become embodied as somatic knowledge.

4.3 Memories of mothering

Memory as a concept has been identified, within this thesis, as an alternative or counter construction to 'maternal instinct'. The concept of memory is being proposed as a way to assist in exploring the ability of women to unknowingly or unconsciously respond to their infants through the use of seemingly appropriate and inexplicable maternal skills and knowledge. By using the concept of memory as a meaning system, the concepts of habitus and maternal somatic knowledge being gained through incidental learning start to be linked and foregrounded. These two concepts of incidental learning and habitus were introduced and briefly discussed in Chapters 1 and 2.

The use of memories has been an essential part of this New Mother study as the women were asked questions about recent as well as long past experiences. At times answers were immediate, while some other answers took a degree of effort by the women to find a fragment of understanding or meaning.[17] Many questions remained unanswered or were only partially answered because of the limitations of language to make meaning of the women's maternal experiences, emotion or sensation. The limitations of language were compounded by the inability of the women to fully

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distressing to think that this article was published in 1999, as it continues to reflect a narrow view of such things as the complexity of the issues surrounding mothering and parenting, current economic and social conditions, the compositions of families and the substantive gains made by women in their educational endeavours and within the paid workforce.

17 Haug and others (1987) in their development and use of memory work to explore women's experiences found that memories which at times seemed fixed started to change when different triggers were introduced. These triggers included smells, colours, sound and music.

remember experiences; even though the experiences could be frequently identified as having a painful physical impact and/or were considered of immense importance by the women. These language limitations and the ability to make meaning of maternal experiences will be explored in greater detail in Chapter 7.

The discussion about memory will initially be located within a medical discourse about the physical characteristics of memory.[18] In the final part of this section counter-constructions of learning to mother will be provided by linking recent medical discourses about memory with discourses about incidental learning and Bourdieu's concept of 'habitus'.

Memory is defined within a particular discursive framing as 'scripts' (Cohen 1989) or "... a store of 'recipes' for handling current problems and current situations" (Cohen 1989, p. 109). These scripts provide understandings of how to cope with practical problems, how to react and behave in specific social situations — people have scripts for going to church, going to the clinic, going to a party or for mothering. Scripts provide what likes, dislikes, and prejudices we may have.[19] Scripts are theorised as default values or basic frameworks for everyday behaviours that allow us to fill in the missing actions (Cohen 1989). According to Cohen (1989) these scripts are not static, as they can be altered, depending on the sub-script or contextual factors. For instance,

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[18] Within this stage of the thesis I have drawn on a medical discourse of memory rather than the poststructural or feminist work on memory for two reasons. The first reason is that the medical discourse on memory is useful in providing a way of understanding the physical working of memory and is suggestive of possibilities for other ways of thinking about how we gain the often inexplicable knowledge and skills of mothering. In particular, this understanding of the physical working of memory complements the theorising of Bourdieu using the concept of habitus. The second reason is that I am a nurse who regardless of my desire to work outside a medical model of nursing, must constantly connect with the understandings that result from medical models.

[19] Shore (1997) and Perry et. al. (1995) offer an understanding that experience is thought to have a profound effect on the development of an infant's brain, as the brain systems are organised during this critical period of early childhood. This concept highlights the possibility that experiences (especially repeated frequently) have the potential to permanently influence the organisation of the brain and functional capacity of the brain (Berlin, Brooks-Gunn, McCarton & McCormick 1998; Shore 1997; Perry et. al. 1995).

if a mother takes her baby to the local early childhood clinic, she will behave in different ways and have different expectations if she has a consultation with a nurse, social worker or doctor. Scripts are, therefore, greatly influenced by issues of power and subjectivity. These scripts could be constructed as another way to name the rituals of everydayness or the socialised subjectivity of a specific habitus.

Memories are thought to be gained from experiences (Perry 1999; Nelson 1998; Perry et. al. 1995) and are open to change, especially if events are recalled and spoken about frequently, as what is said each time can become incorporated into the original memory (Perry 1999; Lewis 1995). The original memory which was constructed becomes distorted (LeDoux 1998).[20] In other words "people may forget events rapidly or gradually, distort the past in surprising ways, and sometimes experience intrusive recollections of events that they wish they could forget" (Schacter 1999, p. 182). A further complication for thinking about memory is the complexity of the brain.[21] This complexity is increased by the changing and varied understandings of the anatomy and physiology of the brain which acts to demonstrate the impossibility of constructing an absolute truth about memory and its functioning.

Memory has been differentiated by some neuro-scientists into two systems — declarative and non-declarative, which are thought to be fully functional within the first years of an infant's life (Rovee-Collier 1997; Perry et. al. 1995).[22] The explicit

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20 When using poststructural understandings, the notion that memories are easily distorted is problematic, as this proposes that memories start out to be pure or exact copies of the experience; a 'truth' which is an authentic representation of 'reality'. Poststructural understandings see all memories as constructions.

21 It is reported that there are over 100 billion neurons and many more glial cells (Greenfield 1997; Shore 1997; Perry et. al. 1995). These neurons and glial cells have been organised into a system which is "... designed to *sense, process, store, perceive*, and *act* on information from the external (eg., visual, tactile, olfactory, auditory) and the internal (eg. hormonal signals associated with hunger) environment" (Perry et. al. 1995, p. 273) (original emphasis).

22 Declarative and non-declarative memory systems have also been referred to as explicit and implicit or procedural memory.

distinction between these two memory systems is used to refer to and contrast the ways in which memory for experiences can be expressed (Schacter 1992).

Declarative memory is theorised as the ability to have conscious recollections of facts and events and is characterised by the conscious awareness of memory retention, which is episodic, concrete, deliberate and voluntary (Squire 1992).[23] Declarative memory has a limited capacity and ability to partially retrieve memories (Rovee-Collier 1997). These memories are the ones in which we can pause, readily call up and reflect on (Roediger 1990), resulting in a conscious awareness that we have these memories or knowledge accessible (LeDoux 1998).

Declarative memories can be very vivid and seem to be exact copies of the original memories, but they are always developed in hindsight (Cohen 1989). So memories are copies or reconstructions of experience, rather than an authentic representation of an experience. Declarative memories blend information from long-term memory with the subject's current experience (Cohen 1989).

Non-declarative memories are unconscious memories of knowledge and skills that are usually available as somatic knowledge about how to interact with people and how to do things without conscious recollection (Squire 1992; Roediger 1990).[24] Often, if this knowledge or these skills are thought about while in the process of completing the skill or recalling the knowledge, performance deteriorates (Roediger 1990). Non-declarative memory allows the retention of learned connections between a stimulus and the responses that occur (Tulving 1985). This connection between stimulus and

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23 Declarative memory is said to be dependent on a specific brain system and on the integrity of the brain connections and structures in the medial temporal lobe and the diencephalon (Squire 1992).

24 Non-declarative memory ability is multiple and includes skills and habits, priming, simple classical conditioning and nonassociative learning (Squire 1992). Non-declarative skills include bike riding and swimming.

response[25] is reported in the literature on infant child abuse[26] and trauma which has drawn on these understandings of non-declarative memories to assist in theorising how behaviours are learned, but are often not recalled until a situation is experienced which triggers these memories (Rovee-Collier & Gerhardstein 1997).[27] For the purpose of this thesis, non-declarative memory will be referred to as unconscious memory which is being theorised as resulting in somatic knowledge.

This discussion about memories has been provided as a framework for developing alternative meanings about how many women learn to mother in a seemingly natural manner. Other constructions of memory could have been used, such as the work of Haug et. al. (1987) who used memory work to explore women's experiences. Nevertheless, even though the focus has been on a medical discourse, similarities can be drawn between these two constructs of memory as they are both identified as being constantly open to change. The information provided about memory is a construction using a medical discourse. It is not meant as the only or definitive way in which to consider maternal learning, but as complementary to other constructions that are being used within this thesis. So, rather than being concerned with it as a truth, my concern relates to what the concept of memory can do to destabilise the potential binaries constructed by the use of 'maternal instinct' discourses.[28] The following section will expand on the medical discussion of memory by drawing on Bourdieu's

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25 Hepper and Shahidullah (1994), in their review of the literature on foetal brain development, identify the possibility of learning occurring while in utero which result in habituation (the foetus stops responding to a startling noise); and development of familiarity with the mother's voice, heartbeat and music. This possibility of learning requires that the foetus is able to perceive a stimulus and is able to retain some memory of that stimulus.

26 For example, the experience of childbirth has been reported as a potential trigger for activating memories of sexual abuse (Waymire 1997; Cassin 1996; Parratt 1994).

27 For example, Lewis (1995), who looks at infantile amnesia and transference through the use of the terms declarative and procedural memory; or Perry et. al. (1995) who explores the experience of childhood trauma and the effect this has on the organisation of brain systems.

28 The potential binaries which are set in place by the concept of 'maternal instinct' include the 'good' and 'bad' mother; or women as lacking if they do not seem to mother 'naturally'; or the linking of women to nature and men to culture.

concept of habitus and its link to incidental learning and the resulting somatic knowledge.

4.3.1 Counter constructions of learning to mother

The use of medical discourses about memory has been established as a possible way in which 'maternal instinct' discourses can be destabilised by providing a counter or alternate reading of how women learn maternal knowledge and skills. Of particular interest for this thesis is the learning of somatic knowledge which has been linked to unconscious memory. Somatic knowledge can also be usefully theorised through Bourdieu's concept of habitus. According to Bourdieu, the body is treated from childhood as:

> ... a living notepad, an automaton that 'leads the mind unconsciously along with it', and as a repository for the most precious values, [it] is the form *par excellence* of the 'blind or symbolic thought' (*cogitation caeca vel symbolica*) (1990 p. 68).

Bourdieu's theorising of the body as a living notepad is complemented by the notion of unconscious memory and the possibility of using this concept to gain understanding about the functioning of incidental learning as an implicit pedagogic practice.[29] The 'precious values' Bourdieu (1990) has alluded to are theorised within this thesis as the expected maternal knowledge and skills to enable a woman to be identified as a 'good' mother.[30] These precious values are gained as a result of an implicit pedagogic practice that is a 'practical sense'.[31] This practical sense is a 'state of the body', rather

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29 Bourdieu proposes that "the cunning of pedagogic reason lies precisely in the fact that it manages to extort what is essential while seeming to demand the insignificant ..." (1990 p. 69).

30 These 'precious values' are being theorised within this thesis as dynamic, as they vary according to such issues as culture, political and social change.

31 For example an implicit pedagogy uses such insignificant interjections as "... 'stand up straight' or 'don't hold your knife in your left hand' ..." (Bourdieu 1977, p. 94) to achieve embodiment. According to Bourdieu (1977), the body acts as an apparatus for the embodying of everyday knowledges that are beyond the grasp of consciousness; a bodily hexis which cannot be made explicit.

than a 'state of the mind'. It is how a subject interacts with the 'field' or culture in which they live. For example, the nurse who reacts automatically in a specific physical and non-emotive way as part of the resuscitation team managing a patient during a cardiac arrest demonstrates how a subject interacts as part of the 'field' or culture in which they participate. This behaviour is expected and it is implicitly demonstrated to the novice nurse by more experienced and practised nurses; or a mother who automatically adjusts her body or voice to soothe her infant. This maternal behaviour may have been learned from observation of others, practice with younger siblings or dolls.

The counter-construction to the concept of 'maternal instinct', which is being offered here, is based on the interplay of incidental learning, memory and habitus. This counter-construction is provided in an attempt to stimulate and offer a more productive way of thinking about the process by which women learn to mother. These counter-constructions allow the development of an argument that, instead of maternal ability being an outcome of 'maternal instinct', mothering is mainly learned informally and incidentally through the everyday experiences we have had as infants, children and young adults.

In the chapters of this thesis I am developing an argument that everyday experiences provide the major component of learning and teaching about mothering. In Chapter 1, this learning has started to be constructed as occurring throughout our lives often happening outside formal learning environments as everyday learning. This everyday learning is being theorised as frequently beyond conscious acknowledgement as incidental to the activities of everyday life (Foley 2000). For mothers, the maternal task of providing infants with everyday experiences can be identified as helping them learn about and tolerate their world through play and other sensory experiences.[32]

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32 Many parenting books discuss the importance of play to enhance a child's development and to assist them learn about their world (for examples, Barker 1994; and Fowler & Gornall 1996). In the psychological literature, discussions of play feature as a potentially important factor in learning to experiment with their world's (see for examples Winnicott 1971; and Bowlby 1965).

However, if the development of unconscious memories are constructed as beginning from birth, then the experiences of early childhood can be theorised as significant in learning to mother. For example, being able to respond in seemingly appropriate ways to an infant by learning the necessary mothering rituals and bodily behaviours through experiencing these as an infant or young child. According to Bourdieu (1990), each society provides exercises that allow and encourage a 'practical mastery' of expected and required skills. This encouragement of practical mastery can include: the older child helping their mother with the new baby by fetching and carrying clean nappies or being encouraged to play with and entertain the baby for short periods. These nurturing behaviours and activities may also be encouraged with dolls or young animals.

A rich way to understand the link between memory and incidental learning is through the concept of habitus. Habitus is important as it locates maternal knowledge within a larger social context. Habitus provides cultural meaning for the process which occurs as women take on the subjectivities of a mother, reproducing cultural and social expectations of mothering that are often implicitly interwoven within the beliefs and behaviours of families and communities in which women live. This process is not often explicitly constructed for and by women as a possibility for the way women learn to mother.

Habitus provides a mechanism by which scripts are embodied, enabling a woman to reproduce everyday rituals (Butler 1996) that are expected from mothers within particular cultural norms. The dispositions that form the habitus are acquired gradually through a process of inculcation or repetition of experiences. A 'disposition' is the term used by Bourdieu (1977) to describe schemes of perception and thought, and generalised behaviours, which are embedded in the subject's body. Schemes of perception and thought are dispositions that divide the world up in accordance to oppositions such as right and left, male and female, east and west, or top and bottom.

Bourdieu (1977) identifies generalised behaviours as bodily posture ways of sitting, standing, speaking, looking or walking. These experiences start in the early childhood period and are of particular importance as they lay the foundation for the social conditions in which a subject must participate (Thompson 1991).

The reproduction of these embodied rituals in the form of discursive practices and behaviours are often beyond our control, even though greater control over actions and words are frequently desired. The following extract from the data of this New Mother study is a response to a question about Julia's mothering expectations, asked halfway through the first interview. Julia's response starts with the identification of several behavioural qualities she has identified such as: *I'm not a particularly tense person but I do tend to keep my emotions bottled up a bit if I'm upset;* and *I hope that I will be fairly calm and collected and not too cranky.* Julia then provides an example of the reproduction of discursive practices she constructs as being gained from her own mother that had occurred during her work as a high school teacher.

Julia: .... But I don't really know what I am going to be like ... teaching's been good because it's given me a lot of patience ..... and .... I know that kids can be very demanding ... but I still tend to find myself doing some things I thought I would never do like ... you know, you sort of say 'oh my mother did that and I'll never do it'. Like, 'I told you so' or 'because I said so'. You know, things that often fall out of my head that I don't mean them to.

Cathrine: And when that happens do you hear your mother in yourself saying that?

Julia: Oh yes, (laughing) cause I sound like my mum as well. So ... it's like playing a tape from the past and I always feel bad after I've done it ...

This extract is usefully analysed in terms of conscious or declarative and unconscious or non-declarative memory and illustrates the formation of habitus. There are two parts to this memory of her mother's behaviour: the first is the ability to recognise the words used by her mother and her vocal qualities which sound like her mother. This

knowledge comes through her ability to draw on conscious memory, as she is able to consciously recognise her mother's vocal qualities and words which were used when she was a child. The second part is her unconscious memory that is triggered when Julia is in a context where she needs to control the behaviour of children by using specific phrases and words. However, the allocation of specific behaviours to conscious or unconscious memories is difficult, as there are potential overlaps as the two memory systems often work in synchrony (LeDoux 1998). Being able to retain the memory of the event may not necessarily mean Julia can consciously reproduce her imitation of her mother's behaviour.

Julia's habitus is that of her mother's behaviour in a similar situation; she experiences the event like — *playing a tape from the past*. The script that informs the habitus Julia has taken on results in behaviours and discursive practices being available as memories, which are triggered when the context is similar to the original circumstances of the memory (Perry 1999). Julia emphasises her feelings of lack of control through her statement *things that often fall out of my head that I don't mean them to*. Julia extends this lack of control beyond discursive practices to behaviours that are often outside of language itself — *I sound like my mum.* Or using the words of Bourdieu:

> ... learning through sheer familiarization, in which the learner insensibly and unconsciously acquires the principles of an 'art' and an art of living, including those that are not known to the producer of the practices or artefacts that are imitated, and explicit and express transmission by percept and prescription ... (1990 pp. 74-75).

This 'sheer familiarisation' is gained, as Bourdieu suggests, through constant or frequent exposure to behaviours to enable subjects to function, in most instances, appropriately within the societies in which they live.

Unfortunately, it appears that we cannot be selective about what memories are laid down from the behaviours and discursive practices we are exposed to during our lifetime.[33] As Julia's words illustrate — *I always feel bad after I've done it* — these behaviours and discursive practices that are used are not always the ones we want to maintain or call into action. The difficulty arises in trying to explain how these behaviours and discursive practices keep recurring, regardless of the effort invested in trying to discard the offending practices. A possible explanation is that memories are not limited to one type of remembering, but frequently linked (Koziol 1994). In Julia's example, a group of words and the sound of her voice evoke the image of her mother and the memory of these things being said to her as a child. These memories could also be a reaction to the sense of powerlessness as a child she may have felt, causing the linking of words of authority and the sound of her mother's voice, resulting in somatic memories of fear, disappointment or anger. According to the medical literature it is the memories of the emotions such as fear, disappointment or anger that are the unconscious components of memory (Perry 1999; LeDoux 1998; Cohen 1989). These memories can often be the 'unspeakable' memories of our past experiences.

In this next extract, Sally provides an example of actively trying to draw on the memories of her childhood to learn how to meet the needs of Cameron, her eight and a half month old son. In response to a question about the difference between 'maternal instinct' and memories and their impact on learning to mother, she stated:

Sally: I think it ..... because I mean .... it's from my memory back of my experiences that's ..... Yeah, that's helping me .....Yeah, to understand this other little person ... I think ... each time you've got to try and Mark [partner] does this too ... Try and remember if I was in that position what would my needs be? ... What would I be feeling? ..... If he cries at night ... he just probably wants me, some

[33] Even though subjects may learn to disassociate from the content of the memory (particularly after traumatic experiences) they may respond to the memory through often distressing physiological reactions of fear, anxiety and panic (Perry 1999).

> reassurance and a cuddle. I mean he might be feeling alone or just ... everyone's here and everything's okay and you're all secure now go back to sleep (third interview).

Sally answers my question by attributing significance to memories of experiences. The pause and the .... *yeah* in two incidences provide an impression that this may be the first time she has made this link between her memories and her ability to attune to her baby's needs. Sally also credits Mark with the same behaviour of trying to use memories of past behaviours to understand what their son may require. Sally describes this process of working out her baby's needs as a conscious and active process. This process could be proposed as using skills of reflecting, problem-solving and making sense of what is occurring in the middle of the night, which ultimately results in the development of maternal knowledge and skills.

However, this ability to describe the process may be in response to being asked questions and the expectation that she will put into words her maternal experiences. It may not have been such a conscious process during the early days of mothering, particularly, in the middle of the night when she had been awoken from her sleep. The memories of her own mother's touch, the smell of a baby, the dim lights of night-time and the sensation of her words or other women's maternal behaviour may have all contributed to eliciting the 'knowing how' knowledge required to attune to the needs of her baby, without providing the factual account of the experience. These experiences could have allowed Sally to take on the habitus or certain ritualised behaviours of mothering which can seem to be an innate ability to mother, as Bourdieu has theorised habitus enables the reproduction of the "... social conditions of our own production ..." (1993, p. 87) which occur in often seemingly unpredictable ways.

The act of being interviewed provided an opportunity to formulate the somatic knowledge of 'knowing how' to the conscious 'knowing that' knowledge needed to

contextualise and talk about her ability to attune to the baby's needs. But the bodily sensations which Sally experienced while attending to her infant and developing an understanding of what was needed to calm and put him back to sleep are not able to be shared through words, as it is impossible to know if a common meaning exists. The words used to describe her maternal behaviours are action words such as, *reassurance, cuddle,* and *all secure.* These words are limited because the meaning comes from our own memories of: what is meant by *reassurance; how* a *cuddle* feels like in the middle of the night; and how we feel when we are *all secure.* Assumptions can only be made that these meanings are similar to Sally's intended meanings. These resulting meanings therefore are limited by the publicly or mutually available discourses for constructing meanings from experiences.

Different possibilities and understandings start to occur if the counter readings made available through the concepts of habitus and memory, in particular unconscious memories, are used to describe seemingly inexplicable maternal actions and nurturing behaviour. These maternal actions and nurturing behaviours can be read as learned skills and knowledge frequently gained through incidental learning, rather than attributing inexplicable maternal knowledge and behaviours to 'maternal instinct'. The use of maternal discourses based on 'maternal instinct' have the potential to result in feelings of distress and guilt, as women are often unable to or desire to fulfil the maternal behaviours or attitudes invoked by these discourses.

4.4 Conclusion

In this chapter I have troubled the dominant discourses of motherhood, including those which perpetuate the concept of 'maternal instinct'. 'Maternal instinct' is frequently called upon to explain how some women come to know about their infants and are able to reproduce the behaviours which have been constructed as maternal behaviours. Yet the concept remains elusive and often beyond description. An

understanding is offered by Maushart about why people attribute so much of their nurturing behaviour to 'maternal instinct' by her comment that "the knowledge of what to do and how to do it has been so thoroughly internalised that it's exactly as if 'you were born knowing it'" (1997, p. 183).[34]

Maushart's understanding of 'maternal instinct' links with Bourdieu's concept of habitus which foregrounds the taking on of a maternal habitus. The rules for this habitus are in constant circulation through the discourses of motherhood that inform children and develop habits, from an early age, of accepted maternal behaviours within a specific culture. These behaviours are frequently historically situated reflecting the requirements of a particular society (Bourdieu 1993); which results in mothering and child rearing practices being constantly open to evaluation, criticism and change.

A counter reading of the concept of 'maternal instinct' has been proposed in this chapter that the somatic knowledge of mothering is gained through the use of memories. This construction of memory has been linked to the concepts of habitus and incidental learning as a more productive way of thinking about maternal learning and knowledge. These concepts assist in thinking about the acquisition of the nurturing skills necessary for mothering as everyday knowledges and skills, which are frequently experienced and retained as somatic knowledge.

In theorising the acquisition of maternal knowledge and skills using memory, habitus and incidental learning three concepts are foregrounded. The first concept proposes that learning the nurturing skills of mothering is a life long process that has its foundations in the very first year of an infant's life — when an infant starts to learn

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[34] Maushart (1997) wrote *The Mask of Motherhood* as a response to her experience of the early motherhood period. Maushart also draws on her work in the field of social sciences and journalism.

about nurturing frequently through its mother's touch and voice.[35] The second concept is concerned with the limitations caused by the available discourses of motherhood to explain maternal experiences and therefore discursively construct maternal positions for women. The third concept is that much of maternal learning is only available through the unconscious memories which rely on sensations that cannot be adequately represented in language. These three concepts start to support a counter reading for understanding how women acquire maternal knowledge and skills, which may not be formally learned and which appears to 'just happen'.

In the following chapter maternal rules, rituals and behaviours will be discussed. The use of Foucault's concept of bio-power will be used to discuss how reinforcement of accepted and expected maternal behaviour occurs through practices of surveillance, normalisation and confession.

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35 A useful metaphor, which has developed from brain development theory is a 'hard wiring' of specific neural pathways within the brain resulting from repeated experiences (Shore 1997): in this case the hard wiring of nurturing.

Chapter 5

Motherhood Under Surveillance?

> Maternal fondling, freedom of the body, and clean linens are proofs of a new love for the baby. In order to provide all this, the mother had to dedicate her life to her child. The 'woman' disappeared behind the 'good mother,' whose responsibilities extended further and further (Badinter 1981, p. 173).

Women throughout their lives are exposed to maternal rituals, rules and behaviours that assist them to act in seemingly accepted and appropriate ways when caring for an infant. The existence of maternal rituals, rules and behaviours are of immense importance when trying to understand and theorise maternal learning, as women must negotiate, conform to, and demonstrate these pre-determined rituals, rules and behaviours to be judged and accepted as fulfilling the 'norms of motherhood'. By achieving the norms of motherhood the status of a 'good' mother, as referred to by Badinter in the above quote, has been perpetuated. These norms of motherhood set in place the potential for a form of maternal determinism which acts to produce the new mother. Nevertheless, this production of the new mother is, not surprisingly, not a smooth, continuous or uncontested process, as examples will be identified within this chapter where practices and norms which support maternal determinism are adapted or even contested and frequently resisted by the women within this New Mother study.

The numerous norms for mothering are potentially problematic as they often result in increasing responsibility to ensure the health and well-being of their children being placed on women. These norms are frequently applied as universal givens or standards, allowing the quality of mothering to be more easily judged and therefore controlled without consideration for social, economic or cultural differences. Women are often complicit in these practices as they perpetuate the learning and surveillance of social and community norms with their infants and other mothers. These norms are frequently used as guides or 'scripts' for maternal behaviour and as proof of a

woman's maternal ability.[1] Within the previous chapters the concepts of habitus and incidental learning have been discussed. These concepts I am theorising act as the possible mechanisms by which maternal norms are perpetuated.

To assist in the facilitation of normative judgements about maternal ability, a notable practice has been developed and accepted in Australia through the development of the early childhood health system.[2] The acceptance of this service has resulted in a practice of bringing infants and their mothers (parents) regularly under the gaze of health professionals through the routine use of physical and psychological checks and measurements.[3] These surveillance practices are theorised by Foucault (1978) as contributing to the concept of bio-power.

The concept of bio-power has the features of being simultaneously repressive and productive; it controls but it can also be argued that bio-power enables the populace to work towards improvements in public health and maintenance of social order. Within the context of this thesis bio-power is being acknowledged as having crucial elements that maintain the safety and well-being of infants and their mothers. This concept of bio-power as both repressive and productive aligns with Foucault's (1980b) concept of power as an ever present, complex productive network which

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1 For example, infants gain weigh at a certain rate per week; mothers breastfeed their infants; mothers respond quickly to the cries of their infants; and an infant's crying should not be allowed to disturbed others. These scripts have already been referred to in Chapter 4 as part of a maternal habitus.

2 It is important to note that currently this service is a universal population-based service that is free of charge. The service has now been in existence for nearly ninety years in NSW (O'Conner 1989).

3 However, there remain some women from other cultures who are reluctant to use the government services for pregnancy, and child and family health. A continued rhetoric of the NSW Health Department is the need to provide culturally sensitive services to encourage and increase the access of families to these services. These culturally sensitive services and activities include the provision of health workers from Aboriginal and Torres Strait Islander, and non-English speaking backgrounds; the development of culturally appropriate measures for postnatal depression; and information pamphlets translated into different languages. This rhetoric and attempts to improve services to meet the needs of minority cultural groups can be constructed as an attempt to bring these women and their infants into the surveillance network. Nevertheless, this surveillance has many potential long-term health benefits for these women and their infants.

infiltrates the whole social body, with subjects simultaneously exercising power and undergoing the effects of power. This understanding of subjects simultaneously exercising power and undergoing the effects of power will be demonstrated within this chapter as the women use the practices of bio-power to their benefit, as well as actively subvert attempt of others to bring them under the control of these bio-power practices.

As discussed in Chapter 1, bio-power is a discursive construct which attempts to describe how human lives and their mechanisms are brought "... into the realm of explicit calculations and [which has] made knowledge-power an agent of transformation of human life" (Foucault 1978, p. 143). Bio-power is described as having two poles: population regulation through surveillance practices and the disciplining of the body to make it docile (Foucault 1978). In describing these two concepts, the intention is not to discuss them in isolation but as two concepts which are interwoven. As a crucial factor in the successful implementation of the concept of bio-power and its supporting practices is the willingness of women to submit and be placed under the gaze of others, especially the gaze of health professionals.

The practices of bio-power have been gradually enhanced by the growing acceptance of confessional practices (Foucault 1978) as a means of normalising maternal behaviours and feeling through the use of activities such as counselling, and the development of support and education groups for mothers.[4] These confessional practices can be identified as also existing beyond formalised structures of counselling sessions or support groups, because of the readiness of subjects, at times, to talk

[4] The concept of normalising maternal behaviours and feelings is problematic — what I am referring to is a process which is often described as resulting in the clarification and modification of women's feelings to either be identified as similar to other women's feelings, behaviours, experiences and/or to be more in line with the normative measures. These practices include a sharing or reconstruction of a discourse about their experiences, feelings or behaviours. For example, it is not unusual for formal activities to be included within mothers' groups to encourage the women to share their feelings of anger, frustration or anxiety about mothering their infants. These confessional activities are thought by health professionals to allow the women to construct a new normative measure which identifies these behaviours and feelings as being 'normal' and acceptable as a discussion topic within the group.

about their feelings and often their seemingly most intimate secrets to family, friends and strangers. However, this readiness to talk is not a universal willingness to share secrets or feelings, as it is dependent on the subject positions which are constructed by and for the confessor and the listener. Within this chapter examples will be provided of how the women actively select who they will talk to about their maternal experiences.

As a form of regulation and discipline, these confessional practices frequently act through increasing the amount of information known about a woman, thereby allowing judgements to be made about her behaviours and feelings against normative measures. Through this New Mother study it is possible to demonstrate that confessional practices act to normalise the women's experiences as mothers and assists them to learn about child rearing practices and maternal behaviours through connections made with other women's or health professionals' experiences.

Foucault's theorisation of bio-power will be used in this chapter for two reasons: as a useful way to identify and discuss practices which assist women to produce behaviours that are accepted and expected of mothers; and to assist in providing a context in which women learn maternal skills and knowledge. This chapter is divided into two main sections. In the first section the development of practices that are used to bring mothers and their infants into the realm of social control, through the use of surveillance practices and the development of norms will be discussed. The second section will explore the concept of confessional practices and how these practices has become widespread as a means of normalising maternal experiences and as a potential source of maternal learning.

5.1 Surveillance: coming under the gaze

The willingness of subjects to conform to the accepted and expected behaviours and to willingly come under regular forms of surveillance and measurement is theorised by Foucault as essential for bio-power's success. Surveillance, is identified by Foucault as involving:

> ...very little expense. There is no need for arms, physical violence, material constraints. Just a gaze. An inspecting gaze, a gaze which each individual under its weight will end by interiorising to the point that he is his own overseer, each individual thus exercising this surveillance over, and against, himself. A superb formula: power exercised continuously and for what turns out to be a minimal cost (Foucault 1980c, p. 155).

Using Foucault's theorising, an understanding develops that surveillance is not just an apparatus that is imposed from a sovereign power or government, but its success comes from being interiorised by the subject. An interiorising of surveillance practices results in the subject exercising surveillance over and against themselves in the form of 'self-discipline'. This self-discipline provides a form of "... government at a distance" (Miller & Rose 1993, p.83) being instituted. Subjects interiorise laws, and social and cultural rules, thereby releasing governments from providing constant surveillance.

A key aspect of surveillance is the ability to measure behaviours and practices against a 'norm' and to willingly get subjects to come under the surveillance gaze. This willingness requires a docile subject or using Foucault's (1977) term a 'docile body'. This docile body is defined as a body "... that is manipulated, shaped, trained, which obeys, responds, becomes skilful and increases its forces" (1977, p. 136). A connection can be drawn between the docile body described by Foucault and habitus, described by Bourdieu (1998) as the ability to have a 'feel for the game' which has been discussed in early chapters. A subject that has embodied the rituals and practices expected of a competent and loving mother which may include willingly allowing surveillance of her infant by health professionals, or sharing stories with friends about her maternal experiences and concerns.

In this discussion of bio-power, poststructural understandings are being used to talk about the subject; these understandings identify the subject as being active and having a multiple and shifting subjectivity. The subject is able to resist the techniques of bio-power or be willingly placed under surveillance which often results in the subject providing self-surveillance and being self-disciplined, thereby allowing the automatic functioning of power (Foucault 1977). This self-discipline is influenced by such things as the power relations between subjects which are constantly present and shifting; access to knowledge; and the contradictions and tensions resulting from the different constructions of that knowledge.

The following section will expand on the notion of normality and the judgement of women's mothering ability through the use of frequently decontextualised normative measures. The use of normative measures are not limited to health professionals, but potentially used by all people within a community to judge others and their own compliance with these norms. These norms are also used as a tool to assist in the acquisition of maternal knowledge and guide mothering practices. For example, a woman who is pregnant or has an infant often receives special surveillance attention because of the presence of a baby that increases her visibility within the community and the contact she has with health professionals.[5] Nevertheless, women also have the potential to consciously and unconsciously observe other women mothering their infants. These observations allow a checking and, if they believe it is necessary, an adjustment to their maternal practices.

Surveillance is based on a notion of normality, which according to Hacking is "... both timeless and dated, an idea that in some sense has been with us always, but which can in a moment adopt a completely new form of life" (1990, p. 160). Normality is perpetuated through the identification of the normal which has become an indispensable word as according to Hacking "... it created a way to be 'objective'

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[5] A woman's visibility is increased in pregnancy because of her increased body size. After the baby is born, the woman's visibility is increased due to the equipment needed (e.g. prams and nappy bags) and because of the potential noise made by the baby.

about human beings" (1990, p. 160). These objective norms are used to identify deviance, by differentiating 'normal' from 'abnormal'. The construction and use of these objective norms to base judgements on have become the foundation for measuring and regulating populations (Urwin 1985). This claimed objectivity is often achieved by ignoring the context of women's lives and their families.

