

Midwives' Emotional Care of Women becoming Mothers

Midwives' Emotional Care of Women
becoming Mothers

By

Sue Barker

**CAMBRIDGE
SCHOLARS**

P U B L I S H I N G

Midwives' Emotional Care of Women becoming Mothers,
by Sue Barker

This book first published 2011

Cambridge Scholars Publishing

12 Back Chapman Street, Newcastle upon Tyne, NE6 2XX, UK

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

Copyright © 2011 by Sue Barker

All rights for this book reserved. No part of this book may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without the prior permission of the copyright owner.

ISBN (10): 1-4438-2730-4, ISBN (13): 978-1-4438-2730-0

TABLE OF CONTENTS

Acknowledgements	vii
Introduction	1
Chapter One.....	5
What is Motherhood?	
Chapter Two	21
Who Supports Women becoming Mothers?	
Chapter Three	45
What is Emotional Care?	
Chapter Four	69
Midwives' Emotional Care of Women becoming Mothers	
Chapter Five	97
What are the Experiences of Midwives giving Emotional Support?	
Chapter Six	127
What is Emotion Work?	
Chapter Seven.....	141
How Might Emotional Support Help Women on their Journey to Motherhood?	
References	161

ACKNOWLEDGEMENTS

I primarily thank all the midwives who took part in this study, without you there would be no study – thank you for sharing your experiences; it was an honour and privilege to hear about your emotional work.

Thank you to my supervisors for your patience, encouragement and commitment to me and the study. Professor Jo Alexander, your guidance, particularly in those early tentative days before a research proposal had been developed and your faith in my ability to undertake a study like this, although I did not always believe you, increased my motivation and my self esteem. Professor Les Todres, your calm, trusting, patient benevolence allowed me to follow Jo's advice and to 'smell the flowers'! Associate Professor Fran Biley who joined Les in my supervision in those long dark days of writing up the study, your challenging and guidance were just what I needed when I needed it. Thank you all.

There are many who have encouraged and supported me with undertaking this study including my midwifery and adult nursing colleagues and I will continue to be grateful and appreciative of them. There are, though, some who need to be mentioned for their particular assistance with writing this book. I am particularly grateful to Professor Jonathan Parker for his critical reading of my writing and to Greta Richardson for her assistance with my idiosyncratic grammar.

Along with all those mentioned above I must also acknowledge my ever tolerant husband, Julian, who has suffered take away meals and has had to endure social interactions with his computer games instead of my scintillating conversation!

Thank you.

INTRODUCTION

This book owes its genesis to a number of factors and offers the journey of understanding of its author. I have spent many years working as a mental health nurse, at times, working with women who were suffering significant levels of mental ill-health during pregnancy and the early days, months and years after the birth of their baby. I have also worked with women who were ‘incarcerated’ in the old mental hospitals due to ‘odd’ behaviour after having their babies. This was many years ago, but, by the time I was nursing them, they were unable to return to what might be considered a normal life. The focus on community care starting in the 1970s and the new treatments available were, in many ways, too late for them as indicated by Enoch Powell’s White Paper in 1962 (NHS 1962).

I have also worked with people who have been diagnosed with the psychiatric label of severe personality disorder. When we were able to find out about their early life experiences, we found many had poor maternal attachments which they were not able to resolve and, therefore, adopted what we perceived as maladaptive coping strategies.

My concern for those who experience emotional distress, mental distress or mental illness at such a vulnerable time for them and their baby was increased further when I, too, developed depression during both of my pregnancies and into the first year of my children’s lives. I was fortunate in the care I received from the mental health services and both I and my children have thrived. Both my children are high- achieving adults of whom I am immensely proud. This is not, though, the situation for all who develop emotional or psychological problems at this time.

When I was offered the opportunity to undertake a PhD, exploring how I could help women at this significant stage was my first desire. As with any research proposal, I undertook a literature review and found many studies on the treatment of postnatal depression, its aetiology and the risk factors. I therefore had some understanding of what happens when women are diagnosed and treated by GPs, psychologists or psychiatric services. The literature also led to some concerns, as it suggested that not all women experiencing emotional distress were identified and treated, either by

primary care or mental health services. It seemed pertinent, therefore, to find out what happened to these women who were not 'picked up'. Likewise, this book has the same focus.