The seeking of a norm is often present in maternal research. For instance, Barclay, Everitt, Rogan, Schmied and Wyllie state in their research about 'becoming' a mother, that the research was generated because of "... a belief that unless 'normal' was understood it was impossible to recognise or manage the problems women face at either a therapeutic or social level" (1997, p. 720). Barclay et. al. imply that their research is about the subjective experiences of motherhood rather than from a health worker's perspective of motherhood. But it is questionable whether a norm can be found for motherhood using the experiences of fifty five women — or even larger cohorts of research participants. The norms which they have identified are problematic as the process of 'becoming' a mother appears to have been reduced into six categories to explain the complexity of Australian motherhood.[6]

Attempts to identify mothering norms are not just isolated to health professionals or to research practices, but women also try to identify norms which they can use to judge their own and other women's maternal competence. In her research into mothers' care giving for low birth weight infants, May (1997) found that mothers looked for signs of normalcy by making a comparison with infants who had a normal birth weight, by assessing their infant's eating and crying patterns, and their infant's technology dependence and development.[7] The processes of 'normalisation' which were identified as being used by the women included seeing progress, getting opinions

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6 Even the concept Barclay et. al. (1997) use that you can 'become' a mother is problematic. The concept that you can become a mother signals the existence of an ideal or core position as a mother that women must aspire to achieve. If such an ideal or core position as a mother exists, does this mean that women lose their other subject positions when they become a mother; and what are the implications for women if they cannot or do not want to achieve this norm?

7 Technological dependence refers to the infant's need for such activities as ventilation to assist breathing, and vital signs monitoring.

and hoping (May 1997). This process of making comparisons with other babies demonstrates the complicity of women in strengthening the acceptance of surveillance practices. It could be proposed that these women willingly participated in surveillance practices as both the observed and the observer. Possibly this willingness to participate is double edged as women may also be learning to adjust their maternal behaviour and the behaviour of their infants to conform with accepted standards.

Regardless of their origins, norms are problematic as they are frequently justified by measures of such things as body weight, sleeping patterns and psychological testing. These measures are then often linked to an essential human nature which has been developed using a standard of the rational, unitary subject as a basis to judge others. These norms rarely acknowledge cultural or societal differences and expectations, thereby enabling a privileged view to exist. Falzon summaries this point through his statement that:

> the modern sciences of the individual present these norms and standards as being grounded in and as reflecting some notion of an essential human nature, such as a true sexual nature, and thus as ways of being to which human nature, if they are to be truly human, truly 'normal', ought to conform. These sciences thereby participate in the operations of a totalising, scientific administration of life in which normality is the rule of life for all, and in which otherness, that which resists and goes beyond prescribed forms of thought and action, is stigmatised as abnormality or deviance, in need of rehabilitation (1998, p. 52).

Falzon's statement provides a reminder of the necessity to trouble the notion of norms — as norms are discursive constructions. Norms are usually based on the dominant group's expectations, beliefs and truths within a particular culture or community. Anything that does not conform to these norms may be constructed as abnormal or not meeting the norm. A difficulty exists that there can be multiple and contradictory norms and adjustment to these existing norms is required. For example, the Edinburgh Postnatal Depression Scale has been validated as culturally appropriate as a measurement tool for Vietnamese and Arabic women living in Australia.[8] The scale

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[8] The Edinburgh Postnatal Depression Scale is a self-administered, ten item questionnaire that is used to measure subjective feelings related to mothering during the past seven days (Holden, Sagovsky & Cox 1987).

was made more culturally sensitive by using different scores to identify the 'norm' and different words were used to elicit the women's feelings (Matthey & Barnett 1996).

However, the development and use of norms to make normalising judgements are crucial requirements for the seemingly successful existence of bio-power as a mechanism by which a totalising scientific administration of life is implemented (Foucault 1978). Norms allow judgements to be made and justified. According to Dreyfus and Rabinow:

> the effect of the normalizing judgement is complex. It proceeds from an initial premise of formal equality among individuals. This leads to an initial homogeneity from which the norm of conformity is drawn. But once the apparatus is put in motion, there is a finer and finer differentiation and individuation, which objectively separates and ranks individuals (1983, p. 158).

The development of norms enables conformity to occur within the populace (Hacking 1990) or the homogeneity Dreyfus and Rabinow refer to, which can result in the adoption of these norms as part of the behaviours or habitus of a particular subject position. The ability of the subject to take on a maternal habitus and clearly demonstrate competence is measured and ranked against maternal norms and other mothers who have been identified as reaching the desired degree of competence.

This measuring of competence by the women was evident within this New Mother study as they frequently made comparisons between their own maternal behaviour, the behaviour of other mothers, and/or their construction of societal expectations of mothers. An engagement in surveillance practices was occurring with resulting judgements being made of other women's maternal abilities and approaches. The use of these surveillance practices positions these women as agents of bio-power, but also as actively reflecting on their own or other women's maternal behaviours. As in the beginning quote by Foucault, a system of surveillance practices has been established where "... power [is] exercised continuously and for what turns out to be a minimal cost" (1980c, p. 155). For example, Emma provided the following comments about a woman who is part of her mothers' group. In this extract, Emma discursively

constructs positions of having greater knowledge than another woman; and of being the judge of what are the norms for mothers and young children.

Emma: In some ways I've become quite judgemental. Like the lady is breastfeeding her four year old and the nine monther. She has just sacrificed her whole life for these children and sees nothing apart from breastfeeding .... That's not okay, you know, she's a person in the real world and it's not okay for her and it's not really okay, I don't think it's okay for a four year old to use his mother for comfort all the time. He should have some other mechanisms at four years old to comfort himself, not go and have comfort sucks all the time (second interview).

In this extract, Emma is participating in a form of surveillance, as she has been observing and making judgements of another woman's maternal behaviour. The meanings and judgements which are being made about the other women's behaviour are possibly based on Emma's professional knowledge as a nurse, her current experiences as a mother and the rarity of Australian children older then two years of age being seen to breastfeed. Breastfeeding discourses only explicitly promote breastfeeding of the infant to one or two years of age; after this time breastfeeding is no longer an actively promoted behaviour for mothers and their infants in Australia.[9] Two of the possible ways in which the power relationships within this extract can be read include Emma as being more 'powerful' as she is positioning herself as having greater knowledge about the accepted norms of maternal behaviour; or of resistance as the other woman resists the imposition of maternal norms for breastfeeding.

Emma's comments are more tentative when she refers to the four year old by the use of *it's not really okay*. The four year old is being talked about as lacking because Emma has identified *he should have some other mechanisms at four years old* rather than using his mother's body to gain *comfort*. By referring to the four year old's behaviour as *comfort sucks*, Emma is drawing on medical discourses which distinguish sucking as either comfort (non-nutritive) or nutritive (Drewett, Wright &

[9] For example, in several breastfeeding books and chapters reviewed there was no or minimal mention of breastfeeding the preschooler (see Lawrence & Lawrence 2000; Richardson 1995; Riordan & Auerbach 1993)

Young 1998). The assumption that can be made is that Emma believes the only need a four year old would have to suck on his mother's breasts is for comfort.

Emma's statement *she 's a person in the real world* suggests that this woman is living in a fantasy world and is out of touch with accepted maternal behaviour. The statement has the potential to imply that the woman is lacking or deviant because she has not complied with the norms of breastfeeding behaviour. Emma's statement — *I don't think its okay for a four year old to use his mother for comfort all the time* — has started to pathologise the activity of a mother feeding her infant to four years of age. Emma's comment is located within, and reflects a specific cultural understanding for, the behaviour of women and their children. The woman's body is being identified as out of bounds for a four year old, in particular, that the child should not be allowed to *go and have comfort sucks all the time.* The woman's body is starting to be discursively shifted from a maternal body to a sexual body.[10] This statement is also attributing some responsibility for his behaviour to the four year old.

The successful establishment of maternal norms are frequently dependent on the compliance of the women through an obedience to enter the "... machinery of power... [which explores the human body] .. breaks it down and rearranges it" (Foucault 1977, p. 138), allowing others to have a hold over their bodies. According to Foucault (1977) what has occurred and continues to occur is a calculated manipulation and disciplining of the body's elements, gestures and behaviours. Through this discipline, the docile body is produced as a subjected and practised body that complies with norms of a specific culture, time period or peer group (Foucault 1977).

Without this compliance, which is made possible through the docile body, the establishment of norms become difficult and potentially fail. The woman in Emma's story has resisted becoming the docile body who would wean her baby within an

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[10] Stearns (1999) provides an exploration of breastfeeding and the 'good' maternal body where she identifies the belief that the maternal body and sexual body are constructed independently of each other.

expected time frame. It can be proposed that the inability to establish norms may be due to conscious opposition or through a silent automatic resistance (Henriques et. al. 1998) by continuing to breastfeed, regardless of the opposition to this act by others. When this opposition occurs, it challenges the truths which underpin these norms — Emma is now required to make a judgement about the other woman's fitness to mother.

Hacking (1982) argues that many of the norms and categories we currently use are the byproducts of statistics and counting which support the deployment of bio-power. These norms and categories have been essential in population regulation to enable the use of networks of observation, surveillance, the development of self-disciplinary practices, and the continued and rapid development of professions and disciplines. The resulting functions of these statistics are the identification of population norms and disciplinary practices, which regulate the social body and enable professionals to gain their power through claims to truth based on scientific research (Rose 1989) and the subsequent authority which is invested by governments in these claims to truth.

To maintain these truth claims, health professionals are themselves disciplined through their education programs and standards of professional practice to assess patients against the current accepted norms. These assessments of patients are reliant on the casting of a normalising gaze or clinical gaze to identify anomalies or deficits. Foucault (1977, pp. 184-185) proposes that:

> the examination combines the techniques of an observing hierarchy and those of a normalizing judgement. It is a normalizing gaze, a surveillance that makes it possible to qualify, to classify and to punish. It establishes over individuals a visibility through which one differentiates them and judges them. That is why, in all the mechanism of discipline, the examination is highly ritualized. In it are combined the ceremony of power and the form of the experiment, the deployment of force and the establishment of truth. At the heart of the procedure of discipline, it manifests the subjection of those who are perceived as objects and the objectification of those who are subjected.

Foucault's description of the assessment highlights its complexity and its ability to make the subject visible so that they can be judged. Assessment is an important

disciplinary practice which is used to assist in the production of a subject whose body is docile but is also productive (Foucault 1977). Professionals and others participating in an assessment function assume a mantle of knowledge, selectively classifying the subject's knowledge, behaviour and experience in relation to how it dovetails with their own knowledge and therapeutic orientation (Chapman 1993). Many subjects accept this normalising gaze because it seems to be omnipresent and has the promotion of health and a disciplined society as its objective. It is not just the responsibility of health professionals but all members of a community to participate in surveillance of others (Gastaldo 1997), resulting in effectively policing the entire population (Urwin 1985).[11]

One of the most constant agents of placing women and their infants under the normalising gaze are nurses who have been identified as playing a significant part in the surveillance, assessment, parenting and health education and advise provision for families (Child and Family Health Nurses Association 1993; Knapman 1993). Within the early childhood clinic setting, this normalising gaze is a central component of the visit. For example, the nurse measures the infant at allocated times, and assesses the infant's development and general appearance.[12] As Foucault has indicated, a ceremony of power occurs. The mother can be identified as having at least two functions during this assessment: as an observer of the ritual of infant assessment; and in many instances as an assistant trying to keep the infant calm so the nurse is able to make an accurate assessment of the infant's growth and development. A verdict is given that the infant is meeting the norms for its age. The verdict is then recorded in the infant's record book, which the mother keeps to show to other health professionals. This verdict is also recorded in the clinic records for later reference.

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11 This point is important, as there has been an immense increase in the ability to access medical knowledge by members of the community which enables the development of a medical knowledge base, for example, health articles with the latest research in newspapers and magazines, television documentaries and access to health information via the internet.

12 These allocated times are usually linked to the developmental age of the infant. The infant's weight, length and head circumference are checked and plotted on a percentile chart. This chart provides a visual check that the infant is developing within the normal range for its age and birthweight.

Participating in these practices frequently positions nurses in a problematic way as agents of bio-power through the use of surveillance practices and régimes of truth which have been put in place by the circulating medical and legal discourses.[13]

This potential problematic for nurses is the belief that surveillance and the use of norms to monitor the development of an infant will enable early recognition of deviations and interventions to correct these deviations. This early recognition and intervention approach is justified by the belief that the infant may have better health outcomes which will result in an improved 'quality of life' than would otherwise be expected. The difficulty is the assumption that the infant who is not meeting the norms will be lacking, based on the norms which are frequently defined by the dominant subjects within a community. The constant tension for nurses is the potential productive nature of these régimes of truth, their legal and ethical responsibilities and the challenge for nurses to provide a supportive, rather than a prescriptive approach to offering mothering information and advice.

To be effectively brought into this government surveillance network, mothers must be accepting of the notion of regularly visiting the early childhood health clinic. To achieve this universal visiting practice, the positive aspects of the clinic are widely advertised during the antenatal period and early postnatal period. The clinic functions through the provision of child rearing advice, surveillance of children's and mother's physical and psychological health, the provision of counselling for postnatal mood disorders, and as a means of expanding the new mother's social network (a meeting place for gaining contact with other new mothers).

The following three extracts will illustrate aspects of the surveillance network and how all members of a community potentially participate.[14] In the first extract, Sophie

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13 As defined in Chapter 2 régimes of truth are an assembly of rules set up to enable the separation of what is true and false.

14 The ethical issues discussed in Chapter 3, of my concerns about the identification of an infant or woman 'at risk' during this research study, demonstrates my participation in an on-going surveillance network.

constructs a position of coming under the normalising gaze of the early childhood health nurse and developing strategies of resistance. In the second extract, Alicia identifies her own surveillance practices towards other parents. In the third extract, Emma provides examples of advice giving; a connection is drawn to the possible surveillance acts and normalising judgements which preceded the advice giving. These extracts provide examples of the potential for all subjects within a community to participate in surveillance practices.

A common reason for women in this New Mother study to access the services of an early childhood health nurse was to measure the growth and development of their infants. Sophie took her baby to visit the early childhood nurse as an expected and routine practice for a mother with a new baby. Breastfeeding had been far more problematic than Sophie had anticipated and Katrina's weight gain was below the expected norm.[15] Sophie's story highlights the conflict that can be caused by these surveillance practices and her resistance to this surveillance. This resistance occurred through the construction of a counter-discourse about her baby's weight gain, enabling an alteration to the existing power relations and her later interactions with the early childhood nurses.

Sophie: ..... Good now ... Early on like we were having trouble breastfeeding and stuff ... I was told by one, 'oh its not a very crash hot weight gain that she's had' ... Cause Katrina only put on ninety grams in a week and everything and I felt just terrible and ..... But Tim [partner] was there with me so he .... he said 'don't worry, ninety grams a week that's really good and everything'. And I thought about it and said 'oh yeah'. And then we just made sure we didn't see that sister again and since then it's been really good (third interview: Katrina is now nine months old).

In this extract, Sophie at first places herself in a powerless position in response to the nurse's comment about her daughter's poor weight gains. This comment constructs a position for the nurse as a judge of Sophie's ability to provide adequate nutrition for

[15] The expected weight gain for a baby under six months of age is two hundred grams per week after the first two weeks of life (Tresillian 1998).

her infant. It can be implied that this statement was the nurse's way of telling Sophie that Katrina was not growing at the prescribed rate.[16]

The initial effect on Sophie was to make her feel *just terrible.* These feelings may have been accentuated because of the breastfeeding problems Sophie had experienced and her desire to continue to breastfeed. After this comment, it is possible Sophie started to position herself as failing. A statement such as — *'oh its not a very crash hot weight gain'* — positions the infant as the object of the statement, but the unsaid component of the statement possibly implies a lack on the part of the mother. It is of importance to note that this story is Sophie's reconstruction of the interaction with the nurse. This reconstruction may indicate that Sophie has internalised the institutional gaze and is struggling with the tension of trying to meet the accepted demands and qualities of being a 'good' mother and her anger at her inability to demonstrate these 'good' mother qualities of having an infant who is gaining weight.

The nurse's function of assessment and judgement making positions her as powerful. However, Tim is able to shift the power relations by constructing a counter-statement — *'don't worry, ninety grams a week that's really good and everything'.* This statement represents a repositioning in relationship to the nurse by challenging the dominant discourse of the nurse which initially acts to discipline Sophie.

Through the use of the counter-statement, Sophie was then able to make a decision to avoid the nurse who had made this negative comment about her daughter's weight gain. The stories about avoiding health professionals and others who the women believed were 'old-fashioned' and/or made them feel like bad or incompetent mothers was a common occurrence during this New Mother study.[17]

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16 There is an expectation that children grow at a specific rate, with some allowance given for cultural background (Robson & Lamont-Herps 1997).

17 Scott (1997) provides an account of her experience as a new mother and the impact of different approaches by nurses on her ability to manage the emotional distress resulting from the difficult behaviour of her infant. Scott highlights how seemingly innocuous comments made by nurses can be identified as offensive by women struggling to care for their new infants. For example, asking a mother — how they were coping? — can be construed by mothers as criticism.

The second extract, provided during the third interview, constructs a position for Alicia as placing other parents under surveillance. This extract illustrates how the enforcement of legislation can occur at a community level. In this extract Alicia is referring to her behaviour as a child care worker:

Alicia: ..... I guess I was pretty judgemental beforehand more so I think from working in child care ..... I'm big on ..... maybe its being judgemental, safety issues. Mothers not putting their small children in seat belts or child seats ... That ... I've actually told them off. That really annoys me

Alicia constructs three subject positions. The first position is one of being *pretty judgemental*. The second position is for the parents who do not use child car restraints as infringing the accepted norm for protecting young children. The third position is for herself as a child safety advocate, who actively pursues parents who are not behaving in the expected manner. This behaviour of pursuing parents positions her as an agent of bio-power, and therefore the government, as she tries to enforce the law.[18] Alicia's behaviour could also be constructed as fulfilling a moral obligation for adults to protect children. This moral obligation can be a powerful incentive for women to readily bring their infants under surveillance.

The norm Alicia is using is based on a legislative requirement that Alicia may have learnt about during her child care workers' program. Alicia's surveillance activities are important as they extend the network for parental surveillance at no cost to the government. The development of norms within communities is an ongoing process that frequently addresses a perceived need for action as in the issue of wearing child car restraints.[19] This type of outcome resulting from the concept of bio-power could

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18 In NSW it is an infringement of the law to transport children in a car without a car seat restraint or seat belt on (if one is fitted in the car). Currently this offence incurs a penalty of three demerit points and a fine (Roads & Traffic Authority 1997).

19 These norms are often based on the experience of people with authority to act and gain government attention. As in the example of the child car restraints, it could be proposed that health professionals in hospital casualty units were concerned by the horrific injuries caused to unrestrained children in cars. This concern was brought to the government's attention and other interested organisations such as the insurance companies and road safety groups. The harm to unrestrained children in car accidents, the financial costs to the community and insurance companies are evaluated, leading to legislation being enacted.

be seen as productive. However, there is a negative side to this legislation: it takes away parents' freedom of choice to decide how they will care for their children; and there is a possibility of a worse injury to the child if they are incorrectly placed in a car restraint (Road and Traffic Authority 1997). The development of norms puts in place truths or régimes of truth. These régimes of truth, Foucault notes, are not truths that are discovered, but "... the ensemble of rules according to which the true and the false are separated and specific effects of power [are] attached to the true ..." (Foucault 1980a, p. 132). Truths are sustained in a circular relation with systems of power (Foucault 1980a), as in Alicia's example, where the truth about car safety is sustained through legislative requirements, moral obligations to protect children and a parent's love for their child.

The final example, once again from Emma, demonstrates that the surveillance and disciplining of mothers comes in many forms and from different sources. This surveillance and disciplining is not just from health professionals or government, but through a network of surveillance which acts on and is enacted by subjects. This surveillance may not always be overt but its unspoken presence frequently precedes the offering of mothering and child rearing advice. Emma is an experienced early childhood health nurse and midwife, but her experience of caring for her son is in conflict with current developmental expectations for the sleep patterns of an eight month old infant. During the third interview, in response to a question about being made to feel inadequate as a mother, Emma provided two examples of receiving advice. This advice was from a work colleague and her mother, which are construed as criticism and of not conforming to the norms of the maternal behaviour:

Emma: Yeah, Gail [colleague from work] has a couple of times, actually ..... She does things like saying ... he should be sleeping through the night. I keep on thinking there must be something I'm doing wrong. Yet, it feels really right to continue with what I'm doing and I'll continue doing it until it doesn't feel okay ... That kind ... I don't think you can tell people what to do ... Mum's told me a few times 'let him whinge for a while. He'll be all right'. I know he'll be all right ... It's whether I'll be all right ... You know.

Emma constructs several subject positions within this story — the vulnerable mother; the mother who is trying to trust her feelings about what is right for her baby; and the mother who is resisting others' advice. The advice which have been provided by others seems to have been unsolicited by Emma.

The first piece of advice is from a work colleague who is also an experienced early childhood health nurse. This piece of advice illustrates the provision of information consistent with the documented knowledge about infant sleep patterns and reproduces the régimes of truth about these sleep patterns. The advice may be an indicator of a potential disjuncture between maternal knowledge and professional knowledge which is frequently based on making generalisations about infants, such as that most babies are sleeping through the night at eight months.[20] This generalisation decontextualises what is occurring for Emma, as it does not take into account the many variables, including infant and maternal temperament, maternal interpretation of the infant's sleeping behaviour, lifestyle and cultural factors.[21]

The second example is of advice provided by Emma's mother. A tension is often present between advice offered by people from previous generations and current advice. The tension possibly relates to the advice being identified as old fashioned, a form of criticism, lacking in scientific basis or of having multiple interpretations. For example, Emma's interpretation of the meaning of the term 'whingeing' may be different from her mother's interpretation.

The advice received by Emma may have been elicited through a comment, her physical appearance or has been triggered by seeing Emma trying to settle Patrick.

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20 There have been minimal studies of the sleep patterns of Australian infants on which to identify norms. However, one study, which is now being used, is from Queensland by Armstrong, Quinn & Dadds (1994). This study is based on the responses of 3269 parents about their infants' sleep habits.

21 For example, a woman may consider her infant is sleeping through the night if it sleeps from midnight to 5 am; this may not be the same interpretation by other mothers or health professionals of sleeping through the night.

This positions the nursing colleague and Emma's mother as acting in a surveillance function, resulting in normalising judgements prior to providing the advice. The normalising judgement that is being proposed as a prologue to giving advice results from information gained through surveillance practices. These normalising judgements position her nursing colleague and Emma's mother in potentially more powerful positions of being able to make truth claims about how to manage an infant's sleep and crying behaviour. The provision of advice causes a tension to develop because, instead of accepting the advice as an attempt by her colleague or mother to be helpful, Emma has possibly constructed the advice as a form of criticism or judgement of her maternal abilities, which positions Emma as lacking.

Emma is troubled by these two pieces of advice, so she has made the choice to ignore both at this stage, resulting in a form of resistance being put in place and a shifting of power. This resistance seems to be based on the tension between her feelings about the appropriate care of her baby and the advice provided by others. Emma draws on a discourse which can be related to somatic knowledge — a sense of 'knowing' what is right for her baby — *it feels really right to continue with what I'm doing*; and *I know he'll be all right*. This 'knowing', as discussed in Chapter 4, is elusive as it may not be consciously accessible; instead it is a somatic knowledge or knowledge of feeling which is theorised as residing in the unconscious and cannot be adequately spoken about using the available language. This 'knowing' through somatic knowledge is also based on a sensitivity to the contextual features of the situation which are frequently beyond adequate quantification in language, such as the sound and intensity of a baby's cry; the emotions of a mother; and the level of maternal fatigue.

Surveillance practices constitute a widespread and often invasive component of bio-power. The surveillance practices identified by the interview extracts within this section are not limited to the practices of health professionals, but are frequently used by everyone in their daily lives. A common thread within the three extracts has been a resistance to the outcomes of the surveillance. In the first extract the woman who was

breastfeeding her four year old resisted the established trends in breastfeeding to wean her child before two years of age. Sophie and her partner in the second extract constructed a position of resistance through a counter-reading of the baby's weight gains. In the final extract, Emma resists her mother's and colleague's advice by positioning herself as 'knowing', possibly based on her somatic knowledge of the situation. Within all the extracts contextual factors are present and of importance; therefore the practice of making judgements based on surveillance using universal decontextualised norms needs to be constantly troubled.

5.1.1 Tightening the surveillance net: enforcing the norms

The surveillance net becomes more controlled and people become more aggressive with offending women when the discourses of the responsible and caring mother are thought to be infringed or blatantly disregarded. Two extracts will be used to demonstrate how others can discipline women if they are thought to have infringed the régimes of truth which are frequently implicit within the discourses of motherhood. These régimes of truth are the rules within a discourse that are developed to produce the accepted behaviours within a community or culture (Foucault 1972). Régimes of truth are often spoken and are frequently circulated through their publication in the professional literature (such as medical and psychological journals), popular media (such as science reports, newspapers and on radio) and within everyday discourses as truth claims. Régimes of truth can be linked to Bourdieu's (1990) concept of habitus as the rules by which 'practical mastery' through rituals are encouraged and embedded. For example, a mother will assist her child to wash their hands after going to the toilet so they will not get sick; or clean their teeth before going to bed so dental cavities do not develop, often establishing lifetime rituals or habits.

Heather, during the first interview, provided an example of the way in which the concept of bio-power and the resulting régimes of truth have infiltrated everyday life and how others act as enforcing agents. The story Heather constructs is about a

recent dinner party she had arranged at her home. Heather's sister is the main character in this story and is positioned as attempting to enforce the régimes of truth about the consumption of alcohol by pregnant women. Within this extract the power relationships shift several times:

Heather: Just getting, getting rest, I suppose yeah the lifting stuff .... drinking, cutting down on that ... Some people that I've found really interesting thing, some people are quite ... alarmed you know. And, and it's often been men too who ... I mean I ... I didn't really drink at all for the first fourteen or so weeks. I didn't feel like it and then I mean I basically was told by a few people who, William's sister who is a nurse at the kid's hospital and stuff and she's quite informed about all these things and my doctor. I did a shared care arrangement and both the GP and the obstetrician sort of said 'look you know you can have like up to say two, two and a half glasses as long as you're not having it every night you know ..... Don't be, don't get obsessed with 'oh my god, I've had half a glass of wine' because that's just harmless. So I, probably, a lot of people think you shouldn't drink at all. If you drink you should only have like an inch of wine or something .... And sometimes I might have like that and I've gone off that in the last month ..... I've just for some reason I haven't drunk as much. But I've just felt its almost like I'd light up a cigarette you know ..... I've never smoked, so that's been a non issue you know. But yeah, the sort of social you know condemnation some people, like my sister last night, she poured. She brought this really expensive bottle of wine, poured three glasses and didn't pour, didn't ask me whether I wanted one you know. Just assumed I wasn't going to drink you know and ..... you know. Because I shouldn't be drinking she made the comment 'oh you shouldn't be having anything' you know. And I and I just thought that and I went ahead you know and ... William poured me a glass of wine. So that's all I had the whole night you know .... But yeah there are those sort of little things people really should stick by.

Heather had identified several areas where surveillance of her behaviour had occurred *getting rest; lifting stuff;* and *drinking cutting down.* The initial observation Heather has made is that men were more likely to be alarmed by the behaviour of a pregnant woman if she transgressed the expected behavioural norms. This alarm at the behaviour of pregnant women which falls outside the expected norms could be identified as contributing to the surveillance of women to ensure they conform to societal norms and potentially essentialist beliefs that the male is the protector of

women and children.

Heather grades the acceptability of alcohol and cigarettes by distinguishing the use of cigarettes in pregnancy as less acceptable than the consumption of alcohol, though she does acknowledge that the use of alcohol is identified as unacceptable by people within her community. This acknowledgement demonstrates the possibility of regulation being linked to cultural differences and not always being universal.

The tension in Heather's statement could be identified as a form of self surveillance to stop her overindulgence in alcohol, as she constructs the impression of an awareness of the potential to transgress social norms as well as causing harm to her unborn child. There is an uneasiness as she contradicts herself and provides an admission of wrong doing by drinking alcohol that is countered by reassurances she provides me with — *I've gone off that in the last month.*

Heather constructs a difference in belief about alcohol consumption between the health professionals and her sister. The health professionals, while still providing guidelines for the consumption of alcohol in pregnancy may also adjust their advice depending on the assessment they make of the woman's ability to control or limit her own intake of alcohol. This ability to change the type of advice for each woman and be less stringent in their application of the medical discourse endows the health professional with a power to manipulate information based on the authority of their position. Heather confirms this belief in their authority and knowing the truth about alcohol consumption through her statement — *William's sister a nurse at the kid's hospital and stuff and she's quite informed about all these things.* William's sister is being positioned as having authority because she is a nurse in comparison with Heather's sister, who through this implied comparison is lacking in authority.

Research about the consumption of alcohol by pregnant women can be identified as providing a significant justification for the population regulation component of Foucault's concept of bio-power, thereby setting up a régimes of truth to dictate

disciplinary practices to be used for pregnant women. The sister's action of withholding the wine provides an example of the invasiveness of bio-power and how overt attempts to control another's behaviour can become.

Heather was annoyed about this incident which was reflected in the tone of her voice, the lack of pauses in her statement and her apparent difficulty in articulating the experience. Her statement — *William poured me a glass of wine* — provides the action taken by her partner which changed the power relations, allowing Heather to regain control of the situation.

The statement *so that's all I had the whole night you know* highlights the potential power of the incident to control Heather's behaviour and the imposition of constraints. The statement has a mixed tone of triumph as well as being defeated. The sister had not won because Heather had a drink of wine, but Heather was made aware of her sister's opinion of the inappropriateness of her drinking behaviour.

Heather's final contradictory statement — *there are those sort of little things people really should stick by* — provides a final repositioning to accepting that there are things that are unacceptable for pregnant woman to do which is inconsistent with her drinking behaviour. This acknowledgement implies a need for self-regulation and discipline by women to conform to the accepted maternal behaviour of a community or culture.

This second extract highlights the development of a new health expert in the past two decades who has undertaken an International Examination to qualify as a Lactation Consultant. However, as Julia demonstrates, this new type of expert may not always be supportive of a mother who is experiencing difficulties and has decided to wean her baby at six months of age.

Julia: ... my lactation consultant friend roused ..... I should have fed her for nine months. And I thought ... 'Well, you didn't have to feed Rachael'.

Cathrine: So how did that make you feel?

Julia: ... Terrible ... really, really terrible. I felt like I was a bad mother ..... I just ... felt like I was doing the wrong thing by her. But ... the other thing is too, like she's put on more weight since she has been on the bottle and that's been a good thing for her. Cause she's still about four hundred grams under weight for her height ..... and ... I feel like ... I don't feel like, I didn't have enough milk, maybe she's just doing better with the solids as well .....

Julia is identifying a régime of truth about breastfeeding of the need to breastfeed a baby until they are *nine months* of age. Julia positions her friend as trying to enforce the régime of truth about the acceptable length of time a baby *should* be breastfed, regardless of the desires of the mother. The use of *should* as a part of this régime of truth acts as a universalising understanding of breastfeeding and disconnects the woman from her body without considering the emotional or contextual factors which influence a woman's ability to breastfeed or mother.

Julia's statement which alluded to the difficulties and tensions in the relationship with Rachael is provided as a form of justification to support her decision to wean. This statement suggests an attempt by Rachael to be defiant and challenge the régimes of truth about breastfeeding that her friend is promoting. These régimes of truth about breastfeeding construct positions for women as either the good or responsible mother who continues to breastfeed or, as Julia has constructed a position for herself, as the *bad mother.*

However, resistance to this discourse starts to occur as Julia rejects the position of *bad mother* and constructs a position of doing the right thing for her baby, using weight gains as evidence. This rejection introduces a counter-reading of the situation by providing an alternative régime of truth based on her infant's weight gains.

The ability to demonstrate that a baby is gaining weight is a powerful way of proving maternal ability. The visual nature of weight gains provides a means of infant and

maternal surveillance, not only by health professionals, but by family and friends.[22] In making the statement — *she's still about four hundred grams under weight for her height* — Julia is drawing on a medical discourse through the importance attributed to the correct proportion of weight gains to growth in height for her baby to be considered 'normal'. She has taken on this medical discourse as a part of her everyday language and is using it as a gauge or form of surveillance for her baby to meet the 'norm'. The use of this discourse positions Julia as a concerned and knowledgable mother.

The final statement by Julia — *I don't feel like I didn't have enough milk, maybe she just doing better with the solids as well* — could be said to demonstrate the power of her friend's judgement of her behaviour in weaning her daughter as she tries to justify her actions. This statement positions her daughter as being separate and beyond her control. There are several possible reasons for the statement: a woman may believe that if they are unable to produce adequate amounts of breastmilk they are not adequate as a mother; by choosing to wean she has taken away the control of her body from her baby; or it is not that the formula milk is better than the woman's breastmilk, the weight gain is due to the introduction of solid foods. However, it may be easier for the woman to draw on a discourse of blaming a lack of breastmilk to hide her own seemingly inappropriate desires of weaning because she 'did not enjoy breastfeeding'. This statement of a dislike of breastfeeding has the potential to infringe the current breastfeeding discourses and may result in positioning the woman as an uncaring mother. Within this extract Julia tries to describe her feelings about breastfeeding and weaning, but the words used provide only a partial account of her feelings and the struggle Julia experienced breastfeeding Rachael.

In disciplining the mother, one of the important practices is to decontextualise her body and make it 'docile' through the use of universalising statements such as mothers should not drink alcohol or mothers should always breastfeed. The mother as

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22 A 'chubby' baby is often used in advertisements to exemplify a healthy baby.

a docile body will readily be drawn into the surveillance network that requires women to actively bring themselves under the gaze of others, as well as encouraging other women to participate in surveillance practices. An important practice within this surveillance network is the confession which will be discussed in the following section.

5.2 Making meaning through confessional practices

Confessional practices are defined by Foucault as "... a ritual of discourse in which the speaking subject is also the subject of the statement; it is also a ritual that unfolds within a power relationship, for one does not confess without the presence (or virtual presence) of a partner ..." (1978, p. 61). Confessional practices as a technique of power allow an increase in the detail and intimacy that is known about a subject (Foucault 1978), thereby enabling an increase in the level of surveillance and judgements which can be made against normative measures (Rose 1989).

Confessional practices have a similar relationship with power as the concept of bio-power, that subjects are simultaneously exercising power and undergoing the effects of power (Foucault 1980b). The outcome of this relationship can be ambivalence that results both in resistance to confessional practices and ready acceptance of confessional practices by women.

For this thesis, an important aspect of confessional practices is the potential for self-disciplining to develop, as women use confessional practices to gain knowledge about what are acceptable maternal behaviours and feelings. These maternal behaviours and feelings act to guide women to reproduce mothering practices which are expected within their cultures.

According to Foucault (1978), confessional practices are complex, requiring the subject listening to the confession to act in specific ways. The listening subject must be able to appreciate and intervene, thereby enabling judgements, punishments,

forgiveness, and reconciliation. For the confessor, the confession allows a purification, redemption and exoneration (Foucault 1978). Confessional practices could also be understood as resulting in learning or making meaning of a situation, as women actively seek out information through discussions that facilitate or result in making a confession to other women, friends, health professionals or their own mothers. Foucault identifies confessional practices as producing "... intrinsic modifications in the person ..." (1978 p.62). The confession can be constructed as a technology of the self which assists and permits individuals

> ... by their own means, a certain number of operations on their own bodies, their own souls, their own thoughts, their own conducts, and this in a manner so as to transform themselves, modify themselves, and to attain a certain state of perfection, happiness, purity, supernatural power (Foucault, 1994 p. 177).

Extending these concepts further, technologies of the self, in particular, confessional practices, can be identified as knowledge making. By speaking out loud about maternal experiences, women are discursively constructing their experiences; these constructions then result in accessible and re-countable knowledge. The self-knowledge constructed during a confession is constituted as a 'truth' that requires a continuous self-assessment, self-monitoring and self-measurement against norms of the subject's own making (Usher & Edwards 1995)

Foucault (1978) has identified the confession as becoming one of the most highly valued truth-producing techniques. Yet confessional practices are totally reliant on the ability to recall memories into consciousness. The confession, if identified as a form of truth making, is based on the assumption that the recall of the memory of an experience is free from contamination or that a memory can be recalled as an exact replica of the original experience. However, as discussed in Chapter 4, this premise can be undermined by suggesting that memories are reconstructions and not just raw experiences which are recalled as interpretations of experiences; and these memories are always influenced by hindsight (Cohen 1989). So the confession is not an 'authentic' representation of the woman's experiences, but is potentially a reconstruction, an ordering, decontextualising and simplification or an elaboration of

experiences to produce particular culturally defined meanings and knowledge.

These understandings of the confession as a reconstruction of experience are in conflict with essentialist discourses about confessional practices. Essentialist discourses emphasise a reliance on talking to identify the existence of a deep and hidden meaning or truth within subjects that potentially leads to happiness, well-being and personal autonomy (Usher, Bryant & Johnston 1997). Nevertheless, making meaning out of experiences within this New Mother study has developed as an important theme that helps women to learn about mothering. The women have possibly made meanings out of their experiences by using several different practices such as building on their experiences and knowledge; asking questions and gaining advice from health professionals; and in particular, talking to their own mothers and other new mothers about their maternal experiences. Their talking often resulted in a combination of the women asking other women questions to elicit confessions and providing confessions about their own negative emotions and maternal behaviours. Confessional practices are being constructed within this New Mother study as having multiple and often ambivalent effects resulting in tensions between the women's desire to talk about maternal feelings and experiences but at other times to limit the maternal stories they tell to others. This section will explore the function of confessional practices and demonstrate how women, through the use of confessional practices, can make general connections between their experiences as mothers and the development of their maternal knowledge. This maternal knowledge seems to be based on generalisations, which are formulated from seemingly similar experiences, despite different contextual factors.

Confessional practices as everyday interactions can be identified through the willingness of many women to share their experiences, feelings and knowledge. The women may not always identify that the situation or their actions are part of a confession or confessional practice. However, some or all of the elements of confessional practices described by Foucault (1978) are frequently present — the listener appreciates and intervenes, judgements are made, punishments occur,

forgiveness is given, and often reconciliation is allowed. For the confessor: feelings of purification, redemption and exoneration are encouraged or start to result. These understandings of confessional practice can be extended to the willingness of women to participate in a research study as an opportunity to confess which is possibly motivated by the desire to provide information to other women learning to mother and assist in knowledge production. Four extracts will be used in this section to demonstrate several ways confessional practices can be enacted: Rebecca's extract highlights the importance of gaining information about other women's maternal experiences and knowing that their maternal experiences were similar; Sally discusses her experience of talking to health professionals or other women about mothering difficulties and watching other women mother; Victoria provides an example of actively resisting confessional practices; and Jane constructs a story about the sharing of 'truths' about mothering that are outside the accepted discourses of motherhood.

In the first extract, I asked a question during the third interview about the mothering information Rebecca found of most value.

Rebecca: ..... I think just knowing that other people have just been there, done that and other people go through exactly the same things. And that I'm not the only person in the world, like when you get up at two o'clock, three o'clock feed, I sit here and think, 'oh well at least there's a thousand other women out there that are sitting here doing exactly the same thing as I'm doing and things like that'. Because sometimes you probably think I'm the only person in the world this is happening to and stuff like that.

Rebecca is able to construct an understanding that feeding during the early hours of the morning is part of the necessity of the early months of mothering. The acquisition of this knowledge about other women's similar experiences is not stated, but an assumption is being made that this knowledge was possibly gained by Rebecca sharing her experiences with other women.

A position is taken up of *not being the only person in the world* feeding her baby at *two* or *three o'clock.* A tension exists in this statement between being awake in the

early hours of the morning and the sense of acceptance and reassurance from the alternative knowledge that other women are also having similar experiences. This tension starts to increase again with her final statement, where Rebecca once again refers to being *the only person in the world.*

Rebecca's statement — *I think just knowing that other people have just been there, done that and other people go through exactly the same things* — acts as a form of reflection which assists Rebecca develop norms allowing her to measure her actions and feelings against those of other mothers. This understanding of being awake at two or three o'clock in the morning and connecting this behaviour with *a thousand other women out there*, was probably gained through the use of confessional practices. These confessional practices possibly assisted Rebecca construct a story which allows her to manage her feelings of fatigue and annoyance, through a form of self-regulation. Edwards (1994, p. 436) offers a feasible understanding for the acceptance of these confessional practices as "... ameliorating, trying to provide us with the coherence and meaning we cannot find by ourselves amongst the abundance and confusion with which we are faced". These proposed outcomes of confessional practices can be theorised as enabling women to cognitively order their daily existence in the presence of the often unpredictable and chaotic experiences of motherhood.

In this second extract, Sally tells a story during the third interview of an incident which occurred while staying at a residential parentcraft centre and the impact of sharing her experiences with another woman. The sharing of experiences as a way of gaining help is overtly connected to education in this extract. The important point Sally identifies through the use of confessional practices is that the gaining of assistance or education about mothering should not put in question a woman's maternal ability.

Sally: ..... It was interesting, like one of the ladies was there for postnatal depression or something and I must have been really open about, you know, having gone to see a counsellor or gone to see a shrink and that. And I think the fact that I just sort of came out 'oh yeah, I've done that', she was able to suddenly come out and talk about it, ... that's

> why she was there ... So I think the interaction with other mums was good as well ..... I think watching other ladies too, its nice to know that other people have problems and watching the reluctance of other people let their child go .... Why should we be doing it this way, failure, and ...and to be able to sort of realise that its nothing to do with being a failure the fact that you're saying that ... that .... you're having a problem and you need help means that or you want the education ... doesn't mean that you're not a good mum.

Within this extract, Sally highlights two activities — talking and watching — which she uses to gain information. Sally's actions of talking openly about her maternal experiences can be equated to a form of confessional practice that allows her to gain legitimacy. Being able to talk with other women about mothering enables the 'normalising' of a woman's experiences, which in turn, allows meaning to be made of the experience. Learning starts to occur from using another's experiences and comparing these with her own maternal experiences.

Using the understandings gained through talking with other women, Sally attempts to normalise her situation through a connection with other people's problems. Nevertheless, this notion of normalising implies that there is a universal experience. This proposed universality (as argued in previous chapters) makes it seem possible to compare and measure one woman's maternal ability and the problems she encounters with another woman's experience.

However, rather than women having a universal experience, the comparisons which are made by women are reconstructions of experience that can be very general, out of context and often with only minor points of commonality. The potential value to the women of these generalisations about experience is not as an authentic replication of experience, but may be as a mechanism by which Sally can construct a measure for her maternal ability in the hope that her problems are not as great as another woman's problems. These generalisations could allow her to construct a position for herself as a caring mother; negate some of her feelings of anger and guilt; acknowledge that mothering is difficult; and identify alternate maternal practices which Sally can use when she is tired, angry and not enjoying motherhood. Hacking (1995) proposes that

to redescribe the past is to become a new subject, as behaviours of the past are explained differently, thereby potentially allowing the subject to feel differently about themselves. Hacking's proposal links with a poststructural understanding that the multiple subjectivity of a person is constructed through the discourses that are available. The confession allows a reconstruction of the events and the development of new discursive positions for women to occupy.

Watching, the second activity mentioned by Sally, assists in the identification of the complexity of the situation and the possible learning which is occurring in these situations. Rather than just being a physical activity of talking, it potentially acknowledges the gaining of information from other sensory sources as both complementary and important to the learning which has started to occur. The link between watching and confessional practices is that Sally is confessing this behaviour as part of the research interview — a purposeful watching is practised by Sally to learn about other women's maternal behaviours. By her confession of watching, Sally is converting a non-discursive practice into a discourse that can be discussed and judged; she is enabling the actions of her body to talk.

Sally sums up her feelings and, in so doing, constructs a position as a learner who needs assistance and education. Taking this position allows Sally to reject the construct of a 'failed' mother and take an alternative position as a mother who needs help or wants education. Confessional practices when used in this manner have the potential to be productive in at least two ways: firstly, to construct a new discursive position from which to mother; and secondly, as a useful source of learning through the provision of alternative maternal knowledge.

Confessional practices are constructed by Sally as having positive outcomes for mothers through the sharing of experiences. However, a form of resistance to these confessional practices may exist, as some women are reluctant to discuss their feelings and experiences of mothering. Foucault (1978) talks about the confession as a practice which is invasive and with similar qualities as his concept of power.

Nevertheless, Foucault (1978) does signal that there are some things which are not spoken of to others, thereby positioning subjects as having the power to withhold or change information and resist the surveillance practices of bio-power. Sally's acknowledgement of the other woman's willingness to talk about her experiences could be interpreted as an acceptance that the woman has provided a truthful and possibly complete account of her experiences. On the other hand, using Foucault's concept of power, the woman may have only partially taken up the discursive positioning Sally constructed for the woman of needing to talk about her experiences.

The ability to resist confessional practices is always present, as the confession is reliant on a subject who is willing to confess. During her third interview, Victoria provides an example which reinforces Foucault's argument that subjects can withhold information through their ability to resist confessional practices by putting on *a performance*. Victoria identifies that this *performance* keeps a *clean and proper surface* but does not resolve the turmoil *underneath*. The other significant feature in this extract is the possible attempts to discipline Victoria.

Victoria: .... She sent me to the psychologist in Liverpool, you know, who works for the council ... and I talked to the psychologist for an hour ... and she said well at the end of it 'okay, what do you want to do?' and I said 'well, if I need to talk again I'll come back' ..... and that was the end of it ..... But the thing is ... that ... I can put up a performance and chat for an hour quite easily ... and ... it might give this psychologist the impression I'm all right. She talked about all the issues and, you know, she said, how to do this and that to remedy this and that ..... And and its like a clean and proper surface but I mean underneath it hasn't been any help to me ..... Maybe its been a help that I articulated certain issues and articulation and getting it out is always good ... But some health professionals have been very helpful, but only to a certain extent

Cathrine: ..... So what would have you liked them to have done?

Victoria: Well, I don't really know ... I don't really know. I mean you know, I went to the doctor and ... I also told him I wasn't feeling great, ... but I wasn't prepared to just take anti-depressants ..... and .... to cure my problem ... that way. I actually don't know what could be done. I think ..... I suppose the informal support network would be helpful, would be more helpful than health professionals, ... having other

> women around you that that support you and chatting, informal chatting with women or women who are in the same situation.

This story is commenced by Victoria positioning herself as being *sent*, which implies a form of disciplining, possibly because she was identified as needing psychological assistance by the early childhood health nurse. The use of the word *sent* also suggests that Victoria is being positioned as 'not in control' of the situation, that she needed guidance. The second attempt at disciplining Victoria is the suggestion to use medication, which she describes as *to cure my problem*. In both situations — the confession and the decision to put women on medication — the woman's feelings are objectified. However, the suggested use of medication can be constructed as a decontextualising approach rather than investigating what is occurring within the woman's life.[23] Instead of curing the *problem*, medication on its own is proposed as relieving the symptoms, but does not assist the woman resolve any underlying issues. Once on medication the woman's feelings and emotions are controlled, which allows her to provide an impression of being self-disciplined — a docile body that becomes productive again by complying with the accepted discourses of motherhood.

Within this story, Victoria has explicitly demonstrated how easy it is for women to resist confessional practices. By resisting, Victoria is possibly rejecting the psychologist's construction of the subject position of a mother who is suffering from some emotional or mental health disorder. This psychological categorisation of feelings which usually occurs when seeking assistance from a psychologist is based on scientific normative understandings through régimes of truth which are linked to the surveillance practices used by the psychologist (Henriques et. al. 1998). These surveillance practices attempt to assist the subject to acknowledge that their feelings

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[23] For example, Lewis & Nicolson (1998) investigated the period of early motherhood and the way discourses of depression regulate women's perceptions and subjective experiences of motherhood. This research suggested that medical discourses used to explain maternal distress are constructed using the ideal mother as the norm. Lewis and Nicolson do not attempt to deny the experience of maternal depression but conclude that certain aspects of motherhood are depressing. This understanding shifts the focus from the woman "... to the social context and to the power relations within which experiences and meanings are constructed" (Lewis & Nicolson 1998, p. 193).

have deviated from the norm and develop strategies to assist the subject to realign their feelings to that norm.

However, in resisting this opportunity to confess to the psychologist, tensions are apparent as Victoria talks about the *surface* and *underneath* or the possibility of unspoken feelings and behaviours. These concepts of the *surface* and *under* may reflect Victoria's belief there is a truth she is hiding about her feelings in regard to motherhood, which can be understood in two possible ways. The first way is as a truth which is linked to the essentialist concept of the unitary subject that resides inside the subject and is waiting to be exposed. This essentialist understanding promotes the possibility of a 'rational truth' or as Flax proposes "... an 'objective' view of the whole" (1990, p. 140). This notion assumes feelings can be quantified and spoken in language. As highlighted in earlier chapters, this belief can easily be troubled through the discourses about memory and the inaccessibility of unconscious memories. The second possible understanding is of constructing a truth or meaning to explain her feelings. So it can be theorised that, instead of an essential truth being hidden, Victoria is hiding the meaning she has constructed for her feelings.

A contradiction starts to occur in Victoria's story as she says that talking to the psychologist *hasn't been any help to me* then she amends this statement to acknowledging the potential value of talking about *certain issues*. Through this statement, *maybe its been a help that I articulated certain issues and articulation and getting it out is always good*, Victoria has not totally discounted the value of the confession. As with the other women's extracts within this section, Victoria highlights the value of talking to and gaining support from other women in the same situation. This acknowledgement may be due to the belief that talking to other women in similar situations is less threatening, as the power relations may be constructed as more equal than talking in a counselling situation where professional judgements are being made about a woman's mental health. This equality, when talking to other mothers, allows concerns, feelings and behaviour to be revealed in a more informal manner, possibly using irony and humour. Unfortunately, Victoria had not been provided with the

opportunity to participate in women's groups because of her lack of access to transport, and the semi-rural area she lived in had few services for new mothers.

In this final extract, Jane illustrates the possibility of making aspects of a person open for interventions, which have previously remained unspoken, when she confesses to her sister her feelings about and behaviour towards her baby. Jane positions herself in several complex ways: the interrogator; the confessor; the out of control angry mother who infringes the accepted discourses of motherhood; the mother who constructs her behaviour and thoughts towards her baby as not acceptable; and the mother whose feelings and behaviour are expected and accepted by other mothers who understand 'what it is like to have a baby'.

Jane: .... with other mothers and people, I've been more ... I'm sort of grilling people about their early days as a mother ... 'and what did you do, and did your baby cry?' ... and all the rest. So I'm really sort of bugging people with questions.

Cathrine: and is it reassuring when they actually reflect some of your experience?

Jane: Yes, especially, you know, with getting angry and the swearing and all the rest. Yeah, like my sister. One morning I was crying saying, you know, 'I hated him, I wished he wasn't here this morning' ... Waiting for her to call welfare ... she just said ... 'So!' Which is a common enough reaction of most women. So, of course, you've got a baby'. You know, how they all thought it was the most awful time, which surprises me with some people. I say ... 'I never saw you like that, we would come and visit and you'd be happy'. And they'd say, 'well that's what you do most of the time', as well you know, you're quite ... well you are happy when we're around ... Or you try to hide it or whatever ...

In this extract, Jane aligns herself with mothers who have confessed to her about their behaviours. These mothers are constructed as providing Jane with alternative knowledgeable discourses to assist in negating her initial behaviour of *getting angry*, *swearing* and *hating* her baby which may be constructed by her and others as deviant. According to Rose (1989) confessional and other self-regulating practices inhabit a space formed by the intersection of disciplinary practices and subjectivity. The act of

talking about feelings, concerns and past behaviours constructs these subjective feelings and behaviours as objects which can be described, examined, used to gain knowledge about the subject and remedy the situation if necessary and possible. This objectification of feelings enables the use of surveillance practices to scrutinise and discipline women. However, a positive outcome of confessional practices is the possibility of an increase in the available discursive constructions of motherhood which increases the accepted positions available for women to speak from as mothers.

Jane constructs women as being complex subjects who are involved in hiding their negative behaviour and feelings from others who may not understand. This construction locates their maternal knowledge as being outside the accepted dominant knowledge about motherhood. A counter-reading of motherhood is being constructed which permits the women to use their knowledge of the negative maternal attributes in a seemingly productive way in order to understand their feelings and behaviour as normal for mothers. According to Edwards (1997b), subjects become active participants in disciplinary practices as they invest their subjectivity by aligning themselves with certain knowledgeable discourses. Jane participated in these disciplinary régimes by aligning and judging herself through the discourses of motherhood, which require mothers to love their infants and not be angry or swear at them. Jane is engaging in self-governance and regulation which acts as a form self-discipline. This act is exemplified by her statement about the anticipated actions of her sister — *waiting for her to call the welfare* — which reflects that Jane has already judged her actions as inappropriate and requiring punishment.

Jane constructs a new discourse that troubles the often accepted discourses of motherhood — a mother is never angry, doesn't swear at her baby and always loves her baby; through this new discourse within this extract she is able to construct a maternal position which is no longer deviant. Jane is now able to align herself with other women and their feelings about mothering. These discourses about mothering are frequently hidden discourses such as the ambivalence of mothering, that are often only spoken through humour, because to speak them without humour places a woman

at risk of being named and condemned as an uncaring or inadequate mother. Within this extract, Jane alludes to the concept of being self-disciplined to meet societal norms for maternal behaviour — *well that's what they do most of the time* or *try to hide it*. This behaviour can be described as active self-discipline that avoids infringing the accepted discourses of motherhood by speaking of the difficulties or a dislike of mothering.

The confession has been identified within this section as firstly, an important surveillance technique, and secondly, a knowledge sharing practice which is often readily used by women to enable connections to be made with other women and their maternal experiences. Women judge and are judged through the confessions that they make to health professionals and others within their community. An important concept within confessional practices is the use of normative measures to enable judgements about the woman's maternal abilities. The confessions made within this section were as a result of this study where women have readily agreed to talk about their experiences of mothering. These confessions are being identified as reconstructions and are not 'authentic' reflections of reality. Nevertheless, an important outcome of the confession can be distinguished as a part of making meaning and knowledge from experience through talking about the woman's construction of her maternal experience. The ability to objectify the feelings of anger, distress and guilt seemed for some of the women to be a productive way to construct new subject positions which destabilise the discourse of the incompetent, uncaring or inadequate mother.

5.3 Conclusion

The concept of bio-power has been described within this chapter as practices that assist in producing the new mother who conforms to societal behaviours and norms. This new mother is a subject who at times becomes docile, self-disciplining, and who willingly comes under the gaze of health professionals and others. This willingness of many women, in particular, to regularly attend an early childhood health clinic for the

routine checking of their infant's weight, head circumference and length, to attend mother's groups (Brennan 1998b; Knapman 1993; Urwin 1985) and to share their maternal experiences is well established (Holden et. al. 1987; Holden 1987). Nevertheless, the surveillance practices used are overtly concerned with identifying the 'abnormal' from the 'normal'. In performing this surveillance, health professionals maintain a significant reliance on standardised developmental and psychological measures to objectify and monitor the progress of women and their infants. Attendance at the clinic allows the current accepted discourses of motherhood and child rearing to be provided to women through various forms of education. This acceptance positions the clinic as a site for the dispensing of the régimes of truth about mothering and child rearing. Within the clinic and elsewhere the confession has become a regular practice, a listening therapy which is encouraged and utilised as an effective surveillance practice and educational strategy for the functioning of bio-power and the production of the new mother.

A tension has arisen within this chapter in problematising public health practices and discourses of science, as it is clearly important to acknowledge the productive aspects of bio-power in relation to the significant reduction in maternal and childhood injury and mortality which has occurred during the past century. The concept of bio-power is unquestionably implicated as the means by which order has been brought to enable the healthy, secure and productive lives of western societies (Dreyfus & Rabinow 1986). This desire of health professionals and others within the community to protect women and infants from harm frequently results in a risk of causing a conflict of authority or, according to Osborne, "... an antinomical relation between the medical and the social spheres, often with the former 'colonizing' the latter" (1996, p. 99). These colonising effects can be identified through the medical discourse which use surveillance practices to produce criteria or norms on which to base judgements such as a norm for a woman's ability to mother; and a child's physical development or intellectual capacity. These norms are widely disseminated by educating women about childbirth and mothering through the parenting literature, in childbirth and parenting classes, and through the circulating discourses of motherhood, which are part of the

everyday knowledge of people within the community. These discourses of motherhood assist in producing the new mother by providing norms which can be used as guides or frameworks for developing maternal meanings and knowledge.

When theorising bio-power and its influence on the production of the new mother several important understandings start to occur. The first understanding is that bio-power is potentially productive as these practices of bio-power frequently act to protect women and their infants by providing protective mechanisms and enabling early intervention for physical, emotional and social problems. The second understanding is of the subject which draws on poststructural theorising of multiple and shifting subjectivity, enabling the subject to resist the techniques of bio-power, or to be conditionally or even willingly placed under surveillance. The third understanding is that bio-power and therefore the attendant norms are not fixed entities, but constructs that change or are amended by communities in response to cultural, social and political experiences and needs.

This chapter has contributed to this thesis through the development of a context in which certain maternal knowledge and skills are condoned and perpetuated within the communities in which women live through the use of the concept of bio-power. The following chapter will explore the construction of maternal knowledge.

Chapter 6

Constructing Maternal Knowledge

The acquisition of maternal knowledge has been theorised in this thesis as potentially beginning in utero and continuing throughout life by the use of medical discourses of memory, in particular, non-declarative or unconscious memory, Bourdieu's concept of habitus, which constructs the body as a 'living notepad', and the educational discourses of informal and incidental learning.[1] In the previous chapter Foucault's concept of bio-power was explored as contributing to the disciplining of mothers to perpetuate the accepted and expected maternal norms and practices. The interplay of these discourses and the concept of bio-power start to raise a challenge for theorising maternal learning in different and possibly more complex ways than attributing the basis for maternal knowledge to 'instinct'.

The major focus of the parenting education literature relating to the period of pregnancy, childbirth and the early months of mothering has been identified, in Chapter 1, as focusing on the development, provision and evaluation of formal parenting education programs, with minimal regard to incidental learning. This period, in most probability, is when a woman's need for and development of maternal knowledge is most intense as she identifies a potential lack in her knowledge of mothering. Nevertheless, for at least two reasons the emphasis on formal parenting education programs seems disproportionate to investigating the acquisition of maternal knowledge in other ways. The first is that many Australian women will only

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[1] Informal learning as discussed in Chapter 1 is where women '... consciously try to learn from their experiences ... [this] does not involve formal instruction' (Foley, 2000, p. xiv). Informal learning experiences may be deliberately encouraged or may occur even when the environment does not encourage learning (Marsick & Watkins 1990). Informal learning is discursively constructed as part of everyday life or learning from experience (Garrick 1998). For example, a woman may be encouraged by the early childhood health nurse to leave her baby in a child care centre to gain knowledge about the routine of child care and to learn how to tolerate separations prior to returning to work. The woman is consciously trying to learn by participating in this activity, but the learning experience may not be formally structured. Within this activity opportunities for incidental learning or learning that is often tacit and frequently not identified as learning (Foley 2000) will also be present for the woman and the infant.

attend between twenty four to forty hours of formal parenting education.[2] The second is that many maternal functions may not be available as cognitively based knowledge or skills that are easily explained or demonstrated in a formal learning situation.[3] Drawing on these understandings a tension starts to occur within the parent education literature, as this formal learning approach does not acknowledge that the majority of maternal knowledge is in most probability somatic knowledge and therefore it can be extremely difficult to share this knowledge with others using available and accepted language. For example, knowing the feeling of labour pains, identifying the meaning of an infant's cry, recognising the feeling of a well-attached baby at the breast, or being able to calm a distressed infant.

Locating significant components of maternal knowledge as somatic, and at times, the difficulty of constructing this knowledge in language can be construed as bringing into question the capacity of health professionals to assist women develop maternal knowledge and the value of formal preparation for childbirth and parenting groups. However, it is beyond the scope of this New Mother study to consider or make judgements about the value of formal parenting classes or to compare the importance of formal versus incidental learning. What this research study, and more specifically this chapter can provide is an understanding of the possibilities for disjunctures to occur between professional and maternal knowledge.

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2 This estimate of possible parent education attendance is based on twenty four hour (six weeks childbirth preparation group, six week new mothers group) to forty hours (four weeks early birth parenting program, six weeks childbirth preparation group, six weeks new mothers group, four weeks transition to motherhood group).

3 Formal learning, as identified in Chapter 1, is a familiar type of learning that requires a curriculum, professional educators and may result in a formal qualification (Foley 2000). Formal learning for the purposes of this thesis includes childbirth and parenting preparation, and new mothers groups. New mothers groups can initially be identified as providing formal learning and have become a regular and encouraged part of providing access to education about child rearing. The overt agenda for these groups is to provide information about such issues as: immunisation, growth and development and infant nutrition. However, there is potential for a great deal of incidental and informal learning to happen, which goes beyond the formal learning about mothering and child rearing practices advertised or identified on program outlines and during program evaluations. This informal and incidental learning can often be identified as occurring during refreshment breaks or after the group has finished, as the women talk about mothering issues of concern to them, or watch the interaction between other mothers and their infants.

The gaining of maternal knowledge is being constructed as a complex and on-going act; and that the contribution of formal education activities to the development of maternal knowledge is often minimal. Maternal knowledge acquisition is more likely to be gained through and be reliant on incidental education interactions between the woman, her infant and others within her community. Nevertheless, these interactions often provide opportunities for learning experiences to be identified and for opportunistic education to be facilitated by health professionals during their contact with women and their new infants. Within this thesis the use of what I will term 'opportunistic education' is constructed as focusing on the current learning needs of the woman through the use of informal and incidental learning approaches. The use of opportunistic education can assist women make meaning and construct knowledge from their experiences.

This chapter is divided into three sections. The first section provides an expansion of the discussion commenced in Chapter 1 about the concept of incidental learning and the development of maternal knowledge. Within this section the use of opportunistic education is foregrounded as an important strategy for assisting maternal learning and the construction of maternal knowledge. The second section focuses on the subjugation of maternal knowledge and the discounting or dismissal of this knowledge by the dominant institutional discourses of motherhood. The third section foregrounds the importance of the infant's contribution to the development of maternal knowledge. Within this chapter I argue that, even though formal learning is the main focus of the parent education literature, incidental learning contributes to the major component of maternal learning through the development of somatic knowledge. This somatic knowledge, as discussed in Chapter 5, is often drawn on as women try to discursively reconstruct their maternal experiences using confessional practices. These confessional practices are frequently used to make meaning of their experiences and to share their experiences with other women.

6.1 Maternal knowledge: beyond formal learning

A displacement that has started to occur in the adult education literature is a shift in the focus from talking about 'education' to 'learning'. As Edwards & Usher (1998) note, this shift can partially be attributed to the postmodern turn and the resulting breaking down and blurring of norms and boundaries. The blurring of these boundaries and norms has become an important aspect of this thesis for two reasons. The first reason is that even though childbirth and parenting education programs have been well promoted and accepted in Australia, it seems these programs can only provide a small proportion of the maternal knowledge required by women when learning to mother.

The second reason is that a problematic tendency occurs when talking about or trying to describe maternal learning and the resulting knowledge, as these descriptions often create an impression that learning and knowledge exist within a neat and uncontested space and as a set of principles or a 'truth' that can be passed from one person to another.[4] However, the order that is created when talking about maternal learning and knowledge does not reflect the chaos or contradictions that often seems to be present when maternal learning is occurring. So the development of maternal knowledge has a potentially greater function than to build maternal competence or develop an accepted maternal habitus. Drawing on an understanding of knowledge, provided by Lyotard, that within the postmodern, "... knowledge is not simply a tool of the authorities; it refines our sensitivity to differences and reinforces our ability to tolerate the incommensurable" (1984 p. xxv); using this understanding of knowledge results in a resonance with maternal knowledge. Maternal experiences can often seem incommensurable at times as women encounter new and often difficult challenges as their infants grow and develop, and at times become unwell. As demonstrated within

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[4] For example, within the literature the parenting education evaluations of programs are usually extremely positive, with minimal discussion of the failure of programs or difficulties encountered. According to Kachoyeanos (1998), the published nursing literature rarely foregrounds ineffective interventions. This lack within the literature results in a fundamental flaw as it does not demonstrate the complexity and difficulties that can be encountered within the clinical practice setting.

this New Mother study, women seek out health professionals and other more experienced mothers to gain knowledge to assist them deal with and tolerate the challenges of child rearing.

However, it is important to note that maternal experiences are often inconsistent with the seemingly rational principles and logical approaches espoused by the child rearing 'experts' and others.[5] These child rearing principles and advice frequently lack acknowledgement of the contextual, social and emotional factors that potentially influence maternal ability or behaviour.[6] This lack of acknowledgement is further compounded within educational interactions when the interaction does not provide assistance to develop the necessary skills and support systems to adapt and implement these child rearing principles.[7] Rather, women seem to have to learn to tolerate, resist or accommodate the infant's demands and the decontextualised maternal norms often used to judge maternal qualities and abilities. This understanding of maternal learning and the resulting knowledge is understood within this thesis as a frequently complex and contradictory occurrence that defies total objectification or quantification, since meaning is in a constant state of change.

The purpose of this section is to explore the sharing of maternal experiences, consciously and unconsciously, with other women, as a possibility for understanding the acquisition of maternal knowledge and skills. The following three extracts highlight an awareness of the crucial part played by observation and experience of being with other mothers to assist in the development of maternal knowledge. Through these examples it could be proposed that incidental learning is occurring in conjunction with the informal seeking out of maternal knowledge.

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5 Child rearing 'expert' can include health professionals and other more experienced mothers.

6 For example, the ability of a woman to financially afford the suggested practice; the type of support system she may have available or the willingness of these support people to agree with the implementation of the proposed practice; or the physical and emotional health of the woman.

7 For example, educational strategies such as the development of problem-solving and decision-making skills; or anger management; and the development of community networks to provide baby sitting or a trusted friend to care for the infant when the mother is sleep deprived.

Rebecca ... You go up to the shopping centre and you see all these pregnant women walking around, and you see kids, you know, little babies in their prams. And they've just had them and you think, 'oh that's going to be me soon' ... (first interview).

Meredith I was glad that I had time to help me prepare ... Yeah, whether ... whether you can ever actually ... Yeah, learn I guess if I'd been around even more people with babies and handled them more then perhaps ... I would have had more confidence handling my own (second interview).

Sally ... Mothers' groups have been great. Just ... going along and as we talk or watching what they do or what toys they have, or what they're feeding their children (third interview).

Maternal learning within this thesis has been identified as an integral part of everyday experience that starts from our earliest memories of being mothered or nurtured as an implicit learning (Woollett & Phoenix 1996). This is a form of learning that is incidental to other activities and frequently not within a subject's conscious awareness (Marsick & Watkins 1990), as this incidental learning is a by-product of experiences (Edwards 1997b). Incidental learning has been identified as a response to participating in an activity or by 'doing'; as an outcome of trial and error activities; and as interpersonal experiences (Marsick & Watkins 1990). Incidental learning is constructed as an unintentional form of learning, as it is not planned or thought about. It is learning that occurs even though the situation does not promote the learning and the learner does not intend to learn (Rogers 1997). For example, a woman watching another woman care for her crying baby in a shopping centre may be engaging in incidental learning. This experience of observation contributes to the development of behaviours, bodily stance, verbal responses and facial expressions of a mother trying to calm a crying baby. The woman at the time of the observation may not consciously register that she is observing another mother calm her crying infant, but incidental learning may have occurred as a consequence of the experience. Incidental learning can be referred to as unconscious learning and a means of gaining somatic knowledge, which contributes to the development of a maternal habitus. Drawing on Bourdieu's

metaphor of a 'feel for the game' this incidental learning results in:

> ... having the game under the skin; it is to master in a practical sense the future of the game; it is to have a sense of the history of the game. While the bad player is always off tempo, always too early or too late, the good player is the one who *anticipates*, who is ahead of the game... she has the immanent tendencies of the game in her body, in an incorporated state; she embodies the game (1998, pp. 80-81).

I am suggesting then, that incidental learning might be equated to Bourdieu's notion of the socialised body or the knowing maternal body that reacts in most instances using socially appropriate and anticipated maternal behaviours. A socialised maternal body has developed that draws on unconscious memories of mothering gained through everyday experiences commencing from our earliest memories of being mothered or nurtured.