The only sensible way to explore the emotional care or support these women were given was to conduct a literature search on the emotional care given to women who experience 'normal' transitions. Armed with this knowledge, I could then look at how this could be improved, so that all women who experienced emotional distress at this time could be helped. This was the point where my literature search met a dead-end. I eventually found a paper by Hunter (2001), which informed me that my lack of success in finding studies in this area was due to the lack of studies, not my lack of ability.

Whilst this was a relief on the one hand, it became a pivotal moment in my PhD work. After discussion with my supervisors it was clear that, to progress, I needed to explore whether women were supported emotionally at this time and, if so, who supported them and what this support looked like. Through discussion with colleagues, meetings with maternity service providers and considering the literature, it became apparent that the health professional who had the most contact with women on this journey was the midwife. The educational literature, their professional bodies and governmental policies all appeared to indicate that midwives provided support for women through pregnancy and into the early days after the birth of the baby.

It became apparent that there was a need to establish if midwives actually were providing emotional support to women through their transition to motherhood and, if so, what it looked like. Given that there was limited information available on this type of care in midwifery, a qualitative approach to exploring the area appeared appropriate. Given my worldview, psychological education and the lack of clarity of the concepts involved, I needed to use an exploratory, yet scientific, method.

There were a number of qualitative approaches that initially appeared worth exploring. Ethnography, grounded theory, narrative and phenomenological approaches, all to a greater or lesser degree, could be considered scientific and all offered a method for exploring uncharted areas for discovery. After much reading, and with supervision, I finally settled on a descriptive phenomenological approach. There were a number of reasons for this, but

probably the strongest was my psychological background - it made sense to me!

Amedeo Giorgi (1979), a psychologist by background too, with an extensive understanding of Husserl's phenomenological philosophy, had grappled with the need to stay loyal to his background, as well as to Husserl. This led to his development of a research approach called psychological phenomenology. It is descriptive phenomenology, but adapted to facilitate the psychological researcher.

Husserl's philosophical phenomenology had developed to allow the philosopher to explore their own lifeworld through transcendental phenomenological reduction. He did accept, though, that phenomenological reduction could occur at lower levels than a transcendental state, but this was the aim. What Giorgi's approach facilitated was the ability of researchers to gain an understanding of other people's lifeworlds by analysing their detailed descriptions of experiences in a phenomenologically reduced state. Giorgi did not make the same claims for the findings as Husserl. Husserl was trying to see the 'thing itself' (noema) without perceptual interference (noesis); the universal essential features (Husserl 1970b). Giorgi's claim was that phenomenological researchers could establish generally applicable features through psychological phenomenology (Giorgi and Giorgi 2003).

Using this approach I set out to establish if midwives normally gave emotional support to women on their journey to motherhood and, if they did, what it looked like. I collected data through individual interviews; these were unstructured. I asked midwives to describe their experience of offering emotional support to women. The midwives seemed very happy to describe their experiences of emotionally supporting women and shared some quite emotive interactions. Quotes from these interviews are mainly in chapters four and five.

My literature review initially was quite small, as I was searching for specific literature on midwives' emotional support, but after completing the analysis of the interview data I found a number of areas where there was literature pertinent to my study. There was a great deal of literature on information-giving and breast-feeding. Also, as I have continued to work on literature in this area, Hunter and colleagues have dramatically increased the research in emotional labour / work of midwives.

This book is based on the literature reviews and findings of my study, initially conceived as ‘how do midwives give emotional support to women on their journey to motherhood?’. I hope I have been able to add to the knowledge base of what emotional support is, how it appears to be part of emotional care and the complexities of how it is provided.

CHAPTER ONE

WHAT IS MOTHERHOOD?

Introduction

This chapter explores what motherhood is and how women experience it. The underpinning political ideologies along with generally accepted myths of motherhood are discussed. Women's experiences of becoming mothers are explored later in the chapter, which concludes with a consideration of women's goal to be a 'good mother'.