However, when drawing on poststructuralist understandings, it is important to acknowledge that the knowledge and skills gained through the learning, as a part of lifelong and everyday learning, are simultaneously boundless, but they are also influenced by a socio-cultural contextuality (Edwards & Usher 1998). In other words, there are no limits to what can be learnt or the sources of learning, as learning is always situated within and influenced by a social and cultural context. This socio-cultural context frequently produces taken-for-granted or commonsense assumptions (Miller & Boud 1996) that influence the construction of the discourses of motherhood and the resulting régimes of truth, which act to guide and constrain women as they learn to mother. The use of socially and culturally approved and appropriate maternal behaviours makes these seem natural, as if this behaviour is the way it always is and has been.[8] The resulting social and cultural reproduction acts to guide and discipline women to conform to the accepted maternal behaviours expected by a specific community, thereby assisting in the production of an ordered and functioning society.

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[8] Social and cultural influences have already started to be identified (in Chapters 4 and 5) through the use of the concepts of bio-power and habitus as discourses explaining the achievement of social and cultural reproduction within a community.

Non-discursive maternal practices are of particular significance for incidental learning, as the learning that occurs is tacit (Marsick & Watkins 1990). This tacit dimension of learning can also be constructed as resulting in somatic knowledge that may not surface until an appropriate context triggers this knowledge (Polanyi 1966). According to Polanyi (1966), tacit learning is uncontrollable because the subject is unable to feel the gaining of this 'knowing'. As discussed in Chapter 4, tacit or somatic knowledge can be disrupted when focusing on or trying to bring specific skills and knowledge from the unconscious memory actively into consciousness such as the ability to hum the tune of a song, ride a bike, or touch type. This concept of disruption may be significant when women are aware that their maternal behaviours are being observed and judged, resulting in the possibility of experiencing greater difficulty accomplishing tasks they had previously mastered. The importance of tacit knowledge is its ability to enable us to "... *know more then we can tell*" (original emphasis) (Polanyi 1966, p. 4); or once again drawing on Bourdieu's (1998) concept of habitus — the ability to have a 'feel for the game'. This 'feel for the game' is not easily or adequately quantifiable within language, but it is a somatic knowledge occurring without conscious effort and theorised as frequently gained through incidental learning within this thesis.

Two extracts will be used from the New Mother study within this section to explore the concept of incidental learning and the use of experience. The first extract is about participation in a new mothers' group and the second extract is about accessing the support of a woman's own mother. The commonality between the two extracts is the importance of contact with other women who are at a similar stage or more experienced. This contact is proposed as an important strategy for the development or enhancement of maternal knowledge.

This first extract identifies the importance for Heather of participating in a new mothers' group, which was facilitated by the early childhood health nurse. The group continued to meet after the completion of the allocated six weeks, even though the group was gradually reducing in size as some of the women returned to the paid work

force.[9] Heather was asked why she enjoyed going to the mothers' group:

Heather: ..... I think ... I think the ability to chat ..... with people who ..... who have got children the same age ... That just, you know, talk about experiences and to .... to compare to watch other kids grow up as well ... you know ... To see ... to see the change ... (third interview).

Participation in this group initially provided a formal learning component, as the group was arranged by the early childhood health nurse and would have had an advertised program of information giving.[10] However, remnants of activities that support informal and incidental learning can be identified through the use of interactive words to describe the behaviour of the group *chat, talk, compare, watch* and *see.* These words imply an active cognitive and bodily engagement in the process, in particular, the use of comparisons between children. These comparisons do not seem to be measured against the normal child of the textbooks, but are gained by observing and experiencing the differences and changes among the children within the group. This comment about *change* could also be implying the changes in maternal skills and knowledge of the women, as their confidence and competence increases. These changes can be theorised as dynamic, sporadic and as an accumulative process which occurs over time.

Talking about experiences seemed to be of importance to Heather and may indicate the use of talking as a process of making meaning. These meanings can also be theorised as being influenced by two significant possibilities. The first possibility is that previous experiences enable either a conscious memory to be accessed or an unconscious memory of an experience to be stimulated such as feelings of fear, joy, competence or loss of control. The second possibility is the ability to access

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9 A possible significant consequence of new mothers' groups is the potential for the development of social capital. Bourdieu defines 'social capital' as "... the sum of the resources, actual and virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalized relationships of mutual acquaintances and recognition" (Bourdieu & Wacquant 1992, p. 119).

10 For example, the program may have consisted of infant nutrition, immunisation, child safety, growth and development, play activities for infants and managing sleep problems.

alternative or counter discourses to explain an experience, as the ability to interpret an experience and construct meaning are limited by the discourses women have available to describe an experience (Fairclough 1992). So a general statement about the commonality of an experience may only ever be possible as the contextual, cultural and social factors that intersect the experience will be different from other women's experiences. The commonality for the women in Heather's mothers' group is their similar stage of mothering or their children being of similar ages. This commonality allows for the possibility that the women use these factors to draw meaning from each other's experiences as they make comparisons.[11] Experiences do not have fixed meanings, but must be assigned a meaning by a subject resulting in a potential for experiences to be constructed with multiple meanings (Merriam & Heuer 1996). This understanding enables a transferability of the experience or engagement with another woman's experience as the possible result. So the women make meaning by using their own or others' maternal experiences and understandings as tools for interpretation. These interpretations are possibly signalled by Heather's comment that they *compare*, as a comparison requires an interpretation to reach a conclusion.

Heather is able to identify that it was important to *talk about experience* and *compare*, enabling these actions to be identified as conscious acts of learning. The incidental learning component is being theorised through the unspoken within the extract, which relates to the activities of watching others and is theorised as allowing somatic knowledge to be gained from observing interaction between other women and their infants.

Within this thesis the major component of maternal learning is being theorised as incidental learning gained through everyday experiences. Nevertheless, the learning that occurs through this everyday experience is a construction that is constantly open to reassessment, allowing the meaning of the experience to be changed in response to

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[11] In making this statement I do not imply a belief that all experiences are the same but that in hearing another woman's experience, meaning is constructed through a subject's current understandings rather than as a 'true' or 'authentic' reflection of the world or the self (Kosmidou & Usher 1992).

the constant making and remaking of subjectivity (Usher, Bryant & Johnston 1997). This construction of meaning from experience is not a straightforward act but is the outcome of non-discursive and discursive practices that require the use of language and discursive rules which are located in and often reflect complex power and social relations (Flax 1990). These everyday experiences allow learners to take refuge in more familiar encounters (Wildemeersch 1992) as they develop knowledge. Hence, this function of everyday experience highlights the potential importance of having access to more experienced women, as well as women at a similar stage of maternal learning, to enable the facilitation of these everyday learning experiences and therefore the contribution of other women's maternal knowledge. A potential source of this maternal knowledge can be a woman's own mother, as her presence enables maternal knowledge to be demonstrated and practised, allowing incidental learning to happen. However, expecting to draw on the experiences of a woman's own mother can be problematic.

For example, within this New Mother study there were mixed responses to questions that explored the emotional and physical support the women anticipated from their own mothers. Some of the women were extremely positive about the assistance they would and did receive from their mothers; and others were disappointed because their positive expectations of their mothers' assistance did not eventuate. Some women were surprised that their mothers' behaviour exceeded their expectations and that they were extremely sensitive to their needs as new mothers. Unfortunately for one woman, having her mother arrive from overseas to stay for the first few weeks of her daughter's life was constructed as a disaster and Victoria anticipated that any future contact with her mother would be limited. Several of the women who had limited contact with their mothers identified older, more experienced women who they constructed positions as surrogate grandmothers. Sally did not anticipate any assistance from her own mother who had been an invalid most of her life. However, she had an extended visit from her husband's birth mother who seemed to act in a nurturing capacity for Sally — encouraging Sally to talk about her feelings and

allowing her time out from her maternal responsibilities.[12]

In this following extract Lisa tells a story about her mother during the early weeks after the birth of her daughter. Lisa had an extremely difficult pregnancy and was forced to restrict her physical activities due to multiple complications during pregnancy. Her disappointment was compounded when she had a massive haemorrhage during childbirth, resulting in emergency surgery and numerous blood transfusions. During the first interview with Lisa, her pregnancy was in its thirty third week. She spoke of her close relationship with her mother, sisters and brothers, as Lisa was one of ten children. During the second interview, when her daughter Indira was six weeks old, Lisa provided the following response to a question about the importance of her mother visiting from New Zealand:

Lisa: Really important, really, really important. It was ... a great consolidating time for me these last ten days ..... and just ... just the bonding of three of us together, the three generations, has just been extremely important .... I had wanted, wanted because my mother hadn't been to Sydney before, I wanted to show her around. But when she got here all we wanted to do was be at home and be with her and ..... just talk ... Talk about parenting, and about babies, and about her experiences ... I just absorbed an awful lot and asked her a lot of questions that I had never asked her before ..... I might be missing out on something, or might not be doing something right, or whatever. Having mum here was just reaffirming .... not that I needed approval, but I wanted to know that I was doing the best I could for her. I needed to know that she was being well looked after. Mum did affirm that for me.

In this story, Lisa provides a sense of intergenerational connection through the use of words and phrases such as: *great consolidating time; bonding of three of us together; extremely important*; and *all we wanted to do was be at home and be with her*. This connection may also have been about needing the feelings of security her mother brought by her presence and the memories of safety and protection her mother was able to evoke from her childhood. These feelings may have been particularly intense,

[12] Sally's husband had been adopted as a young baby and his adoptive mother was now deceased.

as Lisa had been very concerned she may have died during childbirth as her father's first wife had done. Lisa had raised these concerns earlier in this interview.

Lisa positions herself as being 'hungry for knowledge' about child rearing and also about things she had never asked her mother. Lisa does not elaborate about the information gained other than her prior reference *about her experiences* which possibly included memories of mothering Lisa as a baby. A process of making meaning was possibly occurring concerning what was happening to her as a mother, as well as learning more about her mother, to enable a connection to be made through story telling between her daughter Indira and her grandmother. This story telling was possibly allowing Lisa to develop a more comfortable sense of her life where past events were being explored and connected with the present (Thomson 1996). This 'more comfortable sense of life' possibly enables the creation of new and complex subject positions that can be used by Lisa to explain her experiences, emotions and feelings. According to Banks-Wallace (1999, p. 20), story-telling conveys cultural values; "... stories provide guidelines to help people cope with milestones or transitions and assist people in finding their way in the world".

Lisa does not explicitly acknowledge that she is 'learning', even in an incidental way, as in Heather's story, an active involvement of seeking information through such statements as *absorbed* and *asked* are used to describe her actions. This learning process is also reinforced by a testing process of *I needed approval,* and *I wanted to know that I was doing the best.* So it could be proposed that informal learning was taking place because of the active seeking out and checking of information and skills.

It is impossible to know how much of the learning and affirmation Lisa gained from her mother was due to talking about experiences and asking advice or through watching her mother handle and nurture Indira. What is obvious is the impossibility of quantifying or judging the quality of the learning that has occurred for Lisa, as I propose that much of the learning was unable to be adequately constructed using available language and that the learning was not within conscious recall. This

incidental learning may not surface until Lisa is a grandmother and she is able to nurture her daughter Indira as a new mother. Lisa as a grandmother may draw on her conscious and unconscious memories of her experiences of the early days of mothering and being mothered by her own mother.

The knowledge gained through incidental learning may not always be accepted or identified as knowledge, as it is difficult or may be impossible to discursively construct this knowledge within available language or replicate women's experiences as mothers. To accept that absolute definitions or descriptions of the resulting learning can be provided would minimise the complexity and multiple meanings that occur when women learn to mother. The examples that have been provided in this section can also be identified as examples of what I have called 'opportunistic education'.

6.1.1 Capturing the moment: opportunistic education

During pregnancy, childbirth and the early months of mothering, health professionals are strategically placed to provide opportunistic education. Opportunistic education can be described as capturing the moment, by facilitating a woman's explorations of her feelings and experiences and assisting her develop maternal knowledge and skills to manage what is occurring in her life.[13] This educational approach may enhance maternal learning through assisting women to recognise their concerns about mothering and assist them in some circumstances to anticipate future maternal and

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[13] This opportunistic education approach has features of a 'relationship-focused early intervention model' and an 'interaction guidance' model. The first model is described by Kelly & Barnard (1999, p. 151) '... as intervention that is primarily concerned with fostering growth-producing parent-professional and parent-child relationships'. The justification for this model which has a significant parent education component is through research that has demonstrated that child developmental growth can be attributed to programs that increase the level of parental responsiveness to the infant, rather than to intervention programs that focus on family services co-ordination or child-directed intervention activities (Kelly & Barnard 1999). The second model described by McDonough (1993) as 'interaction guidance' has been used to assist parents gain enjoyment from their child and to develop the parent's understanding of child development and behaviour through interactive play experiences. This model focuses on providing parental guidance without undermining the efforts of the parent. The model attempts to provide a therapeutic process by highlighting existing family strengths and competence before intervening in the child rearing concern.

infant needs, as well as assisting women to develop images or metaphors for explaining their somatic experiences and sensations. Assisting women to learn through opportunistic education can also be identified as having elements of confessional practice which was discussed in Chapter 5.

In this section the possibilities for opportunistic education will be discussed using four interview extracts. These extracts provide examples of incidences where opportunistic education is occurring but the women or the facilitators of this learning are not overtly aware of the potential for learning and the construction of knowledge.

Women within this New Mother study frequently reinforced the impact of the assistance and advice gained from contact with health professionals, in particular the support, information and encouragement they received during difficult periods of experiencing the unfamiliar and challenging experiences of childbirth and mothering. For example, it could be argued that an unrecognised learning opportunity possibly occurred during Anna's first interview when she raised her concerns with me about having to return to her academic post shortly after her baby's birth. Anna raised this incident again during her second interview as she had returned to work on reduced hours when Charles was four weeks old.

Anna: I think I told you during the first interview that I was having real problems about anticipating going back to work and how on earth would I leave him but .... I've not had those problems.

Cathrine: So people haven't said its too early or ...

Anna: No ... not since you reinforced the fact that he'll still love me (laughing). I think that was what I was most afraid of ..... that he would think that the creche was his home.

Unbeknown to me, the incident during the first interview had been an important opportunity that assisted Anna explore some of the issues related to returning to work at such an early stage in her mothering. The importance of opportunistic education cannot be overlooked as a crucial component for assisting women learn about and

from their experiences. The difficulty for health professionals is the impossibility of capturing the entirety of an experience as a discursive construction. Nevertheless, opportunistic education can assist women to make meaning and construct knowledge out of their experiences. Within this story the question I need to ask as a nurse is: could I have used this opportunity to assist Anna explore her concerns to a greater extent than occurred?

In this next extract Jennifer provides an example of the potential for opportunistic education and the significance of facilitating an emotional space for women to discuss their traumatic experiences.

Jennifer: The charge sister came in and I just lost the plot ... I was making my bed and she said 'what are you doing that for Jenny, you're a patient'. I said 'oh I've got to do something', and then I just burst into tears and one of the other girls [a midwife] that ... was just doing the early discharge round walked in. So there was the three of us sitting on my bed and ... just talking me through the delivery and that ... One of the girls [a midwife]... had quite a traumatic forceps delivery, she'd had a Keilands as well ... and she could relate to the things that I was feeling, so it was good to ... be able to, you know, just talk to someone else and get off my chest, and have a big blubber as well without like .... I was embarrassed and ... But then they were all really very supportive.

Jennifer was seeking explanations as her professional knowledge, expectations and experience of childbirth as a midwife did not correspond with her new bodily and emotional experience of childbirth. This process of talking, which could also be read as confessional practice, is assisting Jennifer construct knowledge from her experience. Through the act of talking about her childbirth experience, Jennifer was possibly able to start to find words that might assist in partially bringing her unconscious memories and somatic knowledge into language. The midwives, through the act of listening and sharing their own experiences, have been participating in the provision of opportunistic education by providing a space for this education to occur. The types of educational support provided by the midwives may have included asking questions to elicit Jennifer's learning needs; providing technical information about

Jennifer's delivery; sharing metaphors they had identified to symbolise their own childbirth and maternal experiences; and providing alternative understanding or language to describe Jennifer's experience. A further benefit is that, by receiving assistance in the formulation of questions, she can ask the obstetrician about the events associated with her childbirth experience.

In the example provided by Jennifer, it could be proposed that she was having difficulty discursively constructing seemingly positive subject positions about her performance during childbirth. Language used to construct the experience does not capture the somatic sensations or emotions, but it does help to construct a subject position from which Jennifer can speak about her experience of childbirth.[14] This ability to identify language to represent her experiences can be constructed as having two possible outcomes. Firstly, this provision of language contributes to the development of knowledge by Jennifer and the midwives through construction of meaning about Jennifer's experience. Secondly, having access to new ways of discursively constructing her childbirth experience enables Jennifer to potentially construct new subject positions to occupy.

Nevertheless, information which is only partially explained or metaphors are used which are not followed with a clarification of their meaning can result in women worrying unnecessarily. For example, Alicia was provided with a common description of the change over from colostrum to breast milk, which caused her concern.

Alicia: ...The midwife was talking in the hospital about 'when your milk comes in', so to speak. Your milk comes in and I'm thinking 'oh god, what ... was it' ... I remember thinking .... 'oh god, what's going to happen ... when this milk comes in and I'm going to be overloaded' ... (second interview).

Alicia needed more information rather than just the taken-for-granted statement or assumption women will know what is meant by such seemingly common place

[14] Jennifer's baby was distressed and required a rapid and difficult forceps delivery, with minimal pain relief provided for Jennifer because of the urgency of the situation.

information within maternity units as *when your milk comes in*. A possibility exists that language and the resulting images that can be created by such statements as *when your milk comes in* can have multiple meanings which can be ambiguous or confusing for women learning to mother. Using these understandings, I am proposing that opportunistic education is the extension of these often taken-for-granted statements by health professionals, as they provide a trigger to include additional information and a process of checking the woman's understanding.

Unfortunately, an overwhelming constraint to the provision of opportunistic education is the seemingly ever-increasing workload of health professionals. The notion of education as part of their clinical practice is in most likelihood identified as a luxury rather than a priority. Alicia identifies the task-orientated focus of some health professionals as she describes the difficulty of gaining information during antenatal clinic visits.

> Alicia: .... I find at the [antenatal] clinic if you don't ask a lot ... they don't, they don't have time, I don't think, to tell you. I mean it's also crowded and busy up there .... I think ... I mean they've got all the notice ... they've got the leaflets and things. Sort of things to help yourself ... I think the only thing that was sort of ... a discussion about breastfeeding. 'Do you want to breastfeed?' ... 'Yes' ... 'Here's a booklet', sort of thing ... I think if, I mean, if I asked anything they'd, you know, they'd help you. But if you don't ask, if you're not, you know, if you don't ask then they're not going to just, they don't just have time to tell you sort of thing (first interview).

Alicia's example is provided in a very hesitant manner. She highlights the expectation that women will ask if they have a need for information. However, this approach is reliant on the belief that women will be able to recognise a need for information and know what sort of information is needed. Written information on childbirth and parenting is readily available in the form of fact sheets and pamphlets. However, this information may be appropriate for some women who are literate, conversant with the dominant culture and identify a need to be informed about a specific topic. For other women the information remains inaccessible.

Nevertheless, opportunistic education is a common occurrence in the clinical practice of nurses, midwives and other health professionals even though it may not always be identified as a central component of their practice that requires refinement and educational opportunities to be sought. The understanding that all interactions with women have the potential to provide learning opportunities can act as a powerful incentive for health professionals to rethink their definitions of education and to start to acknowledge the importance of education as a central component of clinical practice. A constant difficulty for health professionals, as alluded to in Alicia's story about *milk coming in*, is the potential for different interpretations of maternal experiences and for a disjuncture to result between professional and maternal knowledge.

6.2 Knowledge about mothering

Knowledge is graded, categorised, accepted or rejected by women and others often in terms of its apparent 'validity' as a truth claim. There are certain shifting measures of who has authority to speak, and in what circumstances truth claims can be made. These measures enable some knowledge to be identified as dominant and therefore privileged over other knowledge. As noted by Dalmiya and Alcoff (1993, p. 217):

> ... 'tales' may be interwoven into the very fabric of our daily lives and may even enjoy a certain amount of respect and deference as a useful secret-sharing among women. But nevertheless, it remains the case that they are considered to be *mere tales* or unscientific hearsay and fail to get accorded the honorific status of knowledge.

Dalmiya and Alcoff have foregrounded the privileged status often accorded scientific knowledge over other types of knowledge which results in a subjugation of non-scientific knowledge.[15] Subjugated knowledge is usually dismissed or disqualified, enabling other dominant discourses of knowledge, in particular, scientific knowledge,

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[15] I am using the binary of scientific and non-scientific discourses as generalised statements. Scientific discourses are being categorised as research based on scientific theorising, and non-scientific discourses are based on everyday experiences. Professional knowledge can be identified in most instances as being knowledge which '... enables recognition of deviation from the range normally found in a population' (Callery 1997, p. 31).

to be privileged as the 'truth'. Frequently, this scientific knowledge is used as the standard by which other knowledges are measured, filtered and identified as illegitimate (Foucault 1980b).

A possible connection among all the women interviewed within this New Mother study is of being silenced at times by medical and other dominant discourses about pregnancy, childbirth and mothering which frequently privilege scientifically based knowledge over maternal knowledge gained from a woman's experiences.[16] The problematic for women is the difficulty of constructing experiences in language resulting in the potential for an enormous amount of knowledge that will not be quantified and legitimised by scientific means.[17] This knowledge is identified as subjugated or lesser knowledge frequently gained from talking to other mothers, through experience and by making connections with other women's experiences. The potential for the subjugation of maternal knowledge is compounded, due to the context in which interactions occur and the often automatic positioning of the health professional as the 'expert' (Callery 1997).

Unfortunately, this expert knowledge which is often gained or at least purported to be gained from scientific research is privileged over other less seemingly scientific or everyday knowledge and experience. Yeatman (1996, p. 285) argues that "when scientific knowledge is regarded as knowledge proper, it tends to be practised and organised in ways which sequester it from what are seen as the contaminating influences of the non-scientific types of knowledge". If Yeatman's statement is taken as a reflection of the beliefs about the status of different types of knowledge then an enormous divide is put in place. For example, this divide can result in health professionals being isolated from the people whom they derive their authority and status.

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16 These other dominant discourses include: political discourses which position women with young children as needing to be at home; psychological discourses which have constructed women as being required to take the majority of responsibility for the child's psychological wellbeing; and nutrition discourses that promote breastfeeding.

17 The difficulty to adequately describe experiences will be discussed more fully in Chapter 7.

Three extracts will be used in this section to explore the subjugation of maternal knowledge. The first extract highlights the knowledge Julia gained about her infant and the difficulties experienced having her concerns about the infant's health adequately acknowledged. The second extract illustrates the disjuncture between the construction of the experience of labour by Jennifer and the obstetrician. The third example is an extended story using extracts provided by Sophie, over the three interviews, about gaining maternal breastfeeding knowledge. These extracts will demonstrate the potential disjuncture between professional and maternal knowledge.

The first example occurred during Julia's second interview when she provided a story of her understanding of her baby's health status being discounted by health professionals until a dramatic sign of illness developed — Rachael started to bleed from her bowel. Within this extract Julia can be constructed and she constructs herself in several ways as: the 'unknowing' mother; *being stupid*; the persistent mother; the concerned mother; the relieved mother; and the vindicated mother who knew her baby was unwell.

Julia: I was very worried when she wasn't gaining weight and that was during the time when we didn't know she was lactose intolerant ..... And that was ... was the only time I sort of felt a bit out of control and I knew there was something wrong and I ... I sort of went from one doctor to the next saying 'there's something wrong with my baby, she's not gaining weight, ... she's placid, she's happy. But you know, I'm starting to get concerned about the fact that she's .. she hadn't even regained her birth weight' .... And they were all sort of saying 'oh don't worry about it'... So when something actually did happen to her it was almost a relief in a way, okay I wasn't being stupid, I knew there was something wrong with her ..... So that ... that strong feeling of knowing I was right all along sort of confirmed that, yeah I do know what's right for Rachael

The difficulty for Julia seemed to be an inability to clearly identify her concerns about Rachael's health. The only sign of potential illness was Rachael's failure to gain weight which Julia may have informally learnt about through reading parenting texts, visits to the early childhood health clinic or from other mothers. In this instance, a weight gain that has not reached the norm, which is often used as a means of

surveillance of an infant's health, was dismissed by the doctors. Julia's maternal knowledge was being subjugated and dismissed; even though she has drawn on a medical discourse, she may have been positioned as lacking the authority to use this knowledge.

Maternal knowledge is often gained in the private domain of the home, frequently as an outcome of a woman's close contact with her baby. This closeness results in maternal knowledge, according to Callery being "... by definition not scientific or objective: it is the closeness of the mother to the child that enables her to become an expert judge of her own child" (1997, p.31). Fortunately, a mother is able to do what is often impossible for health professionals — intensively observe their baby over an extended period of time, possibly unconsciously or tacitly monitoring the subtle changes which take place to the baby's physical health and appearance. This unconscious monitoring potentially explains the difficulty of objectifying her concerns about the baby's health and is often dismissed by health professionals as being too emotional or subjective, and therefore potentially unreliable.

The subjugation of a mother's knowledge (in this instance, the knowledge about her daughter's health) has the potential to position the woman as being deviant and labelled as over-anxious, attention-seeking or as Julia has alluded to, *being stupid.*[18] Even though Julia, was concerned that there was something medically wrong with Rachael, only an official diagnosis allowed her to feel *vindicated* for pursuing her concerns about her daughter's health.

Implicit within this extract is the acknowledgement of power relations between a mother and the medical profession. These power relations are constructed through the

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[18] It is important to note that this situation of not being able to confirm a woman's concerns about the health of her infant remains problematic for health professionals; as to attempt to confirm a diagnosis often requires invasive, potentially dangerous, painful and expensive diagnostic investigations, which may still not confirm the existence of illness or abnormality. In making this analysis of Julia's story I am clearly taking up multiple positions as a nurse who understands the frequent limitations of medical practice to be able to provide answers; and as a mother who has had similar experiences of knowing your baby is not well but being unable to convince a doctor.

easy dismissal of Julia's concerns by the doctors with '*oh don't worry about it*'. If Julia pursues her concerns she is risking being positioned by the health professionals as the difficult, anxious or possibly depressed mother who is overly concerned with the health of her infant. Within this extract Julia demonstrates how a shifting of these power relations occurs with the acknowledgement of Rachael's health problems. Julia is now able to construct two new positions of knowing; firstly, knowing her daughter was unwell rather than *being stupid,* and secondly, a position of having greater knowledge of her daughter's health status than the doctors. These positions act to subjugate the initial medical knowledge and opinions she received about Rachael's health.

In the finishing statement Julia once again refers to *knowing*, though she increases the intensity of her feelings to a *strong feeling of knowing.* This *knowing* resists construction in words because of the subtlety of daily changes to the baby's health status and the possibility these memories of her baby's behaviour are unconscious memories, thereby resulting in this *knowing* not being able to be constructed through the use of language, but through somatic knowledge. The *strong feeling of knowing* is often trivialised as 'gut feelings' and dismissed by the medical discourses due to the lack of quantifiable evidence.[19] Unfortunately, a dilemma remains about the level of medical intervention required when the physical evidence for indicating an illness is limited in an otherwise healthy, placid baby.

Jennifer provided the next extract during her second interview. This extract about the knowledge gained through experiencing labour has been discursively constructed as unworthy of consideration by the obstetrician. Jennifer, who has worked as a midwife for many years, highlights the lack of validity of maternal knowledge gained through the experience of childbirth. The obstetrician Jennifer had chosen to manage her pregnancy and the birth of her baby had worked with her for several years.

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[19] The discourse of non-declarative memory provided a possibility of describing the concept of having a 'gut feeling' in an alternative way as being based on somatic knowledge gained through experience (see Chapter 4).

Having a baby has significantly altered Jennifer's view about many aspects of pregnancy and childbirth, in particular the pain that women have to endure. Jennifer's labour and the birth of her baby had been extremely painful and difficult. A question has been identified that needs to be considered when reading the following extract — will Jennifer be able to use her new knowledge about childbirth when she returns to work as a midwife or will she continue to be positioned by the dominance of the medical discourse and the power relations inherent within the medical institution?

Jennifer: When I ... I just had my postnatal check with the obstetrician and he, I told him that, I said 'it's funny how you perceive things, like I thought it was a long time [putting the forceps on and delivering the baby] ... and it wasn't'. And he he turned around said ..... 'forceps delivery its only millimetres extra that's actually like putting in ..... the pain is no different to a vaginal birth'. And I thought, 'no it it'd have to be worse ..... its got to be if you've got those big blades there and they're pulling'. But that that's his view ..... because I thought you know, if I tell him he really hurt me and that's what ... sticks in my mind ..... it might make him ... I mean he's not a butcher anyway. But his theory was there isn't that much difference between the pain that a woman would feel with a vaginal delivery.

After her experience of a forceps assisted birth, Jennifer made an attempt to inform her obstetrician of how painful the birth of her baby had been. Unfortunately, Jennifer's desire to provide the obstetrician with this knowledge gained from her experience placed her in conflict with his medical discourse.

Jennifer had attempted to justify and rationalise why childbirth was so painful and to construct a legitimate subject position. However, she was unable to find a position from which to speak to the doctor so as to be heard. This inability to construct a position to speak from is possibly due to her new knowledge of labour and birth being based on somatic sensation and feelings which resist discursive construction. This lack of language leaves the medical discourse (that refuses Jennifer's experience) uncontested and the only official discourse about childbirth. The truth spoken by the obstetrician has been legitimised by virtue of the obstetrician's position in the health system hierarchy. This truth demonstrates two possible overlapping views: firstly an

essentialist construction of women; that all women are the same in certain salient respects (i.e. women all have the same physiology or even that all vaginas are the same), and therefore the pain for every woman is the same. Secondly, that the body is a machine or object that must be quantified — *it's only millimetres extra* — if it is to produce valid knowledge. The statement that *there isn't that much difference between the pain that a woman would feel with a vaginal delivery* also positions the obstetrician through Jennifer's words as attempting to 'normalise' the use of forceps and possibly provide a justification for his actions.

Another possibility exists that Jennifer has experienced childbirth, where her obstetrician can only ever be an outsider looking on at this intense human experience. This childbirth experience has changed the dynamics of their previous professional relationship where neither had experienced childbirth, but where his medical knowledge was the privileged knowledge. In this new dynamic, Jennifer has challenged the dominant discourse he uses as a result of the knowledge she has gained through experience. The medical discourse is now competing with the subjugated knowledge of Jennifer as a mother and midwife. The contradiction between these competing knowledges places a barrier in the way of Jennifer finding an acknowledged subject position as she can no longer accept the medical discourse on this issue of pain. This lack of an acknowledged subject position maintains the power relationship between the obstetrician and the woman (midwife), as the medical discourse continues to provide the obstetrician with a more powerful position from which to speak. An important understanding is being underscored in Jennifer's story: that all discourses are not equal and some account for and continue to justify the appropriateness of the status quo (Weedon 1997).

The obstetrician's lack of acceptance of Jennifer's knowledge leaves her to struggle with the dominant discourse to understand what has happened to her during childbirth. The struggle comes to the surface as she attempts to reject the positioning of the obstetrician as a *butcher — it might make him ... I mean he's not a butcher anyway. But his theory was* .... This attempt to reject the positioning of the

obstetrician as a *butcher* may be due to a recognition she is infringing the régimes of truth that health professionals, in particular, doctors, have the 'correct' knowledge about childbirth.

Jennifer may be trying to make meaning of her painful experience of childbirth here by drawing on her knowledge of midwifery and by talking about her understandings with the obstetrician. This meaning-making process may be driven by a desire to use the knowledge gained from her experience to assist other women learn, by breaking the silences which exist between an obstetrician's experience and a woman's experience of birth. A disjuncture has potentially occurred as Jennifer tries to make sense of her childbirth experience and understand why it was so painful. On the other hand, the obstetrician may be viewing Jennifer's birth experience as a purely technical encounter.

A discursive conflict has occurred for Jennifer in her positioning as a midwife and the birth, as Jennifer has investments as a midwife in maintaining her faith in the obstetrician's competence and attitude towards women, as she intends returning to work in the same maternity unit as a midwife where he is an obstetrician. The question I raised at the beginning of Jennifer's story, will remain unanswered — will Jennifer be able to use her new knowledge about childbirth when she returns to work or will she continue to be positioned by the dominance of the medical discourse and the power relations inherent within the medical institution? These institutional power relations are internalised and act as a form of self-discipline, disavowing Jennifer's experience and resulting in the potential silencing of the midwife, thereby limiting the range of information provided to women. According to Murphy-Black (1995, p. 283), "the really sad aspect of this is that it is often done in the name of 'being a good midwife' that is, blindly following the rules designed for the smooth running of the institution rather than the needs of an individual". If this self-discipline occurs, the midwife remains an agent of the dominant medical discourse.

These two stories told by Julia and Jennifer have demonstrated how maternal knowledge can be subjugated, due to the difficulty of quantifying or objectifying experience. Maternal knowledge is being theorised here as frequently being developed through the use of the educational discourse of incidental learning. This learning results in the construction of knowledge, which is often somatic and not easily constructed in language, and as not having the same authority as knowledge gained through formal learning which is based in language or other symbolic systems such as mathematics and particularly statistics. If poststructural understandings of subjectivity are used, then this recurring theme of a lack of language to explain experience limits the subject positions women are able to construct as mothers and hence what counts as knowledge.

6.2.1 Changing the dominant discourse: Sophie's story

The identification of differences between professional and maternal knowledge, which is being discussed in this section, is rarely acknowledged within the professional literature, so experiencing these differences can be a surprising outcome of pregnancy, childbirth and early parenting for many health professionals. Within this New Mother study there were four women who are midwives. These women's experiences differed greatly from each other, but there seemed to be two common connections. The first was the expectation of others that mothering would be easier for them because of their midwifery knowledge and skills. The second was the surprise of finding out how some maternal experiences were very different from their midwifery knowledge and understanding of maternal experiences.

Nevertheless, a positive aspect of experiencing these differences was the possibility for learning to occur and the development of new understandings as the women worked to overcome the difficulties and tensions caused by some of their maternal functions. These new understandings have the potential to influence the women's clinical practice as midwives, as already alluded to by Julia in the previous extract about the pain of her forceps-assisted birth. The following story about Sophie's

experience of breastfeeding uses several pieces of extract gained during the three interviews to demonstrate the development of her maternal breastfeeding knowledge.