Mother n. 1. Female parent 7. Hence ~ hood n.

Motherly a. having or showing the good (esp. tender or kind) qualities of a mother (Sykes 1982:660),

“Becoming a mother affects your life in ways you cannot even begin to imagine. It is one of the most dramatic and profound personal transformations a woman can ever experience. It will change your way of thinking in areas you believed had nothing to do with mothering. It will change how you view the world. It will change how you relate to other people. It will change how you see your past, present and future.

Your experiences will take you on a breathtaking journey as intense in joy and euphoria as in pain and confusion”
(Leonhardt-Lupa 1995:1).

What is motherhood?

Motherhood has been described as the ultimate achievement and fulfilment of a woman's life, but others see it as an ultimate example of female oppression (Marchant 2004).

Motherhood has been said to be impossible to define in any helpful way (Ball 1994) but Marchant (2004:74) offers the definition “motherhood implies the act of having given birth”. This simple definition corresponds highly with the dictionary definition, but it is important, when developing a detailed understanding, to consider what it means to the person

experiencing it (Ball 1994). Motherhood, when considering more closely the experiences of women, may be a process involving both physical and psychological changes through pregnancy, giving birth and nurturing a child, rather than just the end point of birth. It is also acknowledged that birthing can be described as a process, rather than an event. It is recognised that motherhood involves strong emotions alongside physical, sexual and spiritual changes (Ball 1994, Page and McCandlish 2006, Atkinson 2006). Whilst the major physical changes may not occur for women who become mothers without pregnancy and giving birth, there are still many social and psychological changes that take place for them.

The term motherhood can be seen as problematic, if accepted as ‘the act of having given birth’ as, within our society, there are many women who undertake the role of ‘being a mother’ without having given birth. Hence the focus in the literature has been on mothering, instead of motherhood (Marchant 2004). Mothering can be seen as a way of caring, exhibited through altruistic, undemanding, selfless love (Marchant 2004). Motherhood can therefore be seen as the state, status or role of being or becoming a mother and mothering as the actions in response to it, such as loving and caring. “Mothering is an intimate kind of caring” (Rothman 2000: 9).

Through our society’s political ideologies, motherhood can be seen to be promoted as an idealised state where mothers appear unrealistically happy and healthy, and the expectation of emotional fulfilment in motherhood has led to some disillusionment (Magill-Coerden 2006). It could also be suggested that the origins of this disillusionment, unhappiness or something that could be labelled depression, are in the nature of care provision – its medicalisation (Littlewood and McHugh 1997).

In the past, motherhood has defined women and their activities - it was their status, it was who they were. Feminists fought against this to gain choices and opportunities for women, but this has led to an even more unacceptable definition of motherhood (Rothman 2000). Instead of motherhood being a status, it has become an activity, a service or work. Rothman suggests this is reducing the enormity of the experience which, in turn, could have an impact on the whole of society. If motherhood can be seen as work or a job, it could be suggested that the loving care that supports it can also be a commodity that is bought and sold. Certainly Hochschild (2003) recognises this as already occurring in her book, *The Commercialisation of Intimate Life*.

Political ideologies influencing motherhood

Motherhood has been part of political ideology since the mid-twentieth century (Magill-Coerden 2006). A political ideology is the power-base for the society, influencing its attitudes, values and morality. This is sometimes referred to as hegemony, which means ruling or leadership by one state over the available others. Hegemony does not necessarily refer to coercive control, despite frequently being seen as such; it can have an underpinning or implicit impact on states or societies. Political ideologies in western societies can be seen more, though, as cultural hegemonies, as established by the Marxist movement. Marxists suggest cultural hegemony occurs where there are differing classes or groups within a society and the 'ruling' class or group establishes the cultural 'norms' for that society (MIA 2010). The less powerful groups then implicitly accept the values and morality of the 'ruling' group without explicit consideration. Political ideologies can therefore be seen as underpinning the attitudes, values and morality of a society and are accepted, without thinking, as the 'right way to be'.