During the past twenty years, a change in infant feeding practices has occurred with a resurgence in the promotion of breastfeeding as the ideal and accepted method of infant feeding. An avalanche of research about breastfeeding has supported this increasing enthusiasm, in particular, quantifying its nutritional values and benefits. Using this new knowledge base, many health professionals have embraced the dominant discourses to promote breastfeeding and increase their knowledge and skills by completing the International Lactation Consultant's Examination to become lactation consultants.[20]

In the following section, a story is constructed of the insights gained by Sophie as she learned to breastfeed. Sophie, a midwife, gained her lactation consultant status several years ago. At the first interview during her pregnancy, Sophie was positive that breastfeeding was a 'natural' process which she would manage without difficulty. In response to my questions about how she planned to feed her infant, Sophie responded immediately:

Sophie: Breastfeed

Cathrine: And you feel confident about that?

Sophie: Yes, I don't see why I couldn't really do it ... Yeah

Cathrine: You feel you have enough information?

Sophie: Yeah, I think I know a lot about breastfeeding ... Yeah .....

Sophie provides positive responses to the three questions that I asked. The only hesitations that occur are at the end of the second and third response — ... *Yeah* — this response appears to act as a reinforcement that she will be able to breastfeed. A

[20] The use of terms such as 'lactation consultant' have the effect of reinforcing the notion of the expert and acts to immediately subjugate knowledge and experiences that has not been legitimised by scientific research or an examination process.

confident reply is provided about her breastfeeding knowledge and lack of need to prepare. Sophie seems to be equating her ability to breastfeed successfully with her professional breastfeeding knowledge.

The next extract followed on immediately. In this section Sophie dismisses her mother's knowledge of breastfeeding.

Cathrine: Have you been getting positive comments about breastfeeding?

Sophie: ..... The midwife is really positive and she's really supportive, because I've ... I'm scared that I'm going to get really sore nipples. ..... But I know that if you attach a baby correctly and all that that they shouldn't really get too sore ... But I'm scared about getting sore nipples. ..... So the midwife has been really positive and .... friends of mine who've had babies breastfed with no problems, ... it gives me confidence thinking they didn't know anything about it and they're good at it. My mother thinks that I'm too stubborn, in that, if something happens that I can't breastfeed that I'm going to starve this baby, because I'm just not going to let it have any formula at all. But I just say, 'why wouldn't I be able to breastfeed?' And she says, 'something might happen'. And I say 'well tell me what'? But she doesn't know ... she's just had her experience, in the past people who couldn't breastfeed like they had not enough milk or whatever, so they had to have a bottle. Whereas I think, if you haven't got enough milk you have to increase your supply .... and things like that. So she's worried that I'm going to be really stubborn and for some reason get really super anxious about it, and my milk's going to dry up and the baby's going to starve.

In this extract Sophie starts to become more hesitant as she tells of her concerns of developing sore nipples. The midwife is portrayed as a positive source of support, which is related to her knowledge of Sophie's concerns about developing sore nipples. Sophie, through these statements, positions herself as vulnerable and concerned.

Sophie then quickly shifts to a more confident and knowledgable position, however, providing a response consistent with the breastfeeding discourse as the usual cause for sore nipples being due to poor attachment of the baby at the breast. Nevertheless, an

inconsistency starts to occur as Sophie does not maintain this position of confidence and knowledge, and after a short pause she quickly shifts to her previous position of concern and vulnerability. A reiteration of the midwife's positive approach towards breastfeeding is then re-offered. The midwife is being positioned as supportive and potentially having greater authority than Sophie. This positioning is understandable as Sophie is placing her trust and life in the knowledge and skill of this homebirth midwife.

After a short pause, Sophie provides further justification that she will be successful through the example of her friends who have breastfed. Sophie positions herself as having greater knowledge than these friends by her statement *it gives me confidence thinking they didn't know anything about it and they're good at it.* This statement could also be interpreted through several alternative readings: breastfeeding is a natural act; a great deal of technical detail about breastfeeding to succeed is not necessary; that the knowledge necessary to breastfeed successfully is somatic knowledge which can not readily be discursively re-constructed and, if thought about, performance of the skill can be disrupted or deteriorate; that scientific information and research findings cannot be universally applied; or that Sophie's confident and forthright approach to breastfeeding has silenced some of her friends from talking openly about their breastfeeding difficulties and discomforts.

The statement — *my mother thinks that I'm too stubborn* — provides a possible insight into how Sophie constructs her mother's attitude to her desire to breastfeed. This statement may signal a tension and conflict between mother and daughter. The impression is gained that her mother believes Sophie would privilege her desire to breastfeed over the needs of her baby. It is difficult to know whether Sophie is attributing the statement — *because I'm just not going to let it have any formula at all* — as an act of defiance against her mother; and/or as a statement of intention that Sophie will not allow her infant to have formula milk, because of her knowledge about the benefits of breastfeeding.

Sophie continues to challenge her mother's cautious attitude to breastfeeding. This challenge results in a dismissing of her mother's apparent lack of ability to identify what might happen to impede her ability to breastfeed and privileges the breastfeeding discourse — that all women can breastfeed. Her mother's attempt to challenge the breastfeeding discourse and the concerns her mother raises are dismissed. This dismissal privileges Sophie's knowledge and experience over her mother's, resulting in her mother's knowledge and experience being subjugated. Sophie's mother is discursively positioned as unknowing and critical of Sophie's breastfeeding stance.

The final part of the extract reinforces her mother's concerns about Sophie's stubbornness and complicates her behaviour further when she discursively positions herself through her mother's words as potentially anxious. This anxiety is reinforced by the use of a description — *really super anxious*. A scenario is constructed of her milk drying up and her baby starving, which once again privileges her desire to breastfeed over the needs of her infant. There is a tension in the way Sophie is positioning herself in relation to her mother. This position may be due to Sophie's belief that her scientific knowledge about breastfeeding overrides her mother's experiences, and thereby subjugates her mother's knowledge. Sophie is demonstrating in a covert way the disciplining effect of the breastfeeding discourse that does not allow her to overtly consider the possibility of giving her baby a bottle.

A final question was asked during the first interview, to find out how Sophie felt about her mother's concerns and comments:

Sophie: It makes me mad, like I just think, 'why can't she ... have faith in me?' I suppose and trust me like. I think, you know, before bottles were invented babies had to have breasts and that's what they're there for.

Sophie draws on an essentialist reading of the ability to breastfeed to justify her annoyance with her mother about her lack of support and faith in her ability to breastfeed. This discourse of — *before bottles were invented babies had to have breasts* — is often used to privilege breastfeeding over bottle feeding. Statements

such as this one construct breastfeeding as a universal accomplishment of women in a seemingly less complex world.[21] However, women historically have been identified as encountering difficulties and indifference to breastfeeding (Hardyment 1995; Thurer 1994; Badinter 1981; deMause 1974).[22]

During the first interview Sophie had positioned herself as a knowledgeable and competent lactation consultant. At the second interview Sophie's daughter Katrina was four weeks old. Breastfeeding had not progressed as easily as planned. A question was asked about her breastfeeding experience:

Sophie: Terrible (giggle) ..... It's been really hard. At one stage, I actually said 'right, this is it I'm giving up. I'm expressing and bottling' ..... It turned out that I had thrush in my nipples ... because we noticed Katrina had it in her mouth, and I've always had really sensitive itchy nipples ever since I can remember and can't wear fancy bras or anything like that ... And it just breastfeeding is excruciatingly painful, really big craters in my nipples and things ... So I was expressing and bottling, and then when we started treating the thrush and the cracks sort of started to heal a bit ... I thought, I'll try her again and got someone from work to come and give me a hand and I got her on again and it was much better ... since we've been treating the thrush, so I'm breastfeeding again now.

Sophie here provides a negative response, since breastfeeding has not been the easy task she had imagined. The response is punctuated by a giggle after *terrible,* this giggle may indicate an understanding that she had portrayed breastfeeding, during the first interview, as an easy task that would be enhanced by her knowledge level and commitment.

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21 Even with the enormous effort to promote the benefits of and encourage breastfeeding, it is estimated that worldwide optimal breastfeeding practices are not achieved by 85% of women (exclusive breastfeeding till the infant is 6 months old as per the 1991 *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding*) (Obermeyer & Castle 1997).

22 For example, Badinter (1981) notes that even though the vast majority of peasant women in past centuries have nursed their infants, this breastfeeding experience was shared often unequally with a 'little stranger' to earn additional money or the wet nurse frequently left her own infant to starve to care for another infant. A constant urging is identified throughout the centuries to encourage women to breastfeed their infants, although this urging has often been countered by the dictates of fashion or modesty to avoid breastfeeding (Hardyment 1995; Thurer 1994; Badinter 1981).

Nevertheless, Sophie does demonstrate an enormous commitment to providing her baby with breastmilk by her statement *I'm giving up. I'm expressing and bottling.* The *giving up* relates to her stopping the attachment of her baby to the breast. *I'm expressing and bottling* implies that Sophie intends to continue to express and provide her breastmilk via a bottle. This statement also provides the impression of defeat — that she had considered never putting Katrina back on her breasts to feed.

Sophie uses descriptive language to describe breastfeeding and the physical effects of thrush on her nipples. The description of the symptoms of thrush constructs a subject position for Sophie as 'unknowing' about the thrush. Several of these thrush symptoms are identified as isolated difficulties prior to trying to breastfeed — really sensitive itchy nipples; and can't wear fancy bras or anything like that. Sophie is now able to shift to a position of 'knowing', by clearly connecting these symptoms with breastfeeding, thereby providing evidence for the existence of thrush. This evidence possibly helps to diminish her sense of responsibility for the breastfeeding difficulties she has encountered.

A contradiction occurs about the sequence of events; initially Sophie gives the impression that she had only thought about giving up breastfeeding, expressing and giving the milk in a bottle. However, Sophie later implies that she did start to express milk and then use this milk to bottle feed Katrina. There is an impression here that the decision was made before Sophie identified that having thrush was causing her breastfeeding difficulties. After thrush treatment was commenced and her nipples started to heal, Sophie was able to restart her attempts to breastfeed. With her new understanding of the cause for her breastfeeding problems, Sophie is able to construct a position of being back in control of her breastfeeding experience.

Sophie finishes talking about her initial experience of breastfeeding with the following observation:

Sophie: ... but its been really hard ... Like ... its just the hardest thing .... I could go through labour again, but I think about breastfeeding, I think 'oh I don't know' ....

Breastfeeding is identified as being *really hard ... like ... its just the hardest thing.* This observation contradicts Sophie's three initial statements about her understandings of breastfeeding, her discrediting of her mother's experience and concerns, and the mechanistic approaches she had constructed about breastfeeding. Sophie reinforces the level of difficulty and pain in her thoughtful response and comparison to labour. This response and difficulty in discursively re-constructing the experience and feelings may indicate she is still trying to make sense out of her breastfeeding experience. Sophie can draw on her conscious memories of how difficult and painful the initial breastfeeding experience was, but she may no longer be able to reconstruct unconscious memories of the physical sensation of pain and distress that she experienced in either labour or during her breastfeeding attempts.

By the third interview, Sophie had returned to part-time work as a midwife and was still breastfeeding Katrina when she was nine months old. At this final interview Sophie was asked if she could turn the clock back to her pregnancy would she have liked some additional information to prepare her for motherhood:

Sophie: ..... I suppose more about breastfeeding ..... But I thought I knew a lot about that anyway ..... I don't really know, ... maybe I should tell everybody about thrush (gentle laugh). I knew about it anyway ... so ..... I don't know maybe more of a realistic expectations about it or something.

Sophie's response discursively positions her as being surprised about her lack of breastfeeding knowledge and is contradicted by her acknowledgement of pre-existing breastfeeding knowledge. Her hesitation of *I don't really know* may indicate the difficulty of telling others about breastfeeding and discursively capturing the emotions and sensations of pain and discomfort.

Sophie's statement *I knew about it anyway ... so .....* identifies the potential difference in knowledge which is available for conscious introspection and her somatic knowledge which is unable to be fully captured in words and is not consciously accessible (Squire 1992). The final statement she makes about *realistic expectations* potentially signals the gaining of an understanding about breastfeeding that had not been previously available. A process of knowledge making may be resulting from her struggle to make meaning of her breastfeeding experiences.

In this final extract Sophie was asked if she has changed her clinical practices as a midwife:

Sophie: Yeah .....yeah I have, like I think I'm a lot more just open to whatever they want to do .. Whatever they feel sort of, instead of going by the ..... you know all the Baby Friendly Hospital Initiative and all that like ..... I just think well you've got to also be mother friendly, as well as baby friendly .....

Sophie positions herself as changing her stance about breastfeeding through the understandings of the difficulties of mothering and breastfeeding. This change in stance may indicate that her level of 'knowing' about breastfeeding has increased; that she is listening more carefully to the women she is trying to assist; and that her understanding about the complexity of breastfeeding have altered. Sophie identifies this change in stance by referring to the international *Baby Friendly Hospital Initiative.*[23] This initiative and the discourses that are used can be constructed as privileging breastfeeding and the benefit to the infant over the rights and needs of women.

However, Sophie has developed an understanding that the needs of women also have to be supported. Unfortunately, the *Baby Friendly Hospital Initiative* does not clearly acknowledge the complexity of the relationship between women and breastfeeding or

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[23] To be eligible to be named a *Baby Friendly* hospital, a hospital must comply with a set of ten rules about the promotion of breastfeeding, which result in restrictions being placed on the use of infant formulas and infant feeding bottles. These rules are identified as appropriate for implementation throughout every hospital worldwide (NSW Health 1995).

women and their infants. The potential difficulty with this *baby friendly* stance is that the needs and ideal outcomes for mothers and infants can be at times in direct conflict. For example, the woman who has been sexually abused may not be able to tell midwives about this part of her history. Memories of this abuse may have been refreshed by the experience of childbirth, causing emotional and physical difficulties when allowing or being forced to have her newborn infant suck on her breast. A high level of sensitivity for the emotional and physical needs of new mothers may be beyond the understanding of the midwives, especially if they are committed to the breastfeeding discourse of 'breast is best' without consideration of women's often traumatic histories.

The story which has been told by Sophie during the three interviews is one of shifting positions as she learns about the complexities of breastfeeding. During the first interview she positioned herself as the knowledgable midwife and lactation consultant who was confident about her breastfeeding knowledge and her ability to breastfeed. In the second interview Sophie discursively constructed two positions: as the mother who found breastfeeding painful, difficult and as the hardest thing she has done; and as the mother determined to overcome adversity. During the third interview, three positions were constructed: of thinking she knew a lot about breastfeeding; of having unrealistic expectations about breastfeeding; and of the midwife who has changed her approach when assisting other women who are learning to breastfeed.

To conclude this section a note of caution is needed. The intention of this discussion about the disjuncture between professional and maternal knowledges and skills is not to privilege maternal knowledge and experience over professional knowledge and experience, but to expose the potential for differences between knowledges. As with professional knowledge and experiences, maternal knowledge and experiences are often problematic as they are not universal truths about mothering. For example, it is necessary to trouble the understandings and somatic feelings gained from a health professional's experience of breastfeeding their own baby and other maternal experiences, as this knowledge and their experiences are not identical and are not a

simple solution to making sense of another woman's breastfeeding or maternal experiences. Firstly, maternal experiences, memories and knowledge are unlikely to be the same for all women. Secondly, using concepts gained from recent theorising about memory, the memories of somatic sensations of breastfeeding may not be consciously accessible but exist as non-declarative or unconscious memory. These memories may be unavailable until a similar emotional or physical circumstance triggers these memories. Finally, the presence and behaviour of a foetus or infant mediate many maternal experiences, which further complicates the interpretation of experiences and the ability to generalise these understandings to all women.

6.3 Dancing with the baby: learning to read the baby's cues

The baby plays an integral and major part in the development of confidence and competence as a mother. Maternal confidence and competence can be theorised as being able to 'tune into', and in most instances, 'read the messages' provided by the baby about their needs. However, a newborn baby does not always provide clear or unambiguous messages about its needs; even though it does come equipped with physiological abilities to adapt and hopefully survive.[24] The baby's inability to provide clear messages about its needs can be understood as resulting from a lack of direct experience of the world from which to develop meaning.[25] So to get to the stage of feeling confident and competent about mothering, considering these major constraints it can be argued to be a mammoth task for women and their babies.

A significant task and difficulty for many women is the ability to recognise and interpret their baby's behavioural cues. This knowledge about their baby's behavioural cues allows them to know when the baby is tired, frustrated, bored, hungry or is needing to be cuddled. So how a woman constructs the behaviour of her infant may

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24 These physiological abilities include innate reflexes such as sucking and rooting; and the ability to call for help when distressed.

25 The infant has only indirect experience of the world at birth as its life to this stage has been mediated through its mother's body.

be a crucial component for the development of confidence in her ability to mother.

For several women within this New Mother study, understanding their baby's cues, in most instances, was constructed as easy to interpret and explained in a matter-of-fact manner. Others found it a difficult or constantly changing process. The ability to accurately interpret the baby's cues was often linked to the developmental stage of the infant. This final section will explore the examples provided by four of the women about their ability to understand their infant's cues and the potential importance of somatic knowledge.

In the first extract, provided during the third interview, Emma constructs her ability to read her baby's cues as an obvious and logical process.

Emma: Working out ... what the cries are and picking up his body language. He's getting grizzly, soon he'll be ready for bed..... Very practical things like that.

Emma describes Patrick's behaviour as providing practical cues, which has helped her tune into his needs and learn how to appropriately deal with this situation. Implicit within her description of Patrick's behaviour seems to be a degree of problem-solving and making meaning of Patrick's cues. A pattern has developed that she attends to, which may be helping her understand her baby's needs. This pattern is made up of a complex of cries and body movements that are more than likely reinforced by Emma's behaviour towards her baby. It seems that a joint learning experience has occurred of Patrick adapting to his mother's cues that it is now time to go to sleep. These maternal cues are possibly often repeated subtle actions and words that act as a form of ritual that becomes embodied.[26] This ritual can also be constructed as the beginning stages of the development of self-discipline; the ability to put himself to sleep. The ritual may consist of several activities such as kissing each parent goodnight, cuddling a teddy bear, having a story told and having a final drink for the night.

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[26] For example, many adults have difficulty sleeping on a pillow or bed that is not familiar or until they have cleaned their teeth.

Patrick is spoken of as separate and of contributing to the learning process. This contribution signals a shift in the power relations as Emma is identifying that she allows him to direct her at times. Much of this behaviour between Emma and Patrick could be identified as beyond words as it is based in the subtle nuances of body movements, emotions and experiences.

In the first extract Emma constructed the process of recognising Patrick's cues as lineal and simplistic which is inconsistent with other stories Emma had told about Patrick's behaviour during this same interview in response to a question about her level of tiredness. For example:

Emma .... I didn't really realise ... how tired you would get ... So the joy and excitement has been well and truly over. The last couple of months have been tempered with ... 'oh my god, if you wake up again I'll kill you' ... (third interview).

In this extract also gained during the third interview, Emma provides a different understanding of the difficulties encountered and the physical struggle of managing Patrick's cues and his needs. Emma's two stories demonstrate the ease with which stories can change as a woman shifts her position in response to a different question or questioner, or a particular set of circumstances. The first extract positions Emma as seemingly in control of the situation; whereas the second extract positions Emma as lacking control of the situation.

A similar experience to Emma's first comments has been constructed by Anna of being able to differentiate between seven and a half month old Charles' different cries. Within this story the possibility of learning through trial and error is alluded to.

Anna: ... I mean with his cries, I can tell which is a whimper, which is building up and what it might mean. ..... So yeah pretty much.

Cathrine: Did you make a concerted effort to ... to learn those?

Anna: No ...

Cathrine: It just happened?

Anna: No, I just ... he, you know. I would be nursing him and he'd make a cry or .... a certain sort of cry and I'd say 'I think he's hungry' and he was and ... other cries of pain which I know..... Yes and now he's just starting to have his little grizzles, when ... when he sort of doesn't like something or he wants a change.

Anna has learnt to identify a behaviour pattern that signals her baby's needs. The baby is constructed as exercising agency within the relationship as his cries are interpreted as providing meaning. The concept of exercising agency allows Charles to take the lead at times which clearly positions the baby as separate and other to Anna.

In response to my question about making a concerted effort to learn a contradiction starts to occur; at first Anna's reply is *no* to my question. The answer remains *no* to the alternative of *it just happened*, this response starts to identify the process occurring as possibly more complex. Anna's response identifies her learning through a process of trial and error: *he'd make a cry or .... a certain sort of cry and I'd say 'I think he's hungry' and he was.* This approach can be constructed as the mother's and baby's learning being mutually complementary; or a synchrony developing between the mother and baby.

Victoria constructs a more hesitant approach in the following story, which reflects the unknowns that can occur when caring for a baby:

Victoria: Sometimes, but not always, like there are times when she cries, like recently. I don't know whether she is doing that because she's got a bit of a cold..... She cries and I can't make out why she cries. She's just had a feed, she has a clean nappy and ..... and I know she's not grizzling its not that..... So and I ... I can feel from her body she hasn't got cramps. Because that's, I can feel that when she arches her back ..... and her body gets tense, ... that she has colic or just has cramps or opens her bowels or something you know ..... And this kind of cry that has been for the last few days, I can't, I don't know what it's all about. [right] So with you know, some body movements, I can now interpret, yes hungry or just give me a cuddle or something. I'm learning (laugh) (second interview).

Victoria provides a hesitant account of the relationship between her baby's behaviour and needs. In this account a tension exists between 'knowing' and 'not knowing' the cause of her baby's cries or behaviour. The story is constructed in five different parts. The first part is being unsure about the meaning or cause of her baby's cries *sometimes, but not always.* Nevertheless, she does attempt to attribute a cause for her baby's behaviour. The second part is the provision of an outline, a form of checklist Victoria goes through to eliminate the potential causes of her baby's unwanted or distressing behaviour. The third part is a 'knowing' about her baby's body — *I can feel that when she arches her back.* Victoria is trying to attribute a cause to her baby's behaviour by drawing on the medical discourse of colic. There is still a lack of an explicit description of what she feels which starts to locate this information as somatic knowledge. In the fourth part of the story, Victoria once again discursively positions herself as 'unknowing' as she identifies that some cries remain a mystery. The final part of the story provides an attempt to reinforce that Victoria is learning. The laugh at the completion of the statement provides an impression of acceptance that it is all right to be still learning.

In this final extract, Lisa, in constructing a story of learning, has also highlighted the contribution the baby makes to this process:

Lisa: ..... Well ..... we tuned in from birth very strongly. ..... We tried sort of intuition from the beginning, but sometimes things remained a bit of a mystery. I was not quite sure ..... I guess I started to ... feeling of ..... well it's sort of that. She reached milestones that ..... it was easier for me to understand then, when she started to become clearer I suppose in communication ... Its just been a gradual — I couldn't say its so many months because the change has just been a gradual getting to know each other..... But I think there was a bit of a ..... really getting to know each other ... Probably six months around about there ... she just seemed a bit more ... a bit more grown up, I suppose and ..... more able to communicate ... when I found that it wasn't just so much guess work on my part ... (third interview).

Lisa provides a mixed account of being able to understand her baby's cues. At first she is definite about her ability to tune into her baby's needs. This ability is initially

attributed to *intuition*, but a hesitation appears — *but sometimes things remained a bit of a mystery*. The importance of *intuition* in assisting her understand the baby's needs has been quickly diminished.

Lisa has started to question her confidence level and her judgements as her ability to interpret her baby's behaviour starts to sound as if it is more likely to be a guess about the baby's problems and needs. A system of trial and error is at work that becomes easier as the baby increases its participation in the process. By the end of this section of transcript Lisa acknowledges that a strategy of guesswork was predominantly happening in the early days of mothering. The baby's contribution to this state of learning is acknowledged by Lisa *really getting to know each other* and *more able to communicate*. This response shifts some of the responsibility and power to the baby to communicate her needs.

Lisa acknowledges that the cues her baby provides have become clearer. This increased clarity can be claimed to possibly be due to the gradual maturation of the baby's physiology; the ability of the baby to communicate in ways other than crying behaviour; Lisa's increased somatic knowledge of her baby; and the baby's increasing experience with the world.

In these stories about reading the cues of their babies the women have positioned themselves as both 'knowing' and 'not knowing', something which frequently defies articulation in language. An explicit theme is the requirement to adjust to the baby as they develop and change the way they communicate their needs. Maternal competence in successfully providing timely and appropriate care to the infant can be identified as the potential beginning of the development of a parenting habitus by the infant, and therefore a later ability for these children to reproduce nurturing behaviours in a seemingly 'natural' way as if by instinct. [27]

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[27] I am referring to a 'parenting' habitus as I believe that men are able to develop nurturing behaviours and that men can possibly gain as much enjoyment and satisfaction caring for their infants as women.

6.4 Conclusion

This chapter has explored three themes of mothering: the importance of hearing about other women's maternal experiences; the disjuncture between professional and maternal knowledge; and learning to read the baby's cues. These three themes on first reading seem to have minimal connection between each other. However, they are strongly linked by the understandings about the limitation of language and the development of maternal knowledge, based on experience.

Within this chapter it has been theorised that maternal knowledge is frequently gained through incidental learning drawing on as well as resulting in somatic knowledge of mothering. This somatic knowledge is developed from unconscious memories; therefore these bodily experiences can not be totally re-constructed or given meaning in language that is available. This inability results in two potential restrictions: firstly, a restriction in acknowledging differences in maternal emotions, behaviours and knowledges. The outcome of this inability is a limiting of the possible maternal subject positions available to women because, without language, existing subject positions go unelaborated and new subject positions are not able to be constructed (Davies & Harré 1990). Using this understanding, the possibility of the struggle in which women are involved is foregrounded, as they try to construct or reconstruct subject positions as mothers based on their maternal experiences.

The second restriction is the silence about and lack of legitimacy that exists in relation to somatic knowledge as a result of incidental learning experiences occurring during pregnancy, childbirth and mothering. Maternal somatic knowledge requires acknowledgement as the crucial component for gaining maternal competence, and therefore given the same privileged status of other more readily quantified knowledge. Within this context, incidental learning provides women with opportunities to acquire somatic knowledge that is being theorised within this thesis as the taken-for-grant and commonsense ability to mother or the ability 'to play the mothering game'.

Chapter 7

'Capturing' Early Motherhood: Words and Drawings

Victoria: ..... It's been great and it's been hard (half laugh) ... What is it like? ... It's ... it puts you on the spot with a lot of things about your ... expectations and ... ideas and views of the world and ... Yes it's ... something that you just absolutely cannot, you cannot think yourself into that position if you're not a mum (third interview).

This final analysis chapter foregrounds an important understanding gained from this New Mother study, that many of the experiences of motherhood, and the resulting maternal knowledge, exists as what I have termed 'somatic knowledge', i.e. bodily or embodied knowledge. As identified by Victoria, in the above quote, this somatic knowledge is unable to be completely captured in language, and therefore any attempt to develop a framework of common meaning will always be incomplete.

As highlighted in previous chapters the inability to adequately describe or quantify maternal experience and knowledge frequently results in contestation between a mother and others such as health professionals, other mothers or their own mothers. This contestation may result in accusation of a 'conspiracy of silence', due to a perceived purposeful withholding of information about maternal experiences.

To explore the tension between language and the difficulty of representing maternal experience, the four women were asked to draw 'what mothering meant for them' as part of the final group meeting.[1] These drawings and the stories told about the drawings have provided a rich additional source of information about the women's maternal experiences many months after the birth of their infants. This activity of drawings was used as an adjunct to the stories already constructed by the women and to stimulate the construction of additional maternal stories.

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[1] For more information about the structure of this group see Chapter 3.

This chapter investigates the complexity and difficulty of adequately describing maternal experiences to others. The first section starts by highlighting the notion of a conspiracy of silence about motherhood and connects this notion with the difficulty of putting experience into words. The second section uses drawings of motherhood drawn by four of the women to explore their experiences of mothering.

7.1 'Conspiracy of silence?': putting experience into words

Inadequate educational preparation for motherhood is frequently raised as an outcome of what Maushart (1997) identifies as the 'conspiracy of silence' or the silence and outright lies about the 'realities' of motherhood.[2] The reasons for this purported conspiracy of silence are expanded on by LeBlanc (1999) to include women's reluctance to take responsibility for emotionally scaring pregnant women; mothers of non-mothers wanting grandchildren; the fact that women 'forget'; that women have selective memories, remembering only what they want to remember; to take revenge on other women; or the sense that women feel vindicated in their maternal struggles when they see other mothers struggling. The impression provided by Maushart and LeBlanc is that women are not told or provided with accurate information and that they conspire and lie about motherhood.

However, is this lack of information about motherhood a conspiracy of silence?: or could it, in many instances, be due to the limitations of the available discursive constructions to adequately describe the experiences of childbirth and mothering? These maternal experiences, as identified in previous chapters, are recalled as memories that only partially represent the experiences, but they assist in providing meaning. Using poststructural theorisings of experience, Weedon (1997, p. 33) suggests that experiences are given "... meaning in language through a range of discursive systems of meaning, which are often contradictory and constitute conflicting versions of social reality ...". Meanings are projected onto experience

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[2] The belief that a 'reality' exists about motherhood is problematic as it signals the belief that there is a universal experience of motherhood. This belief has been discussed in previous chapters, in particular, Chapter 2.

using language and the meanings of previous experiences that are available, rather than experiences having preset, universal or innate meanings. Davies and Harré (1990) argue that meanings are dependent on the positioning of the subjects who are part of the speech act or conversation. These speech acts are the discursive practices that produce the social and psychological 'realities' of an experience. The resulting discourses constitute subjectivity that is not fixed as words or meanings, as subjectivity is always open to the possibility of changing (Ball 1990).

An understanding that developed during this New Mother study was the difficulty and at times impossibility for the women to adequately describe or put into words the intensity of their experiences, their feelings and the new understandings they had developed. Nevertheless, the women were actively making meaning from their maternal experiences through generalisations and the identification of commonalities with other women's experiences and their past experiences of being mothered. These attempts at making meaning of their experiences often resulted in an acknowledgment of the potential for somatic knowledge to develop. Somatic knowledge, I am theorising, enables a woman to automatically respond to their infant's needs or physical state, but the woman is unable to discursively construct this maternal knowledge. The potential difficulty with the identification of somatic knowledge is the ease with which it can be subjugated by more formal forms of knowledge that are expressed through the use of language, as discussed in Chapter 6.

In this section five extracts will be used to explore this proposed inadequacy of language to describe maternal experiences. These extracts highlight; first, the frequently identified conspiracy of silence about motherhood; second, the potential to silence women when they identify an infringement of the discourses of motherhood which may reflect on their maternal competence or commitment; third, the difficulty of transforming experiences into language; and finally, the improbability of gaining a common meaning for understanding experience.

In this first extract, Lisa troubles the notion of a conspiracy of silence which is frequently referred to by mothers in statements such as 'why didn't anyone tell me it

would be like this?' Lisa constructs an explanation for the seemingly conspicuous lack of accurate information that is available to women to adequately prepare them for childbirth and motherhood.

Lisa: I was reading a book and the woman talked about this conspiracy of silence ... and in a way that is what it seems like .... Because women don't talk about the birth, the experience, you think it is a conspiracy of silence. But that implies something deliberately withheld, which I don't, don't think there is. I don't think women are deliberately withholding, it's just really difficult to explain it ..... to talk about the level of experience (third interview).

Lisa provides a considered response to my question about the existence of a conspiracy of silence. There are two points of tension in Lisa's story. Firstly, the tentative acknowledgment of the existence of a conspiracy of silence — *in a way that is what it seems like.* Secondly, a counter argument is offered for the lack of information about motherhood — *it's just really difficult to explain it.* Lisa's response identifies the difficulty of explaining or talking about an experience, rather than as a deliberate silence or an outright lie to keep this information from women, as proposed by Maushart (1997).

This identification of the difficulty of capturing the meaning of an experience is not new; Melamed (1987) notes within her work on 'playful learning', that women frequently reported they understood something, but could not translate it into words. Haug and others (1987) describe how different stimuli were used to elicit bodily sensations when trying to facilitate the recall of childhood memories that had been resistant to general story telling. Oakley (1986a) also identified the difficulty of constructing the experiences of childbirth and mothering into language in her research on motherhood. Oakley troubles existing descriptions of childbirth and raises several possibilities to explain this difficulty of finding accurate descriptions:

> *How can the experience of childbirth be described? Does it defeat words? Or is it twisted by being trapped* within *words so that an event powerfully experienced is reduced to a technical account, a recitation of medical manoeuvres? Some people find it easier than others to put their feelings into words. Questions provoke answers, but answers may only be clues, signposts. Statistics sketch another kind of partial picture; to know how many women had what kind of pain relief during labour is not to know how much pain was relieved; to be told how many babies were*

> *tugged or persuaded into the world with forceps, is not really to know more than that* (1986a, p. 85). (Italics Oakley's emphasis)

Oakley has highlighted the difficulty of describing complex somatic experiences by reinforcing the point that these attempts to capture the experience in words are only descriptions or constructions and not the 'authentic' experience. The descriptions are always made in hindsight and are always inevitably only a partial reconstruction of the experience. The concept that these answers may only be clues, signposts or a partial picture of a complex bodily experience is a significant understanding of the difficulty or even the impossibility of adequately assisting women to learn about and prepare for the experience of childbirth and mothering. In addition to these understandings about experience, the possibility of an event resulting in an unconscious memory exists. This understanding places some memories beyond the reach of consciousness, resulting in a limiting of a woman's ability to express her memories of feelings, events or behaviours in language. However, it does support the notion that 'we know more than we can tell'.

In this second extract during the third interview, Julia also responds to a question about the existence of a conspiracy of silence surrounding motherhood. This response constructs the possibility of a conspiracy existing by identifying a concern by women of being branded as 'bad', 'uncaring' or 'inadequate' mothers if they talk about their negative feelings of motherhood. This concern of infringing the dominant, approved discourses of motherhood is constructed as effectively silencing women from talking about the difficulties and frustrations of mothering:

Julia: .... To some extent yes ... I think a lot of women don't say things because they're worried that they will be branded a bad mother. You know, like .... 'I wanted to lock the baby in the room and go for a walk without her', sounds like you're a bad mother ..... So I don't think people tell you these things ... They keep them to themselves, ... which I think is really silly, ... because I think we've all had those days.