Rothman (2000) suggests there are three political ideologies that apply to motherhood in the US - patriarchy, technology and capitalism. These three political ideologies can be seen in most Western cultures but perhaps are more distinct in the US, as the socialist approaches of some of the European countries are unacceptable there. Rothman (2000) identifies an ideology as a worldview which influences not only how people interact with each other, but also how a person views their own body.

The ideology of patriarchy can lead women to believe they are lesser human beings than men, their views and abilities are less important and less valuable. In her discussion of patriarchy in the US, Rothman is not referring to male dominance; she believes it is the patriarchal kinship that is the foundation of this (patriarchal) ideology. The male, or father, relationship is core in the society and expresses this as "children are born to men out of women" (Rothman 2000: 15). This can be seen in the way in which people express their kinship and their explanations of reproduction. It still appears acceptable to refer to procreation in the US and UK as men's seed growing in women's bodies. Men, in the patriarchal ideology, can be seen to control procreation; the seed of life comes from them. Women in this culture are expected to be virgins at marriage and are controlled through pregnancy, to ensure the protection of the man's seed. Evidence of a patriarchal society can be seen in the

naming of children in the US and UK: children usually receive their family name from the man.

The technology ideology, which has grown out of the Industrial Revolution, changed not only the tools available, but also the way people think about themselves and the world (Rothman 2000), although others, such as Whitbeck, prefer to label this the economy ideology. Within this ideology there is a focus on 'making' rather than 'doing', it is the goal or output that is valued with the "rational pursuit of efficiency" (Rothman 2000: 30). The woman's body and the baby become a resource that can be substituted, or bought and sold. This pursuit of efficiency can be seen in the medicalisation of becoming a mother.

"The ideology of technology dehumanises people by encouraging a mechanical self image – people viewing themselves as machines. Capitalism adds that, not only is the baby a collection of parts, its parts become commodities. In the United States the essential fluids of life – blood, milk, and semen- are all for sale" (Rothman 2000: 39). The paternal ideology, which has been a core ideology in the majority of civilisations for most centuries, guides women to see themselves and their functions, abilities and experiences as being less valuable than men's. With the huge societal changes in western cultures, starting with the Industrial Revolution, this technology ideology emerged which appears to subjugate, not only women, but all human experience. Alongside the technology ideology has been the development of capitalism. Capitalism can be seen to be influential in all western societies as not only a political and economic approach, but also a distinct belief system: an ideology.

Rothman (2000; 39) suggests the capitalism ideology leads to the "commodification of children and the proletarianisation of motherhood". This commodification of 'properties' associated with motherhood, can be seen to lead to people to declaring, and at times demanding, property 'rights'. Although it is politically unacceptable to state children are properties that can be owned in the US or UK, there are 'rights' attributed to them which can be seen to be similar to property rights or legislation. Men and women believe they have the right to have a baby or the right to terminate a pregnancy. There is still legal debate and there have been a number of court cases where the right of the woman to terminate a pregnancy and the prospective father's right to the foetus have been conducted.

There appears to be a strong link between the technology and capitalism ideologies in relationship to motherhood. Both can be seen to lead to a more medicalised experience of the transition to motherhood. With technological advances there are many interventions now that can substitute parts of procreation, such as fallopian tubes and breasts and others to alter the transitional experience, such as amniocentesis and caesarean sections. The capitalist underlying ideological approach to rights, including the right to 'sue' associated with motherhood and fatherhood, promote the acquisition of the elements of technology they choose, in order to control their bodies and their babies.

This very brief exploration of the prevalent ideologies in western societies has mostly focused on how these belief systems affect the individual, but there are also other societal influences in motherhood. Within the UK, most health and social care is provided by the State, which means the pervasive ideology in the UK is not necessarily the capitalist one in terms of health and social care. There is, though, evidence to support all three of the ideologies discussed here, especially when considering the medicalisation of midwifery care.