Julia's response confirms her belief in the existence of a conspiracy of silence surrounding motherhood. A proposal is offered by Julia that these silences about mothering are used by women to avoid infringing the approved discourses of

motherhood, as the sharing of negative information about mothering has the potential to challenge the construction of and régimes of truth about a mother always being loving and protective of her baby.

Julia's concerns that a woman *will be branded a bad mother* have the potential to silence or limit the sharing of information with others about the negative aspects of motherhood. These concerns can be identified as having a long history. In her historical mapping of nineteenth-century French motherhood, Badinter (1981) identified a portrait of the 'bad' mother as 'incapable, absent or unworthy' an opposite to the attributes of the 'good' mother as 'capable, present or worthy'. During this period Badinter proposes that mothers were unable to be conceived as partly 'good' or partly 'bad'. Women could only occupy a position of either the 'good' or 'bad' mother. In an earlier discussion in Chapter 4 about the ambivalence of motherhood, the possibility has already been alluded to of this type of infringement of the motherhood discourses; when maternal emotions of love and hate co-exist women are potentially positioned as 'bad' mothers.

This reluctance or even inability to share negative information about motherhood or to ask for assistance with the accepted tasks of mothering are in most probability learned behaviours incorporated into women's unconscious and conscious memory from early childhood and reinforced by the circulating discourses of motherhood.[3] These learned behaviours or 'feel for the game' result in a maternal habitus that conforms to and reproduces a specific cultural context. As identified in previous chapters, a confounding feature of these discourses of motherhood and the resulting maternal habitus is the widespread taken-for-granted acceptance that many of the more mundane, frequently frustrating and difficult tasks of motherhood are mandatory. Women therefore, position themselves and are positioned by others as no longer having choice about taking responsibility for these tasks (Weaver & Ussher 1997). So if a woman wants to be acknowledged as a caring and competent mother,

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[3] For example, Walkerdine & Lucey (1989) in their research on the regulation of mothers and the socialising of daughters demonstrate how mothers are expected to provide a pedagogy of the home which will socialise daughters to conform to societal expectations of the woman as mother and homemaker.

she must accept the tasks and behaviours of a mother with minimal questioning, complaint or resistance to the demands which are placed on her behaviour and the expressions of her emotions. To achieve this accepted and expected behaviour women provide self-governance, as Julia demonstrates by monitoring her behaviours and feelings.

On the other hand, Julia's acknowledgment of the possibility of a conspiracy of silence may be due to the difficulty of putting the experience and the resulting feelings into words to construct a common meaning that more accurately reflects her behaviour and feelings. The feelings which are evoked when a mother wants to *lock the baby in the room and go for a walk without her* may be impossible to describe other than in these seemingly negative statements, but which potentially portrays the maternal frustration, never ending maternal responsibility or desire for a period of being unencumbered emotionally and/or physically by their infants.

Jane's response about forewarning women of maternal sleep deprivation provides a further understanding concerning the difficulty of developing a common meaning for experience. This example of sleep disruption is used to illustrate Jane's new understandings of the demands on a mother during the third interview when Tim was seven months old.

Jane: I don't really think there is much more you can do to ... warn anyone other than just don't ... I mean people can tell you you're not going to get more than two hours sleep at a time, but you can't really ... imagine what that's going to be like until it's happening.

Jane acknowledges that she was told about the experience of existing on a limited and disrupted sleep pattern, but was unable to comprehend what it would be like until this disrupted sleep pattern had been experienced as a new mother. Jane's understanding highlights the inter-relationship between experience and somatic knowledge. A theorisation can be developed about this inter-relationship that the bodily experience of disrupted sleep produces somatic knowledge about this experience.

Developing somatic knowledge of an experience allows Jane to speak with authority about the experience, as she has done in this extract. This knowledge will also possibly allow her to make meaning from another woman's experience and descriptions by drawing on her somatic knowledge of disrupted sleep. However, this meaning made from another's experience of disrupted sleep will probably not be reflected in words other than comments such as: 'I know how that feels' or 'I can remember how awful that lack of sleep was'. So rather than expecting language to reflect the 'true' meaning of an experience, an alternative understanding is being used, that only a partial meaning can be constituted or constructed in language in an attempt to represent and share this somatic knowledge.

During Heather's third interview she described her labour pains as — *racked, absolutely like your whole body is just ... gripped in this awful vice like pain; oh god I've just got to give up like I can't ... I can't deal with this any more;* and *the most underrated thing that pain.* In response to this description, I asked if she thought she could adequately describe the pain to someone else?

Heather: ..... I don't think so ... I don't, ... I don't, you know, you can describe it like I've just described it, but until you've experienced it ... I don't think you can comprehend it ..... You know, people said to me they're like really bad period pains. So I suppose I had a concept of maybe what it felt like, but I was lucky I didn't have back aches, she wasn't, you know, posterior or anything, and so it can be worse than I had ..... So ... I just, ... I just really, I was quite shell shocked by that pain, you know, for several days after.

The first part of this response is broken into three components: not being able to describe the pain *I don't think so*; an acknowledgment of trying to quantify the pain *you can describe it like I've just described it*; and the understanding that the ability to comprehend was missing until you have experienced something: ... *I don't think you can comprehend it.* The intersection of *I don't think so* and *you can describe it* demonstrates a possible struggle to capture and discursively construct the experience of pain which still remains elusive.

Heather makes a conditional statement about the ability to describe the pain *but until you've experienced it ...I don't think you can comprehend it.* The difficulty identified by Heather in comprehending the feelings of pain is possibly due to the inability to objectify and measure pain. This difficulty of quantifying pain has been raised by Madjar (1997, p. 62), who suggests that "... pain has the capacity to enter the every fabric of one's body and to destroy the familiar, taken-for-granted being in the world". This destroying of the familiar and taken-for-granted could also be extended to the other feelings and emotional turmoil which can be associated with motherhood and the similar difficulty of being unable to objectify and quantify these feelings.

The reference to *until you've experienced it,* positions Heather as 'knowing' and as a subject who can speak with authority about the pain of labour. This reference also foregrounds her lack of 'knowing' and of being unprepared prior to the experience of labour. Even though Heather has experienced labour, her efforts to objectify and measure the pain is achieved with minimal success. She talks about the pain in several ways as: an object — *it;* a comparison between types of pain in an attempt to find a common understanding or experience of pain — *like really bad period pains;* and to quantify and grade the pain — *it can be worse than I had.* The difficulty remains that sensations and feelings cannot be fully quantified, as theorised in Chapter 4, and that they are often generated within unconscious memory. So until a woman experiences a similar context or pain, the unconscious memories of the pain or other bodily sensations may not be accessible. So pain, other than in general terms, in most probability evades the descriptions that are provided by women about their experiences of labour.

Heather incorporates the use of a medical discourse by referring to the position of her daughter in utero, as *posterior,* as a means of comparing her labour with other women's labours. The comparison has two potential outcomes: firstly to allow a measurement to be made against an accepted norm that if the baby is in a posterior position the labour is expected to be more painful. Secondly, quantifying the pain has a potential effect of minimising the construction of the pain's intensity, as an understanding is provided that the pain could have been *worse than I had.*

Heather's attempts to discursively minimise her pain through comparison are quickly countered and contradicted by her final statement *so ... I just, ... I just really, I was quite shell shocked by that pain you know for several days after.* The hesitation and repetition of *I just* and the use of *shell shocked* to describe her behaviour provides an impression of becoming overwhelmed and made speechless by the experience. A withdrawal from the world for several days, a distancing to provide a space to take on new positions and possibly a way of closing off the 'rawness' of the experience. The description of *shell shocked* is related to a war experience and implies a battering of the sensory system.[4] This concept of *shell shocked* goes beyond a more generalised position of being shocked, and therefore potentially reflects the struggle Heather was encountering trying to construct a subject position in response to her experience of labour and childbirth.

The ability to take on common meanings for experiences and words is a point of conflict, which will always be present, due to the constantly shifting and complex meanings of discursive and non-discursive practices as a dimension of cultural and social change. According to Thorpe, Edwards and Hanson (1993, p. 1) "how and what we learn is an expression of our culture, whatever form that takes". So the making of meaning is being constructed as an active process, which is dependent on the subject's social and cultural position and the resources they have at their disposal (Fairclough 1992). Subjects are actively positioned and re-positioned within the meaning making process through the discourses they use to describe their experiences. Two potentially contradictory subject positions are constructed within Heather's story: the first position of being in control because the pain could have been *worse*; and the second position was of being out of control or *shell shocked.*

In this final extract, Victoria constructs an explanation of the complexity of capturing the meaning of an experience into words and the possibility for variations in

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[4] The Oxford Dictionary defines shell shock as a '... nervous breakdown resulting from exposure to bombardment and other battle conditions' (Sykes 1976, p. 1050).

interpretation. Victoria's explanation was in response to a question about the relevance of the information supplied about labour and parenting.

Victoria: No, because I think they can tell you what it's like, but you still, you perceive it, ... you might perceive it completely differently. It's just words, it's just descriptions ..... and you make, make a mental picture out of this ..... and that might have to do with your previous experience ... Do you know what I mean? ... Like someone tells you about the yellow jumper. The yellow that they might be talking about is not the yellow that you have in your mental picture. They might talk about the lemon yellow and you sort of think about a honey yellow..... So I think, you know, even though the information was, is very well set out on paper and I think the midwife in the antenatal course did a really good job in telling us about it (second interview).

The use of the colour *yellow* provides a rich example of the impossibility of providing a universal meaning. Victoria identifies words as a medium for constructing meaning, which is created through interacting with others within environmental, emotional and social contexts. Or as Weedon (1997, p. 24) notes, by drawing on Derrida's understandings, a plurality of meaning is present because "... the signified is never fixed once and for all, but is constantly *deferred*" (original emphasis). Using the example of the multiple interpretation of the colour yellow clearly highlights the complexity and potential for disagreement about meanings formulated by women about their experiences of childbirth and mothering. This understanding results in an acceptance that meaning is constantly open to multiple readings and reinterpretation. Or in the words of Boud, Cohen and Walker (1993, p. 10-11) in a specifically educational context:

> we may use language and ideas to express meaning, and in the process use externally defined objects, but only the person who experiences can ultimately give meaning to the experience. In working with others, we attempt to share meaning and we can reach commonly accepted interpretations of the world which operate within that context, but these can never fully define the experience of the participants.

Using these understandings about the development of meaning, positions the subject as having to actively participate in the making of meaning and the resulting knowledge. Victoria's comment supports Boud et. al.'s (1993) statement that a person can be told about an experience but they may construct it differently from others. These understandings are crucial as they signal the potential for multiple

meanings to be constructed from an experience, the lack of a singular truth and the difficulty of sharing the meaning of an experience with others.

The notion that language has limits and is unable to adequately describe much of the somatic knowledge of an experience remains a constant difficulty within research about mothering. The inability to know if one woman's description of an experience is the 'same' as another highlights the possibility of multiple and shifting truths, thereby rejecting the notion of a universal truth about the meaning of experience. So, rather than the existence of a conspiracy of silence, it is probable that there is an inability to develop a universal, complete or adequately communicable meaning for experience. These understandings about the lack of available words to describe an experience require an acceptance that there will always be unknown and inexplicable factors and sensations which have to be negotiated in all experiences.

7.2 Drawing the words to describe motherhood

The difficulty of discursively capturing the experiences of mothering became an intriguing problem for me as the interviewing process within this New Mother study neared completion. To try to develop a greater understanding of the stories that had been constructed by the women of their maternal experiences, the group meeting was used as an opportunity to try to elicit some of the women's somatic knowledge into language by the use of drawing; coloured felt pens and white paper were supplied to the women with a request that they draw 'what mothering meant for them'.[5] No other instructions or prompts were provided to the four women — Zoe, Meredith, Jane and Rebecca.[6] Initially, Rebecca was reluctant to draw, but the other women provided supportive encouragement and reassurance that her drawings would not be

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5 Unfortunately, only four women were able to attend this group meeting. None of the women had met before and were unaware of each others' backgrounds. At the beginning of the group the women introduced themselves by their first names and the only additional information provided at this stage was about their child's age and sex.

6 I left the table and prepared afternoon tea — this action I had decided was important to assist in physically removing myself from the process.

laughed at. After the drawings were completed, which took about ten minutes, the women were invited to show their drawings and talk about what they had drawn.

Drawing has been identified as a method commonly used with children (DiCarlo, Gibbons, Kaminsky, Wright & Stiles 2000; Carroll & Ryan-Wenger 1999; Klepsch & Logie 1982) and adults (Miljkovitch de Heredia, R. & Miljkovitch, I. 1998; Bower 1995) to gain a greater understanding of their psychological state and to assist with healing.[7] The use of drawing has been identified as assisting a person clarify the meaning of their experience (Kaye 1998). Drawing can also be constructed as a form of communication that can be basic and elementary, or allow a person to speak eloquently through the use of a pictorial language (Klepsch & Logie 1982). The potential value of drawings for the purpose of this research study has been to provide an adjunct to the interviews, to stimulate the construction of additional stories about maternal experience. A significant understanding about drawing is its lack of dependence on spoken or written language. Children, for example are able to draw long before they can write.

The following section explores the stories constructed through the use of the drawings. These drawings were used as a mechanism to stimulate maternal storytelling; therefore the drawings are being used as an adjunct to the research, rather than a central part of the research process.[8] The drawings and the accompanying stories provide differing views of the struggle to learn to mother. Jane's story is of depression and sadness; Meredith provides a story of learning and final body peace; Rebecca tells of her surprise at how hard the early months of mothering had been and of being unprepared for the somatic experiences of childbirth and mothering; and Zoe tells of gaining an understanding of the importance of sharing the responsibility of caring for her baby.

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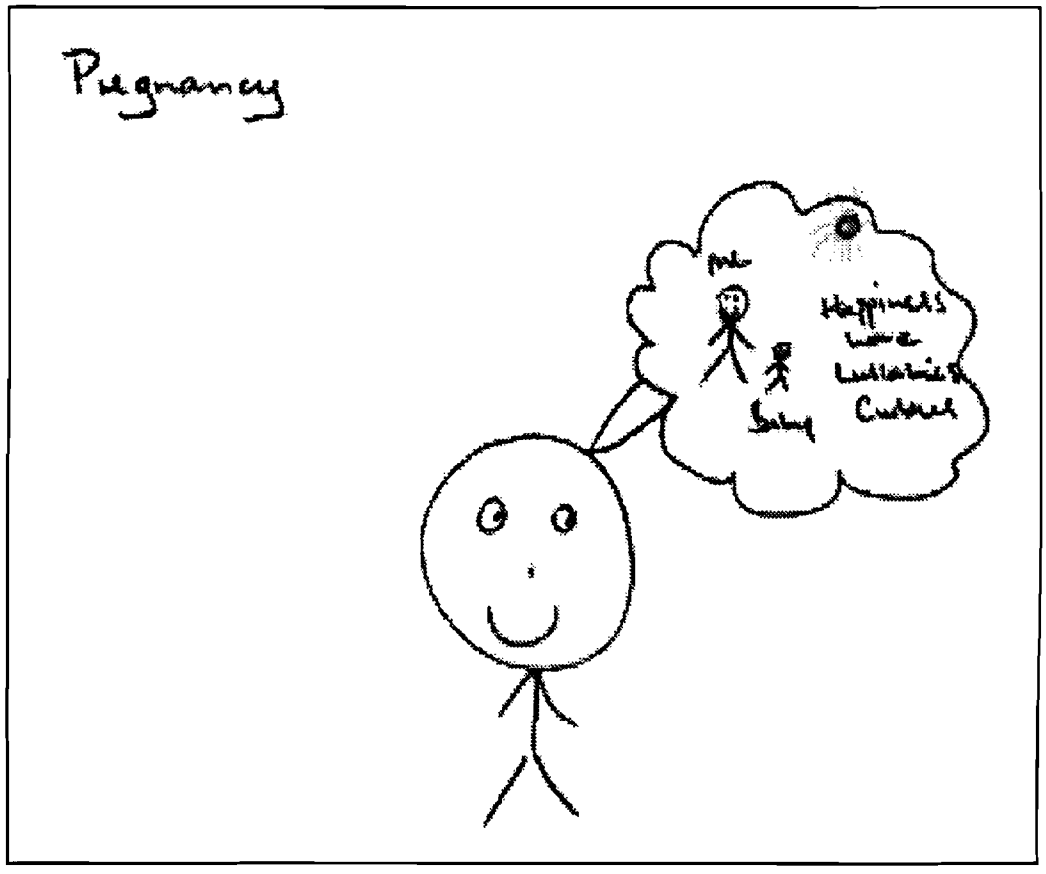
7 The drawings are not being used to act as a mechanism to reveal the 'hidden self' of the subject as is proposed within much of the psychological literature about the use of drawing. For example, see the work of Klepsch & Logie (1982) and Leibowitz (1999).

8 A great deal of analytic work could be done using these drawings, although for the purposes of this thesis the main focus will be on the stories constructed by the four women about their drawings.

The stories will be discussed in the sequence in which the women told them during the group meeting. The first drawings were by Jane who was eager to show two drawings she had completed.[9] The first is of her pregnancy and the second as a mother.

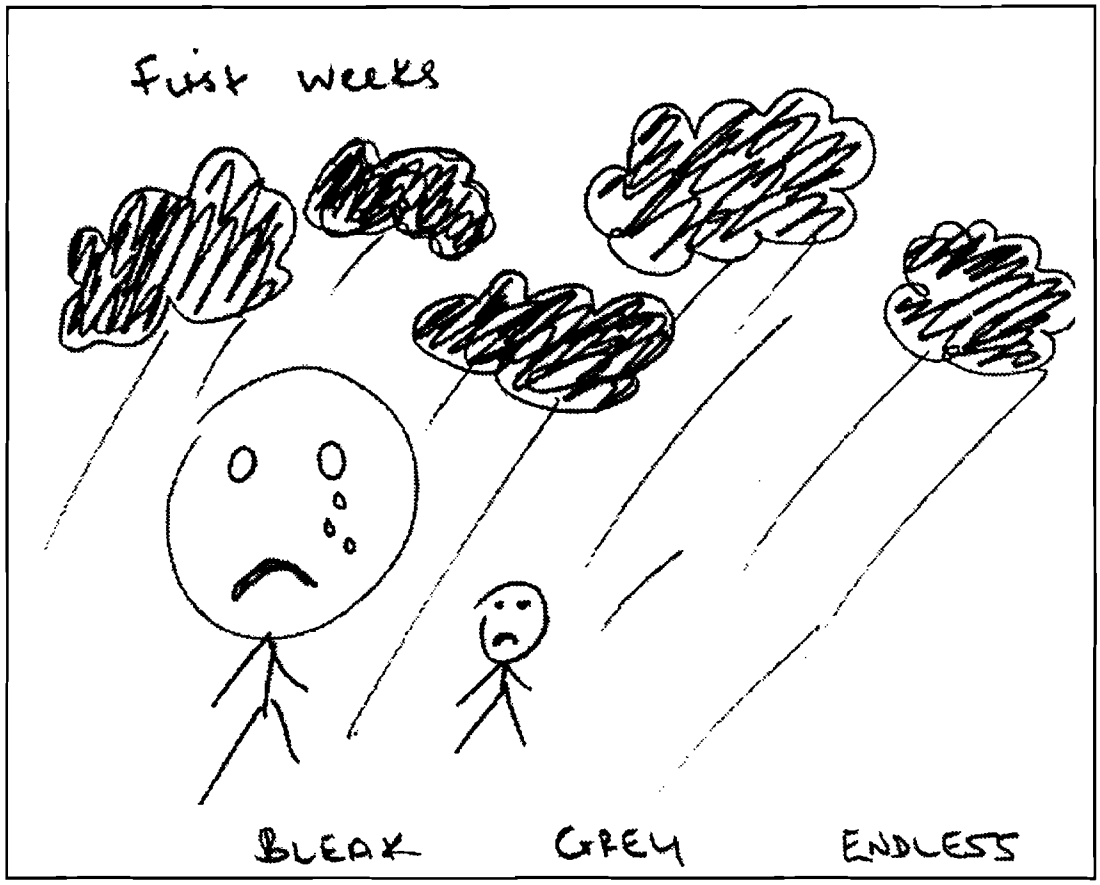


[9] Jane's response to the process of drawing and her eagerness to share her drawings with the other women, surprised me. My impressions of Jane were of a withdrawn, vulnerable and very 'private' woman who was very selective about who she would talk to about her feelings.

Jane: Do you want to have a look? [yes] ..... Its simple ..... I guess my pregnancy is basically imaging what its going to be like ... which is good. (laugh) ..... The reality, I suppose, looking back is just yuk and bleak. I mean nothing really stands out that much except its all blah, you know ..... Yeah its .... yeah nothing really happened as such, but it's just all very miserable. I think for me anyway ..... (Tim was now eleven months old).

Jane starts with the drawing of her pregnancy (also see Appendix 2) which predominantly uses the colour blue. Jane depicts herself as the central stick figure on the page, a speech bubble contains a smaller image of herself and a young child, with the words which are associated with the discourses of motherhood frequently depicted in the media and literature — *happiness, love, lullabies, cuddles.* There is no physical connection with the child in the speech bubble, but the words provide an emotional connection.

The description of the pregnancy Jane provides is consistent with her positive comments during the first interview and her excited anticipation of motherhood. Jane is positioning herself as enjoying pregnancy — *I guess my pregnancy is basically imaging what its going to be like ... which is good (laugh).* The laugh at the end of the statement can be read in two ways as a signal of joy and amusement, because as Jane talks she may be eliciting the pleasurable somatic sensations and unconscious memories of her pregnancy. The laugh could also be read as irony and disappointment, as she reflects on her memories of desire and fantasy about what it was going to be like to be a mother. From the tone of the laughter disappointment is the most probable reading.



The second drawing (also see Appendix 2) is in stark contrast as it is drawn in black. The drawing covers the entire page with the stick figure representing Jane, drawn on the first third of the paper. The figure representing the baby is unconnected to the mother figure. The facial expressions are of down-turned mouths and tears are coming from the mother's left eye.

The background of the drawing consists of black storm clouds and sheeting rain. The words which Jane uses to describe motherhood — *BLEAK, GREY* and *ENDLESS* — reflect the darkness of the drawing and her construction of the early days of motherhood. The lack of a physical or emotional connection between the two stick figures of mother and baby and the words used position the figures as potentially alone and emotionally unconnected. The description of this drawing provided by Jane uses words that describe feelings or moods — *bleak, yuk and miserable.* These words are not the accepted public discourse to describe maternal experience, thereby

providing an opportunity for Jane to be discursively constructed as sad or disappointed, or even as the selfish mother who should be grateful she has a healthy baby.

The potential difficulty of capturing the experiences and emotions of the early months of mothering are highlighted in Jane's words and the drawing. Through her statements a contradiction is occurring; on the one hand Jane minimises her experience by the statement — *nothing really happened as such* — but on the other hand she quickly clarified the statement — *but it's just all very miserable.* This contradiction may be an example of the struggle that Jane has been experiencing in trying to find the words that adequately describe her maternal experiences and the disappointment she has encountered. Without these words to construct her experience, Jane is potentially limited to the discourses that are available, and therefore this lack of discursive construction restricts or influences the subject positions she can construct for herself or that are constructed for her by others. For example, Jane has constructed a subject position of experiencing emotional difficulties through her words and the second drawing of despair, vulnerability and misery.[10]

As soon as Jane had finished talking about her drawings, Meredith immediately started telling her story. Meredith's response of — *that's not my experience at all* — immediately signals that she is constructing her experiences differently from Jane's experience of motherhood. Meredith has used two drawings to provide her impressions of motherhood. The first drawing (also see Appendix 3) is constructed in three sections using different colours to assist her in defining her experiences and feelings.

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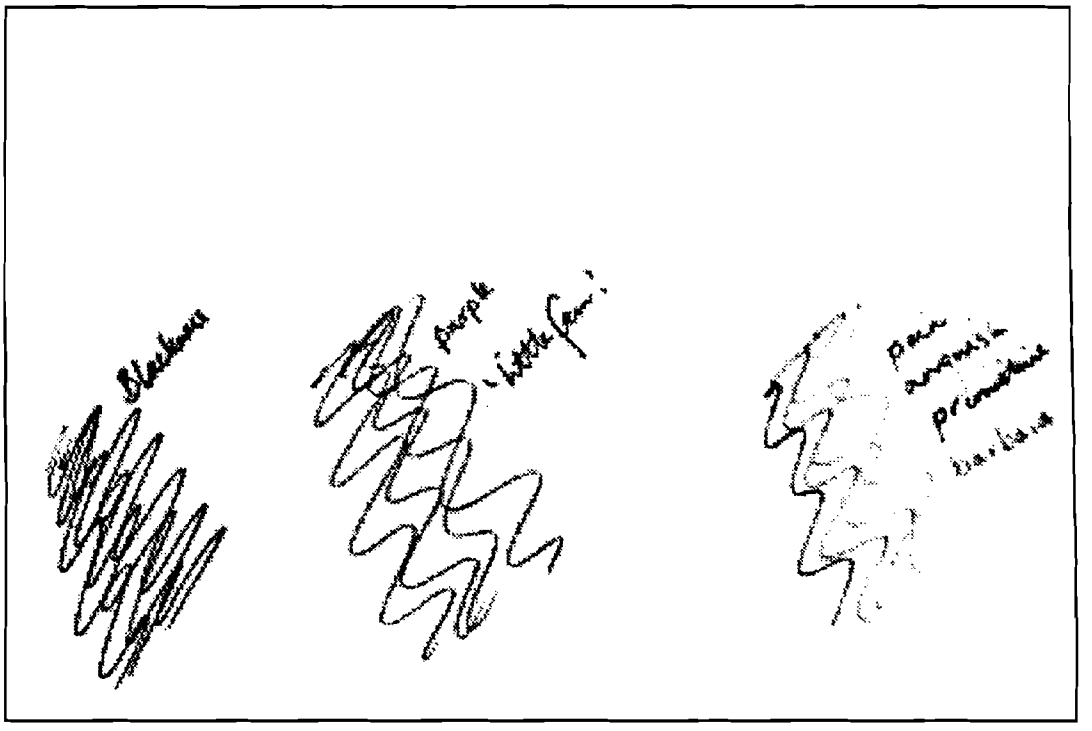
[10] In the third interview when Tim was seven months old, Jane had told of her experience with postnatal depression and her need for medical intervention. Knowing about Jane's experience of depression can be used to explain the darkness of her drawings and the distress which is portrayed.



Meredith: That's not my experience at all..... I did mine in colours ... and think in my body .... This is my uterus ... and that's blackness, that's what I thought of motherhood for a long, long time and I was never going to have a child. And once I could change my image of my uterus ... then it became purple, a feminist colour and I thought ... I called my baby little fem and that's how I felt very positive about him ... That I was growing a feminist ... And then, ... and then the red parts, the labour, the pain and the anguish, ... but the good clearing out ... And then after he's born its all gold because I realised he's what I needed ... to fully ... cleanse myself, and feel like I've got all of me back. And I changed from having this black part of me to a really gold ... beautiful part ... and ... we ..... I don't think of the first part ..... things just got better and better from here... Even though it was hard for me at that .... you know, of course when he's born and everything ..... We went away you know two weeks after I came from hospital ... for the weekend with friends and it went well and all those sorts of things ... So all though I felt you know a novice and and like .... that, it was a huge learning curve and everything like that it was ... it was ... still far outreached what I'd hoped it was, you know, was the best I could hope it would be ... So ..... yeah, so it was really positive ..... (Daniel is now twelve months old).

Two statements are made to commence her story — *I did mine in colours* and *think in my body.* The first statement about the use of colour seems to be a purposeful act or a way in which she can relate motherhood to a meaning system that she may have constructed about different colours. The second statement implicates her body and the possibility that her body holds knowledge or memories. The story Meredith tells is complicated by the knowledge that she had experienced father-daughter rape.[11] The first black squiggle could be identify as Meredith discursively constructing her memories of rape as being associated with blackness, and a blocking out or disassociating of her emotions from the physical act of rape.[12] This blocking out acts to eliminate or restrict the ability to construct subject positions, in particular, for Meredith a subject position of a mother, as she states *I was never going to have a child.* A negative link is being constructed between her uterus and motherhood. The squiggle she has made to represent the blackness of her uterus is more intense and compact than the other squiggles she has produced. This black squiggle potentially provides a feeling of tension and closure.

An active process or possibly a struggle is implied through her statement *once I could change my image of my uterus.* The use of *could* suggests that something had been stopping her from changing her image of her uterus. This statement seems to indicate a change in the way Meredith discursively constructed her uterus, possibly from a place of being abused and contaminated, to a place of birth and renewal.

The second squiggle of *purple* is constructed as signifying feminism and therefore for Meredith a positive way of identifying her unborn son as *little fem.* The belief that she was *growing a feminist* appears to be signalling a significant beginning step in emotionally attaching to her unborn son. Meredith, as discussed in Chapter 4, had wanted a daughter, so thinking in this way about her pregnancy and her unborn son

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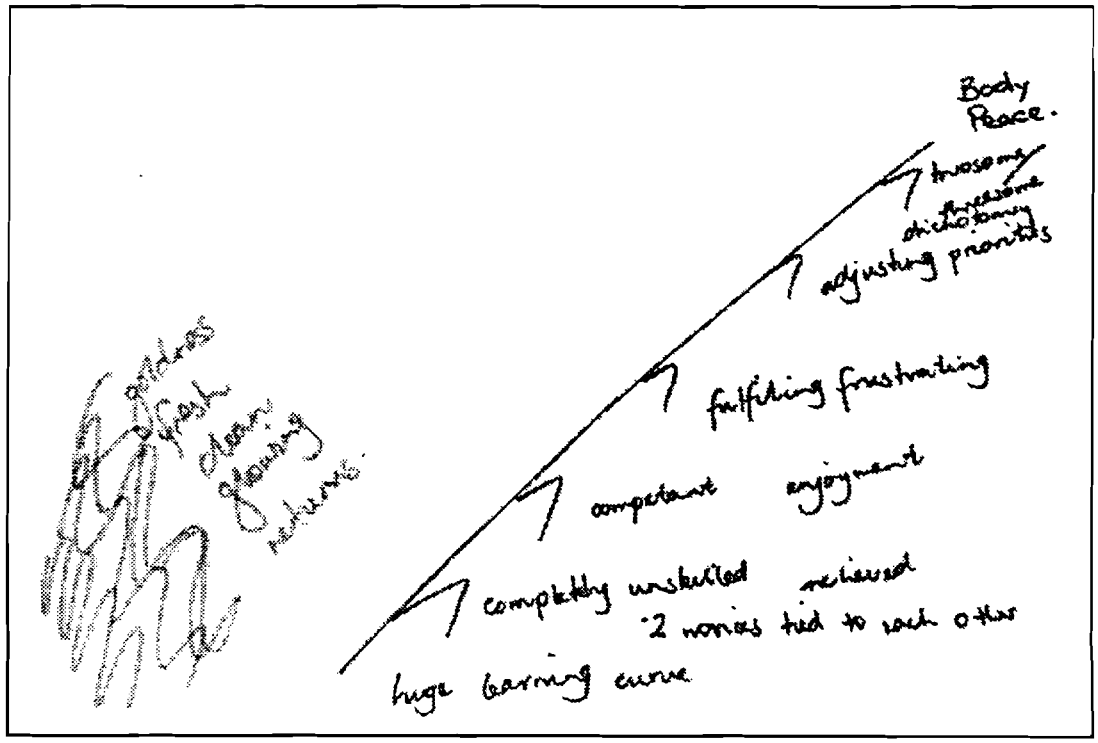
11 The other women in the group were unaware of Meredith's experience of rape. If I was also unaware of this knowledge of Meredith's past history her transcripts would possibly be read in different ways (see Chapter 4).

12 I am making an assumption that black is used to signify a negative attribution of lifelessness and being unclean. According to Kitzinger (1992b) it is common for women who have been raped to emotionally dissociate from their bodies when placed in situations where they believe control of their bodies has been lost, such as during childbirth.

possibly indicates her desire to ensure her son does not have the negative masculine characteristics of her own father. By calling her unborn child *little fem* she discursively constructs a subject position for her son, and therefore starts to allow herself to potentially consider an alternative position for men and a position for herself as a mother.

The third squiggle is red and the comment of representing the labour as *the pain and the anguish,* is consistent with Meredith's descriptions of the birth in previous interviews as difficult. Her comment suggests that the *pain and anguish* is balanced by the *good clearing out* resulting from the birth; it is possible that the labour and birth acted as a cathartic experience which resulted in a symbolic cleansing of her experience of rape. *Pain, anguish, primitive* and *barbaric* are powerful words used to describe the labour, in particular, *primitive* and *barbaric* which imply a reversion back to an uncivilised time of cruelty. These descriptions are in stark contrast to common expectations that medical science has the ability to control the body during childbirth or that childbirth is a joyful occasion. Of course, Meredith's powerful description of her childbirth experience must be converted into a meaning by the listener or reader, as the words are not, in themselves, somatic sensations but representations of an event. As discussed in the previous section, these words can have the potential for vastly different meanings, depending on the reader's experience of childbirth and/or other types of body pain and the resulting feelings of lack of control or power.



The second page of drawings (also see Appendix 3) continues with a fourth squiggle of yellow with words written beside it of *goldness, fresh, clean, glowing* and *returns.* The imagery provided — *its all gold* — to describe her experience after the birth of her son can be read in two complementary ways that gold denotes value; and sunshine, radiance and happiness. Her baby son is attributed with the outcome of being *what I needed .. to fully .. cleanse myself, and feel like I've got all of me back.* This outcome is attributed to her son, although it is possible that Meredith was referring to the act of having a child, as it potentially allows her to rewrite the script of motherhood and lay to rest the ghosts of her past. Meredith positions herself as now being whole — *I've got all of me back.* Within this positive statement, an intersection occurs of *things just got better and better from here* and a clarification of her meaning *even though it was hard for me,* which relates to the difficult tasks of mothering, that mothering has not been something that 'just happened'.