Medical-political ideology of childbirth

There has been a lot of discussion surrounding the area of the medicalisation of child- birth within midwifery services, research and in academia. There has certainly been a dramatic increase in the medicalisation of the journey to motherhood over the last century which may have prompted these discussions. The twentieth century saw 15% of births occurring in institutions in 1927, increasing to 24% by 1932 and 45% by 1944 (Leap and Hunter 1993). This had increased to 64% by 1952 (Rhodes 1995). The National Health Service was introduced in 1948 and midwifery services were included in this. By the 1960's there was a call for all births to be in hospital and in the 1970's and '80's, with increasing medical interventions available and a consumer- led health care, this gained momentum (Peel report 1970, Court report 1976, Welburn 1980 cited in Littlewood and McHugh 1997). This has developed with professional midwives and obstetricians taking women through the process and increasingly using technological screening of both mother and baby. This can be seen to be leading women to feel that they are objects being processed through a factory (Rhodes 1995) and it has led to an increase in psychological problems for women (Littlewood and McHugh 1997).

There appear to be two major political discourses in motherhood in the UK, through which the disjunction between expectations and experiences can be explored; they are the discourses of medicine and nature. The medical discourse can be seen in the professionalisation or expert-led maternity care (Littlewood and McHugh 1997), which is underpinned by the technology ideology. The nature discourse establishes becoming a mother as natural or instinctual (Miller 2007), which can be seen in the political ideological stance (Magill-Coerden 2006) taken in the UK, and is closely related to a more paternalistic ideology. Despite this dichotomy, the paternalistic ideology could arguably be said to underpin both discourses as professionalism and medicine have a predominantly masculine approach (Morrison 1992). Miller (2007:337) labels both these views the “unrealistic assumptions embedded in gendered discourses that pattern women’s lives”.

Given the Marxists’ understanding of cultural hegemony and the dominant political ideologies, it can easily be seen how women, whether pregnant, new mothers or midwives would accept the medical-political ideology and submit themselves to professional control. If women accept the medical-political ideology with both the professional and nature discourses it can easily be recognised that women may experience cognitive dissonance and emotional turmoil at this significant time in their lives.

The women’s movement in the second half of the twentieth century sought to deal with the inequalities that women experienced, due to the paternal ideology underpinning most western societies. The ideologies of technology, capitalism and paternity do not appear to be mutually exclusive. Despite the feminist impact on legislation and education, their efforts appear to have only intensified the contentions associated with motherhood (DiQuinzio 1999). Feminists have tried to conceptualise motherhood in a way that is emancipatory, but which at the same time addresses the needs and desire of both mother and child. In the US, mothering is a contentious issue, not least for feminists as they struggle with a monolithic view. Some have argued that motherhood is oppressive, and others that it leads to fulfilment and a sense of identify (DiQuinzio 1999).

Despite these debates and discussions, there is general agreement that there are social expectations of mothers – those who experience motherhood (Marchant 2004, Magill-Cuerden 2006, Miller 2007). Magill-Cuerden (2006) states that, to be a ‘good parent’ the person needs to conform to

social expectations. Marchant (2004:75), highlighting this, presents a table of what are considered to be socially normal and deviant behaviours attributed to mothers. To be considered normal, women are expected to be maternal, home-centred, care about their families and men, controlled by their bodies, inferior to men and submissive. Deviant women are those who reject the caring role and are career-orientated, not accepting an inferior position or bodily limits, and are over assertive. Society's concept, outlined by Magill-Cuerden (2006), of a mother is very similar to this, but perhaps more exaggerated. Normal mothers are controlled by their bodies and are emotionally unstable. They are also, paradoxically, expected to be child like at the same time as nest-builders with the urge to care. Socially deviant mothers struggle with childbirth, are unwilling to give up their past life and expect partners to share responsibility. This is very clearly supported by the paternalistic ideology (Rothman 2000).

The stereotypical characteristics listed above are what DiQuinzio (1999) has labelled 'essential motherhood' and states that it puts women in a subjugated position. The paternalistic, technological and capitalist ideologies are enacted in western societies in an individualist manner. This overarching individualist approach identifies each individual as unique; they are objective and can make their own choices based on the resources available to them. Therefore, each individual makes their individual decisions based on their personally determined desires and needs. If all mothers and mothers-to-be are expected to conform to a predetermined stereotype, they cannot be considered individual and are always, therefore, subjective. The expectation to be individualist and conformist is the paradox of the politics of mothering expressed by DiQuinzio (1999). She does, though, offer a way forward, in her suggestion that a politic of mothering could involve a movement between contradictory positions accepting different ways of being, whilst at the same time recognising there are some common needs.