The final section of the second drawing is a purple diagonal line with arrows facing upwards with words providing a form of progression as Meredith learned to mother. The words acknowledge the *huge learning curve* Meredith has been experiencing

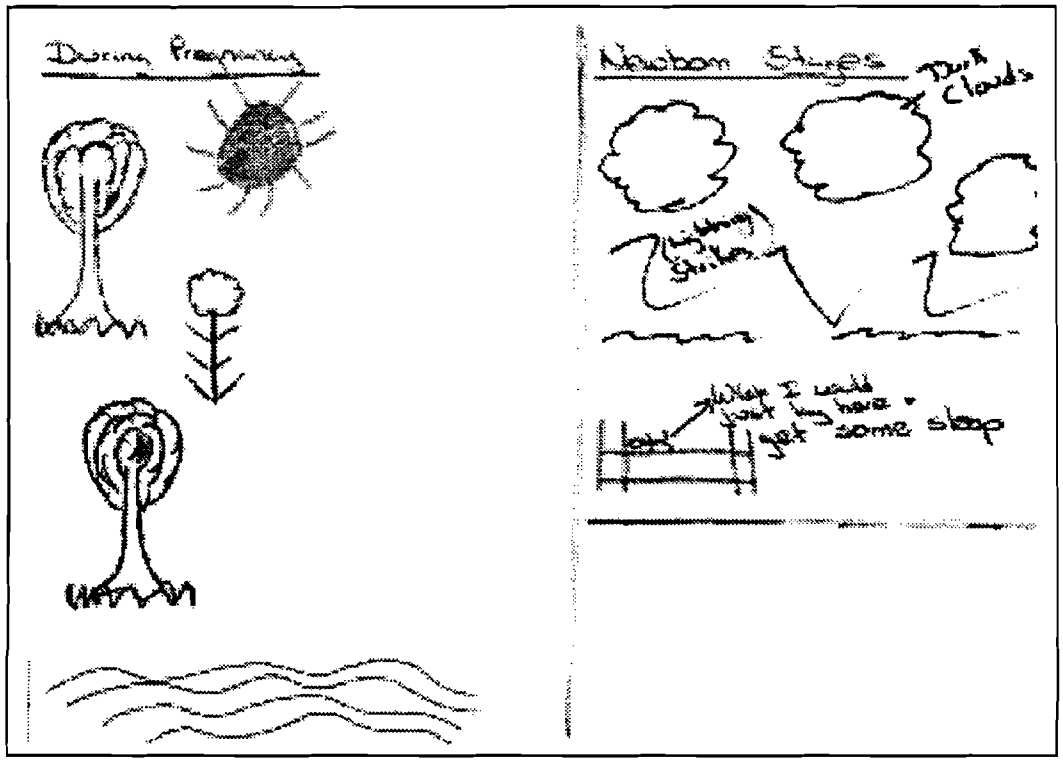
and the various positions that she has constructed during this learning curve. These positions included *completely unskilled* and *competent*, to a final position of *body peace.*

In several instances the words used together on the drawing appear in opposition: *fulfiling* and *frustrating,* and as unconnected: *completely unskilled* and *relieved.* These words give the impression of tension and contradiction, but also a balance between the feelings these words evoke.

The work of family adjustment is alluded to in the final words of her learning curve — *adjusting priorities, dichotomy, threesome/twosome* — the threesome could be the inclusion of her partner, though this inclusion seems fleeting as she reverts back to the notion of the twosome. In her final statement Meredith provides an impression that motherhood has been a positive position to occupy resulting in a gaining of *body peace*. The meaning of *body peace* can only be guessed at as contentment, negation of her experience of rape and possibly a sense of fulfilment.

The story that complements the drawing of her learning curve includes friends who went on a weekend away. The importance of these friends to the story is possibly that this weekend was the first time her maternal skills were on show to others and an important experience that contributes to Meredith's ability to construct maternal subject positions. An acknowledgment within the drawing of the novice level of competence as a mother is extended to her baby as also being a novice, that this experience is new for both of them, and that a position of learning is being constructed for both of them.

The drawing (also see Appendix 4) completed by Rebecca consisted of two drawings on one page. Rebecca was far more tentative about showing her drawing than either Jane or Meredith. Within the story Rebecca constructs tentative links to nature through her use of metaphors of sunshine and thunderstorms.



Rebecca: ..... During pregnancy ... I was sunshine ... I had a wonderful pregnancy ... I wasn't sick or anything like that ... so I couldn't complain about that ... even though my labour ... I really couldn't complain about the labour either .... I wouldn't say that it didn't hurt, but it was nothing like I thought it was going to be.

Meredith: No wonder she's going for round two so fast (group laughing).[13]

Rebecca: I'll see what happens. (laughing) ..... I would probably say the first four months, five months was a bit of a blur for me, ... cause I was the sort of person who always liked their sleep and things like that ... And this getting up every four hours and this feeding ... The newborn stage, I thought it was just like a thunderstorm that hit me ... I really didn't know what hit me ... I didn't have any idea, although I tried to imagine how hard and what it was going to be like ... It just was nothing to what I really honestly had been through ... and he's been a good baby ... But it was just that lack of sleep ... That sleep deprivation that got to me ... (Marcus is now twelve months old).

The first drawing representing Rebecca's pregnancy takes more than half the page. The words used to portray her pregnancy provide the impression of a positive

[13] Rebecca was seven months into her second pregnancy at this group meeting.

experience. A metaphor of *sunshine* is used and she emphasises how wonderful her experience of pregnancy had been. The labour experience was not drawn, though it is mentioned as a connecting event between pregnancy and mothering. The labour being different than expected potentially highlights the difficulties of sharing or trying to educate women about the bodily experience of labour. This theme of surprise about the experiences of labour continues as Rebecca talks about her inability to prepare herself for mothering during the first few months, even though she had *tried to imagine how hard* it would be *and what it was going to be like.*

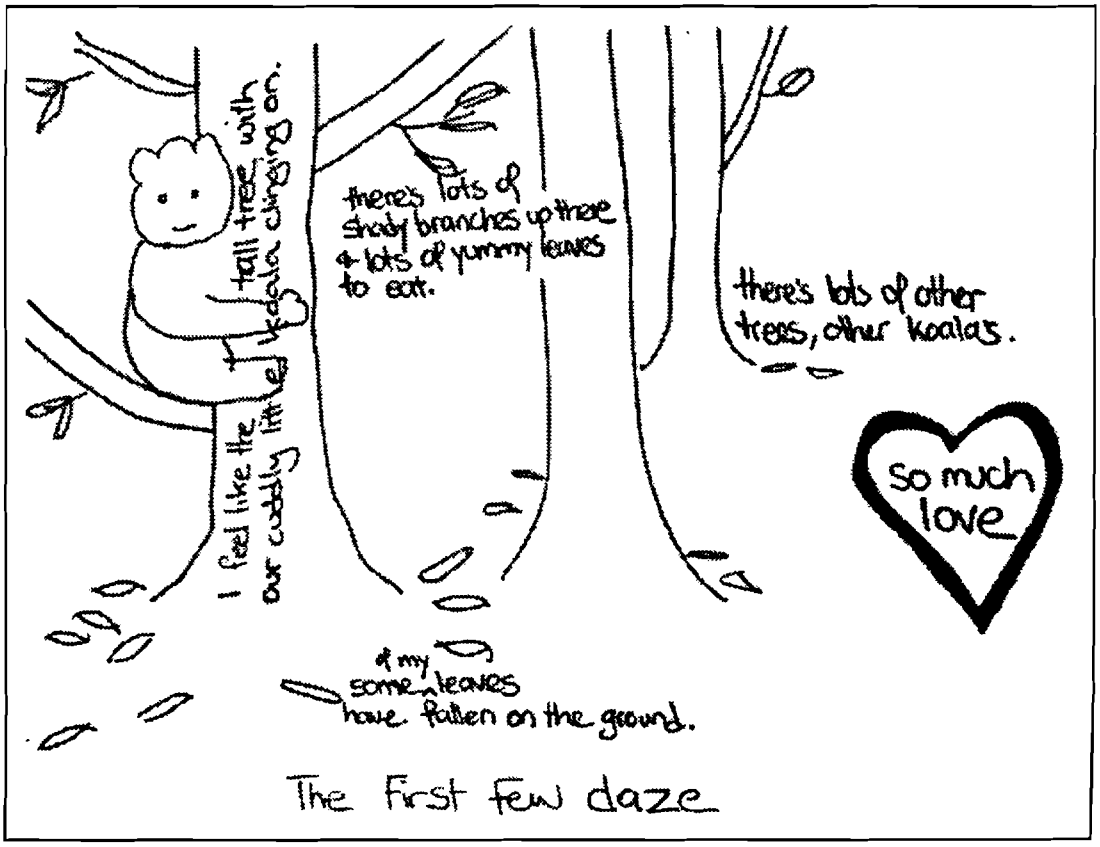
In this second part of Rebecca's story, she uses the metaphor of a thunderstorm to describe the physical demands caused by her baby. This metaphor gives an impression of darkness, being weighed down by the black clouds, being volatile and unpredictable like the lightening strikes depicted in her drawing. The use of the two metaphors of *sunshine* and a *thunderstorm* provide an effective way of communicating the difference between the two experiences of pregnancy and the early months of motherhood.

The striking thing in Rebecca's response is the impression of trying to understand what having a baby would be like and the lack of success in gaining this understanding. Prior to having a child, Rebecca had no experience that she could use as a comparison to construct meaning when people tried to tell her about the physical demands of a baby and the resulting sleep deprivation that can be experienced by mothers. The language used to explain motherhood to Rebecca had apparently not 'captured' the experience; nor had efforts to make meaning of what it would be like to have a child been successful in preparing Rebecca for the early months of mothering.

Rebecca punctuates her story of how physically demanding the care of a newborn infant can be with an attempt to provide a measure of how the situation could have been worse — *and he's been a good baby.* This statement deflects any blame from Marcus and potentially positions his behaviour as being 'normal' or possibly better than normal and that the situation could have been even more difficult if he had been

an unsettled or 'difficult' baby. This acknowledgement could also be read as a mother who does not want to blame her baby for her emotional difficulties in adapting to motherhood.

The final drawing (also see Appendix 5) provided by Zoe's is very different from the other women's drawings as she depicts a forest with a Koala in a branch. The trees have leaves and there are leaves on the ground. A red heart is prominently displayed in the lower right hand corner of the page with the words *so much love* printed inside the heart. Zoe uses a play on words to title her drawing — *the first few daze* — this statement requires no explanation by Zoe as everyone laughs when she shows her picture.



Zoe: I didn't get to do my pregnancy thing, I just started on the first few daze (group laughing) ... I just felt like she was this cuddly little koala and I was the big tree and ..... that I'd seen that some of my leaves had fallen off on the ground and it was all very strange and I wasn't sure how it was all going to work out ... or what to do or ... how to do any thing ... but I just felt like ..... There was lots more branches for her to climb up and you know ... Lots of other trees and other koalas ... And I just ... there was just so much love in our house too ... It was so wonderful so that's mine (Ruth is now twelve months old)

Zoe draws on an explicit discourse of nature as she positions herself as a big tree who is unsure. This story and drawing are different from the other stories as Zoe acknowledges the role of others in the baby's life and that she is not expected to care for this baby on her own. However, the metaphor of a tall tree suggests that a mother needs to be strong and able to nourish and protect her baby.

Zoe's reference to *it was all very strange* highlights the potential difference of maternal experience to any other experience women will encounter in their lives. Within Zoe's story a lack of preparedness and uncertainty is evident, but also a sense of surprise at the love and of how wonderful having a baby can be. The story that Zoe has told positions her in several different ways as being unprepared and bewildered by the experience of mothering; of being willing to share the care of her baby; and of being strong enough to protect, care and nurture her baby.

Through their drawings and stories the four women have constructed multiple subject positions from which to speak as mothers. Jane is positioned through her story as enjoying pregnancy, but as unhappy and disliking much of her maternal experience. Meredith provides a story of learning to mother and of discursively constructing new subject positions, resulting in a positive view of mothering and her body. Rebecca's story positions her as enjoying pregnancy, but experiencing the early months of motherhood as difficult because of sleep deprivation, and of being surprised by the disjuncture between her prior expectations of motherhood and her experience. Finally, Zoe's story positions her in several ways as being bewildered, sharing, strong and nurturing. The women have attempted to make meaning from and share their emotional and physical experiences of mothering using everyday experiences

and metaphors. Nevertheless, these four women's drawings and stories have continued to reinforce the understanding of the complexity of mothering and the inability to describe the experiences of motherhood adequately in within available words.

7.3 Conclusion

This chapter has identified that the women in this New Mother study have provided only partial constructions of their maternal experiences. An argument is developing that the ability to produce common meanings for maternal experiences or appropriate language to provide descriptions of the somatic experiences of mothering is necessarily limited to the available and frequently restricted maternal discourses. Infringement of the available and accepted maternal discourses can result in the construction of maternal positions for a woman as an abnormal or deviant. As also discussed in Chapter 6, these understandings provide an insight into the importance of language as a mechanism to construct knowledge and subjectivity. The limitations of language therefore have a significant impact on the availability of maternal knowledge and places constraints on the development of subject positions that are able to adequately reflect the women's maternal experiences and feelings.

The limitations of the accepted discourses of motherhood, I am also proposing, contribute to the notion that a conspiracy of silence exists about maternal experiences. Certainly, the women within this New Mother study told of choosing to dramatically edit or not to share their stories of motherhood as they select who will be supportive or critical of their performance as mothers. Nevertheless, many women do talk about their experience, often in graphic detail about the joy, wonder, pain, discomfort and disillusionment to interested listeners. The difficulty, it seems, is the inability to comprehend these descriptions and start to make meaning of them when a woman has not been part of the experience or has not had a similar experience of pregnancy, childbirth and the early days of mothering. These experiences often elude construction in language as they are based in emotions and physical sensations that I have termed somatic knowledge. The memories of experiences, that are at first

readily recalled, may also be rapidly forgotten until a similar experience starts to occur, therefore enabling women to emotionally and cognitively move on to the next pressing maternal experience.

Chapter 8

Conclusion

A significant outcome of this study has been the enormous sense of complexity, specificity and contradiction that has resulted from the stories told by the fifteen women. These features of the stories have not acted as impenetrable barriers, but instead have opened up possibilities for different and potentially more productive ways to theorise maternal learning by troubling the commonsense or taken-for-granted understandings used to represent the inexplicable experience of 'knowing how to mother'.

Two underlying arguments have formed the basis of this thesis. The first argument is that mothering is a complex and socially mediated experience that cannot be quantified or standardised to a framework which normalises the act of learning to mother. The second argument is that mothers are produced through the circulation of cultural practices and the accompanying régimes of truth. The learning of these cultural practices of mothering commence at least by the mother's own birth and continue throughout life.

Within this thesis, poststructural and feminist approaches have assisted in the identification and exploration of four main themes of importance for maternal learning. The first theme is the dominant discourses of motherhood, in particular, the essentialist concept of 'maternal instinct' and the ease with which these discourses are used to describe and justify the often inexplicable attributes of women to enable them to mother their infants. The second theme is the production of the new mother by the use of a concept described by Foucault as bio-power, which is identified in this thesis as an important mechanism that contributes to the reproduction of the social norms for maternal behaviour. These first two themes assist in understanding the contextual factors that influence and mediate women's maternal experiences. The third theme is the construction of maternal knowledge and the possibility of thinking about the development of maternal knowledge that seems to be inexplicable,

as learning that occurs incidentally to other activities. The final theme is the difficulty of describing the somatic component of maternal knowledge using the language available to women. This difficulty is identified as contributing to a subjugation of maternal knowledge and therefore, allegations of a 'conspiracy of silence' about motherhood.

The themes explored in the analysis of this New Mother study have allowed several crucial understandings to be foregrounded. These understandings and the analytic tools provided by poststructural approaches have the potential to assist nurses and other health professionals trouble and rethink the way in which they have theorised their work through the development of counter readings of the experience of maternal learning. To facilitate this process of rethinking maternal learning, the discourses of memory, habitus and incidental learning have been used. By using these discourses, counter readings have been provided for exploring and understanding maternal learning and the resulting maternal knowledge. However, these readings are not meant to set in place an unproblematic interpretation of, or truth about, maternal learning, but rather to act as a starting point to trouble the dominant discourses of motherhood.

Maternal learning is not limited to the formal setting of a parent education program; nor is the learning linear or at times easily identified as learning, as the women seem to be constantly drawing from their everyday experiences and memories of mothering. Within their experiences of maternal learning, the women within this New Mother study frequently collided with contradictions, tensions and censure of their maternal knowledge and practices. In making such generalisations, I seem to be contradicting previous statements about rejecting universalising approaches and statements about maternal learning. However, within this statement there is an acknowledgement that many unknown factors remain and the fifteen women within this New Mother study constructed fifteen very different stories of their maternal experiences and learning. These understandings have implications for using a poststructural approach to nursing and parent education theorising and practice.

8.1 Implications for nursing

Poststructural understandings and research approaches provide an important shift in the way motherhood and maternal learning can be theorised by nurses and other health professionals, as questions are not necessarily asked about *what it is* that is often encouraged as the focus of dominant research approaches. These types of research approaches enable a description of a woman's experience to result in a purported authentic representation of the 'lived experience' of the woman. Instead, a poststructural approach focuses on asking questions about — *how it works and why we act in certain ways and not in other ways?* According to Hartman (1995 p. 5):

> this intrusion by postmodern thinkers is not so much an attempt to improve and perfect as it is an attempt to make underlying assumptions explicit and to undermine their foundational claims.

Through this statement Hartman is encouraging nurses, when working with families, to take an 'incredulous' approach to scientific research results and knowledge. This approach is not about rejecting scientific knowledge but, as Usher et al (1997, p.7) state, it is about "... recognising that these are claims not truths [but rather are] claims which are socially formed, historically located cultural constructs, thus partial and specific to particular discourses and purposes". Poststructural approaches provide an opportunity to alter the way we theorise maternal experiences, allowing an exposure of such things as shifting and multiple subject positions, power relations and the function of language in the construction of subjectivities. As Lee (1992, p. 2) notes, the value of a poststructural approach to research is that it "... attempts to work productively with, rather than against, the complexity of human existence. It seeks to avoid the various reductionisms which are an inherent part of other research paradigms". The use of poststructural understandings and approaches to research are not always easily understood and are not readily accepted as a research method for nurses to use, in comparison to the more familiar qualitative and quantitative research methods, as there are no reassuring certainties of coming to an end point within a research study or being able to find a 'truth' about women's experiences of maternal learning that states — this is the way women learn to mother.

A desired outcome of this research is that it contributes to the ability of nurses to examine or, at the very least, start to gain an awareness of the discourses of motherhood and how they are used in educational and clinical practice settings. If this awareness does not continue to develop, then nurses will remain locked within a system that perpetuates and sanctions often restrictive attitudes and beliefs about maternal behaviour and the care of infants. These discourses are frequently based on an invasive essentialism that is often enmeshed within the socially constructed belief systems about motherhood.

8.2 Maternal knowledge

The discursive concepts of incidental learning, memory and habitus used within this thesis have acted to challenge the essentialist discourses and understandings of mothering as an instinctual behaviour. The use of poststructural approaches has provided opportunities for a counter reading — that the ability to mother in seemingly taken-for-granted and inexplicable ways is a result of learning, with minimal support given to the concept of 'maternal instinct'. This maternal learning is rarely a formalised type of learning gained through parent education groups; instead, it is being theorised as developing over a lifetime, frequently as rituals or habits of a culture or community in which women live. This maternal learning has been constructed as often occurring incidentally to the experiences that women have been exposed to during their lives.

Hence, maternal knowledge can be identified as being mainly located as somatic knowledge acquired through incidental learning, thereby, enabling women to mother in a seemingly 'intuitive' manner. Drawing on the understandings gained from Bourdieu's concept of habitus and the recent medical research into brain development allows links to be made to the crucial importance of having opportunities to develop unconscious memories of maternal behaviours, for example, being nurtured as a baby by experiencing cuddles, being held and massaged (Shore 1997). These memories of bodily sensations I am suggesting will later assist women to replicate maternal behaviours in a seemingly 'natural' or 'instinctive' manner with

their own babies. These understandings also offer women who have not had these opportunities to be nurtured as infants, children or young adults to hope that it is not too late for them to learn to mother.

These understandings of somatic knowledge have highlighted the difficulty of describing maternal experiences and knowledge using the commonly available language. So descriptions of maternal experiences and knowledge are identified as limited, as they do not adequately describe the somatic knowledge about mothering which allows us to interact in a seemingly 'intuitive' or 'instinctive' manner as a learning that 'just happens' or as a knowing 'how that feels'.

This thesis has only started to investigate the potential differences between maternal and professional knowledge and further investigation is required to explore these differences and the apparatuses of power which act to subjugate maternal knowledge. Differences between professional and maternal knowledge are possibly located within the emotional and sensation dimensions of somatic knowledge, which in many instances may be difficult to construct discursively, thereby often denying the ability to share this knowledge with others or at times even being able to intentionally bring this knowledge into consciousness. The most a mother may be able to acknowledge is that a piece of advice or an action 'does not feel right' or knowing that 'there is something wrong' with their baby; as Callery (1997, p. 3) notes maternal knowledge is "... private, intimate knowledge of everyday contact ...". An acceptance of this difference between professional and maternal knowledge, I am proposing, is crucial to effectively working with women learning to mother.

Language has been identified within this thesis as being an important, though by no means the only mechanism by which subjectivity is constructed, allowing women to position themselves and to be positioned by others (Weedon 1997).[1] These understandings locate language as central to organising the human experience (Lee

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[1] But see my earlier comments on somatic knowing which I would argue is a significant component of subjectivity. This accords with contemporary feminist theorising of the body (Bordo 1993; Butler 1990a etc).

1992) of mothering and what counts as knowledge. Language is essential to enable the naming of experiences or feelings, as without this naming it is difficult to believe an experience or feeling exists and this restricts a woman's ability to position herself within the world. Language allows a description of an experience to be formed in such a way that it can be examined, enabling meaning to be made out of the experience, thereby resulting in a woman being able to construct multiple subject positions.

These understandings about the difficulty to describe and name maternal experience and knowledge are crucial for nurses, as they are well located to assist women construct new stories about and meanings for their maternal experiences using opportunistic education (as discussed in Chapter 6) by providing information, sharing their own maternal experiences (when appropriate), helping women develop metaphors about their experiences or making connections with similarities in other life experiences. Opportunistic education has the potential for a more exploratory approach to the provision of information that may challenge régimes of truth and discourses of motherhood, in particular those discourses which result in the provision of decontextualised information about mothering. This decontextualised information, often provided as part of a set parent education program, frequently relates to only one aspect of mothering and disregards the complexity of a woman's experience and life history.

In many instances, nurses are already providing this opportunistic education by focusing on the immediate information needs of women; acting as therapeutic listeners; helping women construct stories about their experiences; providing anticipatory guidance by alerting women to future child care requirements as their infants develop; assisting women draw on their previous life experiences; and creating maternal networks through the use of new mothers' groups. The timing of this education is possibly a crucial element if it is to be effective, as women rapidly shift from one significant maternal experience to another, particularly in the early days after childbirth or before their memories of experiences become less acute. Opportunistic education, if provided in a timely and appropriate manner, can be

theorised as having the potential to go beyond assisting with the formation of maternal knowledge and to act in a therapeutic manner. However, the effective use of opportunistic education within nursing practice may require a rethinking of how we define and rate the authority and significance of maternal knowledge, and how nursing practice is described.

8.3 Final thoughts

Throughout this thesis I have raised many questions about maternal learning and concluded that learning was occurring when the women may not have agreed with this conclusion. A final question I need to ask myself is: am I doing a colonising reading of these women's lives by construing that the women are learning through their maternal experiences, when they may not have identified their experience as learning? A realist reading of this would be that 'they have a lack of knowledge and I have the truth as an educator'. However, the use of a poststructuralist approach is more likely to propose that I am caught up in an educator's discourse which seeks to construe these women's experiences as learning because in doing so I believe a better outcome can possibly be imagined for the women.

Appendix 1

Profiles of the women — Realist tales

Alicia

Alicia was a twenty six year old woman with German parents. Brent, her husband, was a thirty year old American. She has qualifications as a child care worker. During the winter she worked in a child care centre and during summer she worked at a sports centre.

The birth was painful, but uneventful. Alicia remained active during her labour and only required gas to assist with the management of her pain. Alicia seemed to enjoy motherhood; other than being tired. Breastfeeding has been going well and Felicity was settled most of the time.

By the third interview at six months, Alicia had been experiencing difficulties with Felicity. She had become exhausted by Felicity's behaviour, as she was a very active baby, always on the move and sleeping for only short periods of time each day. Alicia found motherhood extremely difficult even though she had experience as a child care worker; she had not realised that your time was 'no longer your own'.

Anna

Anna was a forty two year old academic. David, her partner, was also an academic. They had only recently come to live in Sydney after several years working overseas. This pregnancy was planned by Anna against the wishes of her partner. The pregnancy was uncomplicated; Anna attended childbirth classes on her own as David refused to attend. Anna was upset about David's lack of support and interest in the pregnancy, but she did believe he would change once the baby was born.

Charles' birth was by an elective caesarian section, because of her age. Anna had been happy about this option. David became very attentive after Charles was born and he started to provide physical and emotional support.

Breastfeeding was a problem at first and overshadowed any pain from the operation. Eventually the feeding started to improve. Anna had returned to part-time work when Charles was four weeks old. The decision to return to work had been difficult, but Anna had believed she did not have any options, as her research profile needed to be maintained. Charles had accompanied Anna to a conference in Canberra and to Melbourne to do some research. She was very proud of him and how easily he fitted in with her lifestyle.

Emma

Emma was a thirty three year old, who worked as an child and family health nurse. Emma and Andrew had both been married before and met shortly after they had separated from their other relationships. Andrew was a Buddhist (this religious involvement was a new choice for him) and he had embraced many of the Buddhist ideals which included vegetarianism, not being concerned with worldly goods, going to bed very early and getting up at five o'clock to meditate.

Emma's pregnancy was not planned, but had been wanted. Emma's father died when she was three years old and her mother used excessive discipline to control her children. Emma would have liked her mother to be more attentive and outwardly affectionate, but she talked of her belief that her mother was not capable of being emotionally and physically supportive.

Emma had joined a 'continuum concept' group during her pregnancy. The women in this group cared for their children in a very 'child focused' manner. The babies slept in their parents' bed, were breastfed on demand and never left to cry, as they were picked up immediately.

Emma had started labouring on her due date; she stayed at home for as long as possible. During her labour she started to get concerned that her baby maybe in danger, so she went to the hospital earlier than she had anticipated would be necessary. The labour was difficult and Emma was said to have 'failed to progress'; she was transferred to the labour ward for augmentation (medication via a drip to increase her contraction). Even though she had an epidural, Emma pushed Patrick out herself, as she said she knew he had been in danger and his birth needed to occur fairly quickly.

Patrick was a bright, active baby, but he has also been an extremely unsettled baby. Emma got to the stage of almost hitting Patrick, as she was so tired. These feelings had resulted in her making a decision to move him out of their bedroom and into a cot to sleep. From the very first night he spent in the cot, he slept through the night. Emma has been amazed by his changed behaviour.

Emma had stopped going to the 'continuum concept' group as she found many of the things they advocated beyond her ability to implement. She also found some of the women's attitudes disturbing — focusing on their babies to the detriment of other children, themselves and their partners.

Heather

Heather was a thirty two year old who works as a social researcher, she lived with her husband, William. Heather was a very friendly woman who was eager to talk about her pregnancy. The pregnancy was planned though it took quite a while for her to become pregnant. Heather enjoyed her pregnancy and liked her pregnant body. She believed her body had not become all bloated; and that her body seemed to be in proportion.

Labour had been six days late in starting and took about thirty hours. An epidural and vacuum extraction were necessary, as Heather was having difficulty pushing Carolyn

out during the end stages of childbirth. Heather stated the pain of childbirth had shocked her.

Carolyn had been very unsettled, especially at night. Heather got to the stage where she started to fear the night, as she had been sitting for many hours patting and rocking Carolyn to sleep. In the end, Carolyn was left to cry for a while, instead of immediately responding to her first cries. Carolyn very quickly learned to settle herself, so the nights were no longer a problem.

Jane

Jane was a thirty one year old woman, who worked as a dental nurse. Joe, her husband was born in Australia of Greek parents. She had a miscarriage a few years ago, so when she became pregnant, discomforts such as morning sickness were identified as a positive sign. Jane had really enjoyed being pregnant and liked her pregnant body. Her expectation, or at least her hope, was that she would be a 'good' mother. Jane seemed to enjoy being in 'full control', as she wanted a very ordered life.

Jane's labour did not progress as she had expected; her doctor ruptured her membranes, she required an epidural because of the pain, and because her cervix was not dilating, a syntocinon drip was necessary to increase the strength and duration of her labour contractions. She had a forceps assisted birth and an episiotomy. Jane was quite accepting of this intervention; and said that at least she did not have a caesarean section.

Breastfeeding had been progressing reasonably well, though Tim had been projectile vomiting. Tim was very unsettled and Jane was very tired. Jane had been teary and she even said she missed being pregnant. She also felt guilty that she had sworn at Tim. Jane felt a lot better when a close friend had reassured her that she had also sworn at her baby. At this stage, Jane had started to question if she was depressed. By the third interview, Jane had been diagnosed as having postnatal depression.

The relationship with her husband had been put under a great deal of strain. She had returned to work part time because of financial problems and really disliked having to work. Jane was really disappointed that she did not want another baby. She would love to be pregnant again and even go through the labour.

Jennifer

Jennifer was a thirty year old midwife who was married to Angus. Jennifer expected a reasonable amount of physical and emotional support from her family and friends. Her pregnancy had been planned, but it took seven months to conceive. Morning sickness had occurred from the eighth to sixteenth week. During the pregnancy, Jennifer put on a great deal of weight, as eating had made her feel better. She has been experiencing pain down her left thigh, which then went numb, and she had developed carpel tunnel syndrome in both wrists. Pregnancy had been an uncomfortable experience.

Jennifer started to develop a support network with other midwives who have babies. She had found at work that, since she has become pregnant, her relationships have changed with some of the other midwives, especially the ones with children. These midwives became very supportive.

Jennifer had a very difficult labour and childbirth. She ended up requiring an epidural because of the intensity of the pain and the onset of hypertension. At times, she had hallucinated, ranting and raving in between contractions. They tried to use the vacuum extraction, a soft and then a hard cap, which failed. Forceps were then used to pull Nicholas out. The intensity and location of the labour pains surprised Jennifer, she had not imagined it would feel like it did (she had supra pubic and back pain). Jennifer did not pass urine for all the time she was in labour which resulted in a large post partum haemorrhage. Jennifer was very angry with her obstetrician because he would not accept the information she wanted to tell him about how painful the experience of childbirth had been.

After the birth, Jennifer heard four different stories about what had occurred during the birth of her baby. Three of the stories were from people that were present at the birth. The fourth story was from a friend who rang up and had been told the story by someone who had been present at the birth. The midwives working on the postnatal ward had been very supportive and had allowed her to talk about her experience which she believed was important to assist her understand the events of the labour and birth. It took Jennifer a little while to feel confident with breastfeeding, as Nicholas had been unsettled at first. Angus has been very supportive and involved with Nicholas' care.

By the third interview, Jennifer looked and sounded really confident; she was enjoying motherhood. Jennifer had organised an active social life, maintaining contact with the other midwives from work who had young children, as well as regularly seeing the women she has met through the early childhood health centre.

Jennifer developed a rectocele (prolapse of the rectum; part of the bowel protrudes outside the anus) as a result of the Nicholas' birth and she may require surgery at a later stage. She was angry about the indifference that her obstetrician has shown towards this physical problem — *he touched me on the knee and said.. 'oh it will be alright and just brushed it off'*. The obstetrician laughed at Jennifer when she said she was too young for a rectocele. The doctor did not offer any management suggestions and she has gone off to a private physiotherapist. Jennifer did not blame her obstetrician for the rectocele, but was angry because of his disregard for her feelings and concerns about her body.

Julia

Julia was a thirty one year old high school teacher, married to James. Julia was a warm friendly woman, who laughed a lot. When I first interviewed Julia she was thirty five weeks pregnant. The pregnancy had been reasonably uneventful with only

a couple of hypertensive episodes. Julia has not liked what pregnancy had done to her body.

Julia had to have labour induced because of her hypertension. The hospital staff had not kept her informed during the labour about what was happening to her and the baby; this lack of knowledge resulted in Julia being upset and frightened. Shortly after she was induced they told her to get on a trolley without telling her she was going to the labour ward. The anaesthetist arrived in the labour ward and put in an epidural. This procedure was done without any explanation of why it was needed. The staff had to hold her down, while they put the needle into her back. She had a hospital gown on which was pushed into her face; she panicked as she felt like she was being smothered. Julia had found this experience extremely traumatic. They took her blood pressure regularly and checked monitors strapped to her abdomen. Her husband was upset and felt he was going to faint, he was persuaded to lie down. After six hours she told the midwife she could feel the baby's head; the midwife told her it was not possible but when they looked, Rachael's head was on view. The epidural had started to wear off, allowing Julia to push. Unfortunately, the baby's shoulders got wedged under her pelvis.

The obstetrician arrived and Julia saw him put on gum boots; he made a comment to her that there would be quite a bit of blood. Julia asked him if he was going to cut her? In reply, the doctor held up a pair of scissors and made a cutting motion. He turned the baby into a new position using forceps. This intervention was successful and Rachael was pulled out. The baby was pale and limp with a low apgar (score out of ten done at birth and at five minutes to gauge colour, respirations, tone etc). Rachael was immediately taken to the neonatal intensive care unit. Her husband went with Rachael, and Julia was left in the labour ward.

Julia was able to accept all that had happened to her, as Rachael and her own life had been in danger because of the hypertension and the risk of eclampsia (fitting). However, Julia believed she had lost all control and knowledge of what had occurred to her during labour.

Breastfeeding had been difficult to get established, as she had developed mastitis and Rachael was lactose intolerant. Julia kept raising her concerns about Rachael's health with health professionals, but was told not to worry about it, that Rachael was healthy. She knew something was wrong, but no one took any notice of her concerns until Rachael started to bleed from her bowel. Eventually the problems with breastfeeding and Rachael's health were resolved.

Lisa

Lisa was a thirty five year old New Zealander, who was married to Matthew. Lisa worked in the banking industry and was currently completing a Masters degree. Her mother was visiting from New Zealand for a few weeks and planned to return after the baby was born. Lisa came from a big family of ten children (some were half sisters/brothers).

The pregnancy was planned. Being pregnant had been difficult, as Lisa experienced extreme morning sickness which stopped her from working. She had lost a lot of weight and became dehydrated. During her pregnancy, the doctors identified she had a heart murmur, diagnosed that she had a Strep B infection and she had started to bleed from her nipples. Becoming unwell during pregnancy had been unexpected, as Lisa had travelled extensively and always remained in good health. As her pregnancy progressed she developed sciatic, which limited her movements.

Lisa was very confident with her ability to care for her baby as she had lots of experience helping her mother with younger siblings, nieces and nephews. Lisa believed she had fairly realistic expectations about motherhood. Lisa spoke warmly of her mother and the support she provided.

Lisa's labour was long and painful and took about three days; even though Lisa acknowledged that the hospital staff would not have called all that time labour. At the end of labour, Lisa was in the birth centre pool and had a water birth. The only

pain relief she had was nitrous oxide. After the birth, the pool started to turn bright red with her blood. Lisa stood up to get out and fainted, her husband who was in the pool pulled her out. Lisa kept going in and out of consciousness and required oxygen. The haemorrhaging did not stop, so Lisa was rushed to theatre for a manual removal of the placenta under a general anaesthetic. She had to be given a blood transfusion.

It took Lisa several days before she could stand up or do anything for Indira. Breastfeeding was not commenced at first as Lisa was bleeding from her nipples. This gradually decreased as the milk came in and by the sixth day had cleared completely. Lisa's memories of Indira in these early days are very vague. For Lisa everything felt like it was 'out there' in the darkness and she was not involved in what was going on around her. Lisa looked very pale and unwell during the interview.

At the third interview, Lisa had just returned from New Zealand where she had been for a month. Lisa spoke of her family assisting her to regain her health, during this visit home.

Developing a social network has been very difficult for Lisa and she seemed to find the lack of a network frustrating, as she has to rely on the health system as a main source of support. Lisa had been lonely, as other women in her neighbourhood all seem to have family and friends close by or they had returned to work.

Meredith

Meredith was a thirty year old, who worked as a school teacher. She lived with Thomas, her partner in the western suburbs. They intended moving to the inner city before the birth of the baby. Meredith talked about the importance of the planning and decision making part of becoming pregnant. Meredith had originally thought she did not need to have any children, as teaching would provide adequate fulfilment.

This belief stemmed from her experience of being raped by her father when she was a teenager.

Meredith no longer has a relationship with her parents. She had cut herself off from any communication with her mother; as her mother had chosen to believe her father's story. Meredith has a very close relationship with her sister.

The concept of being a mother was difficult for Meredith, as the experience she had with her own mother was not positive. Meredith did not want her child to call her mummy or mother. To compound these emotional issues, Meredith has found out the baby was a boy. This news had not been well accepted by her group of friends, who have made her feel she was 'letting the side down' by having a son. Near the end of this first interview, Meredith spent a long time asking me how I managed being a mother of boys.

The pregnancy had progressed well. Meredith did not like her pregnant body because of the excess weight she had put on and her inability to exercise adequately. Body image issues seemed very important. Meredith had chosen a female obstetrician and intended going to a birth centre.

Meredith's pregnancy went over her due date by ten days. An admission to hospital was needed and labour was induced. When the labour started she was allowed to go home. After about fifteen hours she went back to the birth centre, as the labour pains had become unbearable.

The labour was difficult, but Meredith refused all pain relief except for nitrous oxide. She eventually had to be moved to the labour ward for a vacuum extraction as she had become exhausted and could not push Daniel out. The midwives who assisted during labour and in the postnatal period were unaware of Meredith's history of incest.

Meredith's description of the labour was 'barbaric' with horrendous pain. However, she did acknowledge that at any stage during the labour, she could have asked for the pain to be controlled. A great deal of the labour and birth were a blur to Meredith and she needed to ask lots of questions and talk to her partner and sister about what had happened. They had taken lots of photographs which she found helpful; but seeing them for the first time caused her to cry as she started to remember the pain.

After Daniel was born, Thomas stayed with her in the hospital (he brought his own mattress and bedding) for several days until Meredith felt confident enough to go home. Some of the midwives did not like this breaking of the 'rules'. Breastfeeding was established without any difficulty.

By the third interview, Meredith was confident and comfortable with her positioning as a mother. The issue of what to call herself had resolved and she now thought of herself as Daniel's mother. Meredith had returned to casual work and had resumed physical exercise.

Meredith discussed her concern that her partner was able to care for Daniel in a far more confident and competent manner then she felt she could. At times she believed Thomas' confidence and competence had undermined her confidence as a mother. Meredith was enjoying caring for Thomas and was starting to think about the possibility of having another child.

Rebecca

Rebecca was a thirty three year old secretary, who worked for a large national corporation. Christopher was her thirty eight year old husband; they have been married for seven years. This pregnancy was planned; though it took her nine months to become pregnant. Rebecca was a very bubbly, friendly woman (she giggled and laughed throughout the interview), who was excited about the prospect of having a baby.

Rebecca's mother seemed to be a very important person in her life and she anticipated a lot of support, emotionally and physically from her after the baby was born. Rebecca's main concern seemed to be about getting enough sleep and how she would cope with this aspect of motherhood. Rebecca was unhappy about what the pregnancy had done to her body, as she had always had a slim figure.

Rebecca's labour started at home; and before she left for the hospital her membranes ruptured. The labour had been painful, and an epidural and a vacuum extraction were necessary to assist her give birth. Breastfeeding started without any problems.

Marcus had been very unsettled and Rebecca had experienced sleep deprivation. A visit to the local day stay unit had been arranged, so Rebecca could learn to settle Marcus. I stayed for about an hour after the interview had ended, assisting her to settle him. I found it very difficult to leave because she was very anxious about her inability to settle him on her own.

Rebecca complained about having urinary incontinence which was causing her distress. The obstetrician has told her not to worry about her incontinence, as the problem would fix itself without any treatment. The incontinence was starting to restrict some of her activities as she felt embarrassed by the smell and the possibility of having an 'accident'.

When I arrived for the third interview, Rebecca looked rested, confident and she was really enjoying motherhood. Rebecca liked being at home with Marcus and had decided not to return to work (at the group interview she was pregnant again). A network of mothers has been established and Rebecca enjoyed the social contact and activities they did together.

Sally

Sally was a thirty three year old who was married to Mark. Sally was an only child with parents who were elderly; they were in their early forties when she was born. Sally's pregnancy was planned and problem free. Sally talked about the sadness she had felt at finishing work as a high school language teacher. After I had completed asking my questions, we talked for a while. Sally identified that I also had an older mother and she started to ask questions about my mother and my feelings towards her. I told her I had felt cheated because she had died before my children had been born. After making this statement, Sally talked a great deal about her mother and the anger she felt about her mother; as she was an invalid and 'never there for her' when she needed support or assistance.

Sally stated that she was having difficulty preparing herself for motherhood, as her father was injured at birth. He was a twin and both babies had trouble breathing at birth, resulting in cerebral palsy. Sally stated she could not get past the moment of birth and until she knew her baby was safe, she would not be able to think about 'being a mother'. These fears and concerns had not been shared with anyone else, not even her partner.

Sally's membranes ruptured at home, she was really excited and went to hospital; but labour had not commenced. Contractions started the next morning and she required an epidural to relieve the pain. The contractions became weak again; a syntocinon drip was inserted to increase the contractions' effectiveness. Sally was eventually able to push the baby out without any assistance. Sally said she became very aggressive and bossy during the second stage of the labour. The labour took about ten hours.

Sally was surprised by the intensity of the responsibility and workload that was necessary when you are caring for a baby. Sally was sleep deprived and seemed resentful. She was still anger about her mother's inability to be there for her.

By the time I visited Sally for the third interview, she was much more confident with her ability to mother. She had gone to the local day stay unit and then to Tresillian, where they had put her to bed and looked after her for a week. Cameron was now much more settled.

The relationship between Mark and Sally had become strained since the birth, especially in the first few months, she had become very resentful of the amount of freedom Mark enjoyed as a father. Sally felt she was carrying the full burden of responsibility for Cameron's care.

Mark's birth mother came to stay for a month. Mark had been adopted as an infant; his adoptive mother was no longer alive. Sally really enjoyed this time and was sad when she left. Sally said her mother-in-law cared for her as she had dreamed a 'real' mother would. Mark's mother had allowed Sally to talk for hours about her feelings as a mother.

Sarah

Sarah was a twenty nine year midwife (who has just completed her midwifery program). She was married to Simon, who had Greek parents. The pregnancy had been very tiring, as Sarah had been studying for most of the pregnancy. To her surprise, she gained top marks in her final midwifery examination. The pregnancy happened earlier than expected; but it had been semi planned.

Sarah had chosen to go to a maternity hospital other than the one where she had just completed her midwifery education; as she wanted to feel uninhibited about her behaviour when in labour. She thought her colleagues would expect her to perform and be the 'good patient'.

A 'beached whale' was how Sarah described herself; though she said her husband thought her body was wonderful. Sarah admitted that she was a bit afraid because of the things she had seen during her midwifery program. She did not know what her

pain tolerance was going to be like. Sarah was concerned that she might know too much which would inhibit her ability to mother.

Sarah looked tired when I arrived for the second interview. The baby had been eleven days overdue; which she found difficult, as she was so big and felt uncomfortable. The doctor induced her labour. The labour was very quick and painful. Sarah was quite shocked, angry and overwhelmed by the speed and pain of the labour.

About an hour after the birth, Sarah had a large post partum haemorrhage. They had to rush her to theatre to remove a large blood clot that was stopping her uterus from contracting down. The postpartum haemorrhage resulted in anaemia and it took Sarah a long time to regain her health. Sarah said that she had never felt as tired as she had since the birth of Colleen.

Sarah was suffering from sleep deprivation and had lost a great deal of her confidence. She felt she was very reliant on her mother and had not wanted her mother to leave her alone with Colleen.

By the third interview, Sarah looked rested and confident. She was enjoying motherhood and talked about having another baby. Sarah had to return to work for financial reasons, but also because she was desperate to go back to work for some intellectual stimulation.

Sophie

Sophie was a twenty seven year old woman, who was married to Tim. Sophie had decided to have a homebirth. She has thought a great deal about her decision because her local hospital (according to the local newspaper) has the highest obstetric intervention rate in NSW. Sophie also works at this hospital as a midwife.

Sophie and the home birth midwife provided education to her husband and mother; as they were quite concerned about the safety of having a home birth. She had mixed support from her colleagues at work. Her local doctor was not at all supportive, especially as Sophie had chosen not to have the usual blood tests and investigations.

One of Sophie's sisters, her partner and two home birth midwives were present at Katrina's birth. Sophie talked about the birth as a great experience and that the pain had not been as bad as she had anticipated.

Sophie has returned to work as a midwife (on a causal basis). When Katrina was younger and Sophie had to work night duty shifts, she took Katrina with her so she could breastfeed during the night. The other midwives were very supportive of this breastfeeding arrangement, as several of the midwives had also combined breastfeeding and work.

When Sophie returned to work she received several very negative comments from some of the doctors; one in particular, who was giving a mini lecture on hypoglycaemia and the neonate. During his lecture he made reference to Sophie's baby; saying that they would never know if her baby was the bottom of the class because it was born at home (as they would not know if it was due to the baby being hypoglycaemia at birth). Other comments were heard by Sophie about the risk she had put her baby under having a home birth. Sophie felt that there was a group of people at work, who would have loved to see her fail and turn up at the labour ward door.

Sophie wants to get pregnant in the near future, but felt disappointed that she will probably have to go to hospital to have the birth because of financial reasons; as home births cost a great deal of money. Mothering her baby has been a much better experience than Sophie had anticipated.

Victoria

Victoria was a thirty five year old woman, who was a doctoral student and she was married to Steven. Victoria was from a central European country, and lived on a farm in a semi rural area on the outskirts of Sydney owned by her in-laws. The relationship with her in-laws appeared very strained. Victoria was not emotionally close to her own mother, who lives overseas. Victoria stated that her relationship with her mother had always seemed to be negative.

Victoria had found being pregnant very difficult, as she did not like what pregnancy has done to her body. She was also annoyed at the way pregnant women were treated with derogatory comments being made and that people often staring at a woman's pregnant abdomen.

The labour had been very long, taking thirty six hours. Victoria gave birth to Anita with minimal intervention, as she only needed a drip when she had become exhausted and an episiotomy at the time of birth

Victoria's mother came to Australia for a visit, but their relationship deteriorated further during the visit. Victoria was very angry with her mother and the lack of support that she provided. She no longer wanted anything to do with her mother. Victoria looked very tired and had been experiencing sleep deprivation.

By the third interview, Victoria looked and sounded a lot happier with her ability to mother. She had resumed work on her PhD. Anita had been weaned and she was in regular child care. Victoria believed that going back to her PhD had helped her get over her depressed feelings. She now loves mothering Anita and believes her feelings for Anita are the strongest emotions she had ever experienced. Physical problems have occurred since the birth and Victoria now requires major abdominal surgery, which will significantly restrict her physical activities.

Zoe

Zoe was a thirty nine year old film maker, as well as a part-time lecturer in film and television. Her partner, Edward, was a university student. Zoe has lots of support, as her brother and his family lived four doors down the street, and her mother is available to help. Nevertheless, Zoe did not think she would ask her mother for help; as she constructed her mother as not having current knowledge about child rearing and that she did not always approve of mother's ideas about child rearing. Her pregnancy had been planned.

During her pregnancy, Zoe was well, except for tiredness. Zoe was comfortable with the way her pregnant body looked. Edward was being very supportive of her and would be off on university holidays when the baby was born. Zoe and Edward attended childbirth classes and planned to have the baby in a local birth centre.

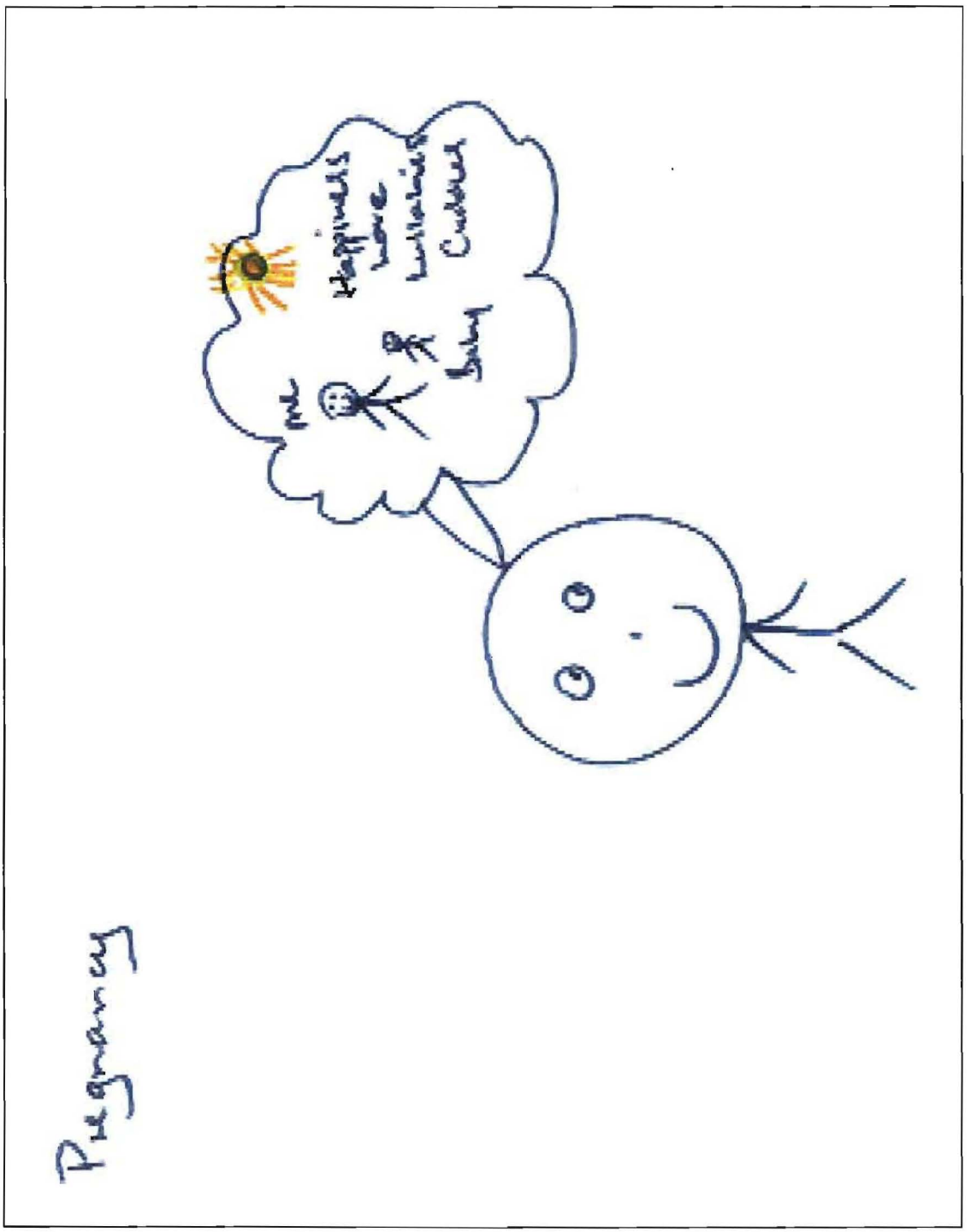
Ruth's birth occurred ten days after her due date. It took approximately forty six hours for Ruth to be born from the start of the first pains. By the time Ruth was born, Zoe and Edward were exhausted, as they had been awake all this time. Minimal pain relief was required to assist Zoe manage her labour pains.

Breastfeeding was commenced in the birth centre. Zoe and Ruth went home within about ten hours of Ruth's birth. Zoe was delighted with Ruth and enjoyed her experience as a mother. Zoe has started to make friends with the women in her new mothers group. At the end of this interview, Zoe started to talk about her concerns in regard to having to go back to work as a freelance film maker, as she found it difficult to turn down offers of work.

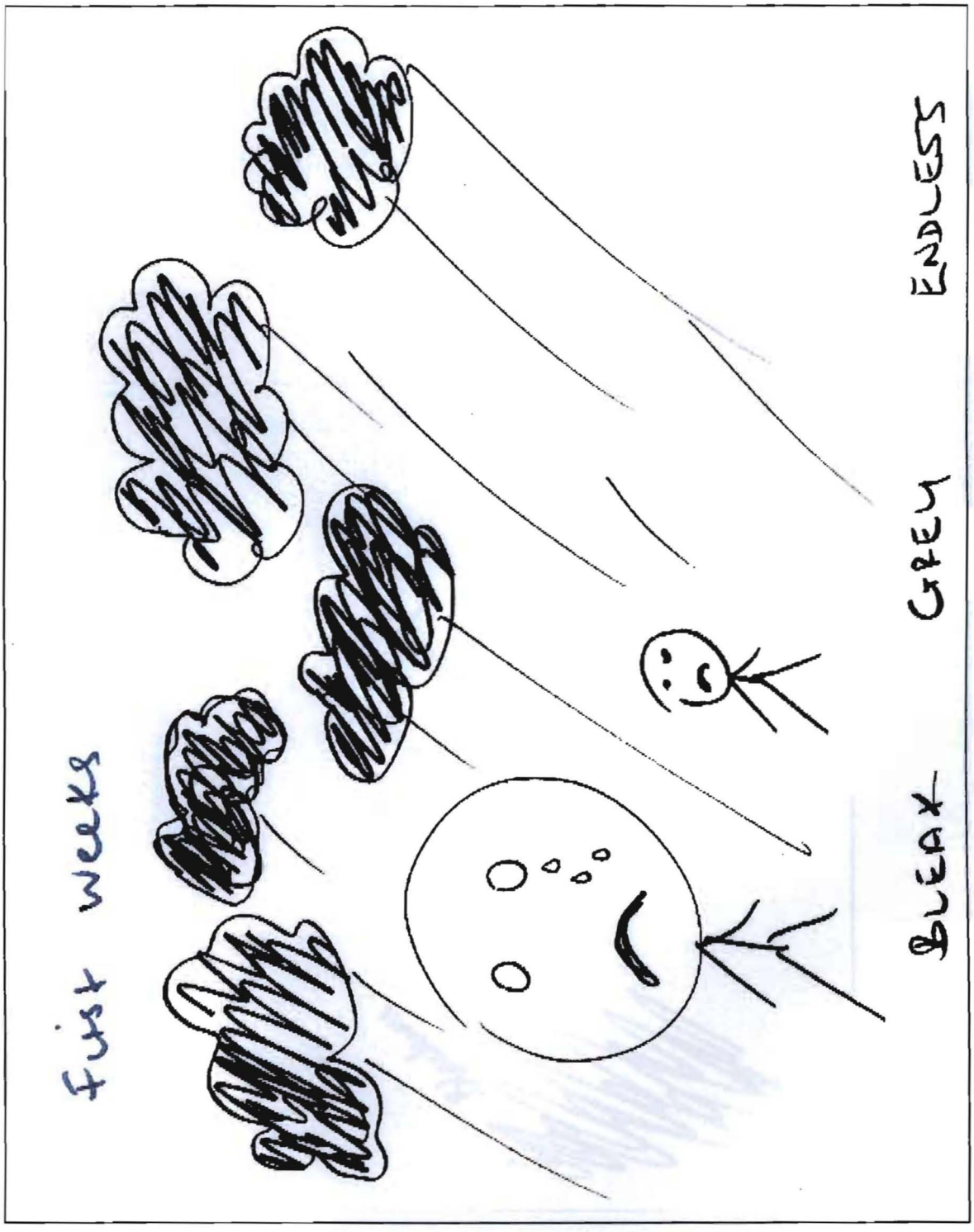
The third interview occurred when Ruth was nearly eight months old. Zoe was feeling happy and confident with her ability to mother. The greatest disappointment she faced was her decision not to have another baby; this decision was because of her age and concerns that her relationship with Edward was experiencing difficulties.

Appendix 2.

Drawing 1



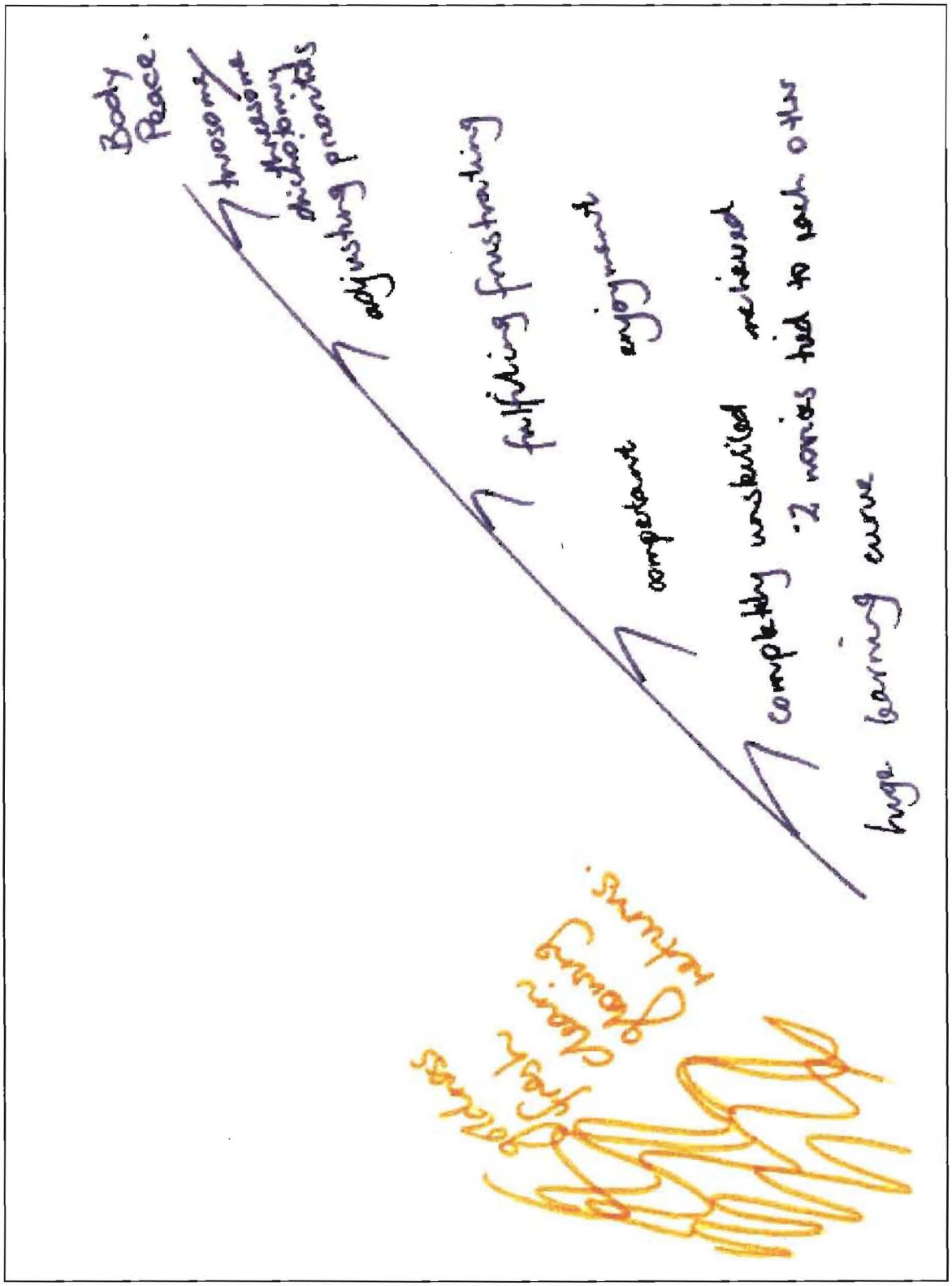
Drawing 2



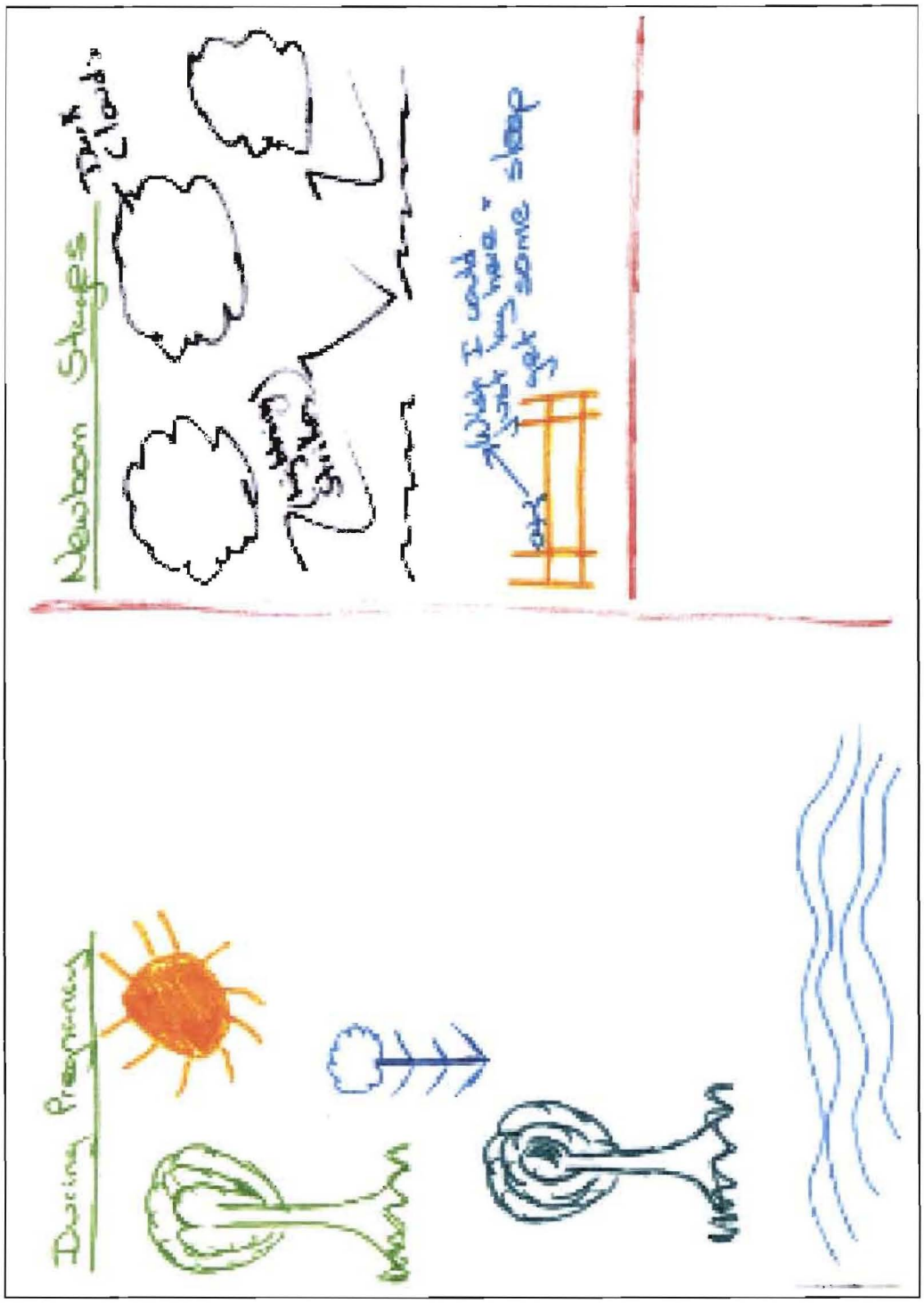
Appendix 3.

Drawing 1

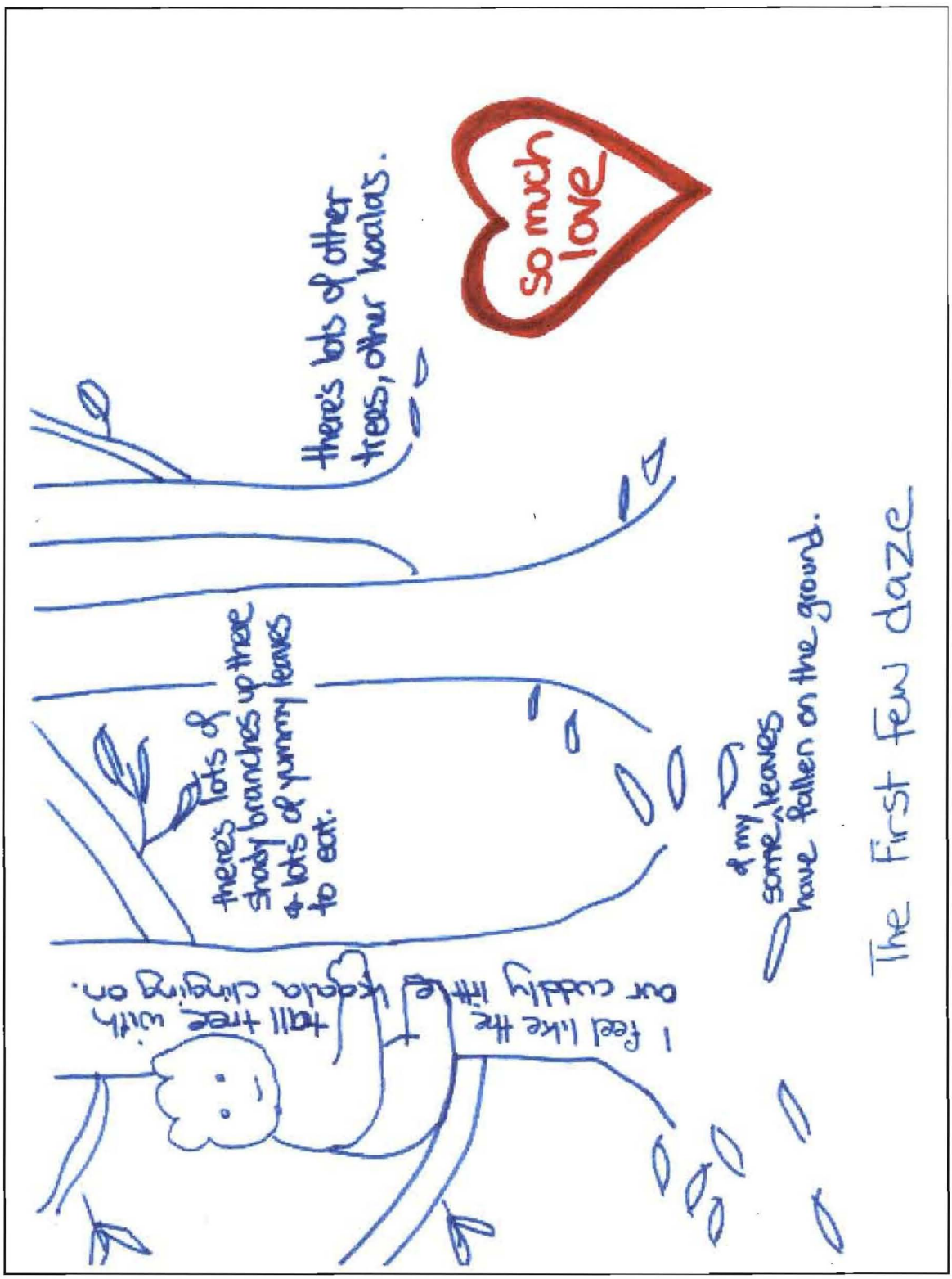
Drawing 2


Body
Peace.
adjusting principles
fulfilling frustrating
competence enjoyment
completely unsatisfied unpleasant
huge learning curve

Appendix 4.



Appendix 5.


The First few daze
some leaves have fallen on the ground.
I feel like the
our cuddly little koala clinging on.
tall tree with
there's lots of
shady branches up there
& lots of yummy leaves
to eat.
there's lots of other
trees, other koalas.
so much
love

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