The dissonance associated with cultural hegemony discussed above may be seen to present the experience of motherhood in a rather negative way, with women encouraged to have certain expectations that cannot be achieved and immense societal pressure on them. The reader, though, can be reassured that, although the majority of women experience what is labelled the 'baby blues' in the first week after the birth (Lawrie et al 2002), for many, the experience of becoming a mother is a positive one (Fullerton 1997, Green and Kafetsios 1997).

Myths of motherhood

Barnes and Balber (2007) highlight the myths associated with motherhood and parenthood and guide their readers to more realistic expectations. They write “Babies may embody all the magic, innocence and wonderment of a fairy tale. But the realities of pregnancy, childbirth and the postpartum period can be a very different story” (Barnes and Balber 2007: 8). The myths of parenthood include ‘all women “glow” during pregnancy’, ‘having a baby can save a strained marriage’, ‘children are destined to repeat their parents’ mistakes’, ‘life will not be that different once the baby arrives’, ‘the maternal instinct’, ‘maternal bonding’, ‘the average baby’ and ‘the perfect parent’. They state that each of these is a myth, as each may apply in some part to some parents, but these things do not occur in everyone spontaneously.

The myths explored by Barnes and Balber and the advice they go on to offer prospective parents, highlight again the social nature of parenthood. Whereas Magill-Cuerden (2006) and Marchant (2004) acknowledge the social expectations and identify how difficult it is for a mother to be recognised as acceptable if she does not fulfil these, Barnes and Balber (2007) suggest women have choices. They assume that women can grasp the individualist approach and make objective decisions.

Barnes and Balber (2007) appear to suggest women can put on one side the acknowledged stereotypical expectations which are less clearly defined in contemporary society. They are attempting to lead those on the journey to parenthood to develop what they would consider to be more realistic expectations of themselves. They suggest parenting is about trial and error and write of the ‘good enough’ parent.

From this brief overview, motherhood can be seen to be a process, as well as an event. The event is the giving birth, which is in itself a process, and the processes of physical and psychological changes through pregnancy and birth to the early days of being a mother. All of these are experienced within a political and social environment, which has clear expectations of the woman.

Despite this, understanding is limited unless the women’s lived experiences are also considered. To gain a more in-depth understanding of motherhood, becoming and being a mother, there is the need to explore the experiences of women at this time (Ball 1994).

The experiences of women becoming mothers

Most research in this area has been undertaken using a qualitative methodology, but not the same methodology. Studies have used a variety of approaches, including narrative analysis of a longitudinal study (Miller 2007), content analysis (Cronin 2003), phenomenology (Bondas and Eriksson 2001) and grounded theory (Barclay et al 1997). Studies have also been conducted in different countries: UK (Miller 2007), Ireland (Cronin 2003), Finland (Bondas and Eriksson 2001) and Australia (Barclay et al 1997). They can all, though, offer some insight into the phenomenon of how women experience becoming a mother, and those identified above will be explored in chronological order of being undertaken.

A total of fifty-five women in nine focus groups were asked about their experiences of becoming a mother in Australia (Barclay et al 1997). The core category identified was labelled 'becoming a mother'; all the other categories fed into it. There were six other categories: 'working it out', 'alone', 'realising', 'loss', 'unready', and 'drained'. Many adjectives typified each of these categories. For example, for 'alone' the suggestions offered were: isolating, trapped, suffering, confused, vulnerable, being there, feeling supported, safe, frightened, resentful.

The core category of 'becoming a mother', offered the story line for the phenomenon. Despite biologically becoming a mother, the women did not appear to become a mother emotionally and personally until sometime afterwards (Barclay et al 1997). When the women recognised the impact of being a mother, it came as a shock. Eventually, the women tuned in to their babies as they worked out how to be a mother. The social process was identified as both maturational and developmental (Barclay et al 1997).

Forty women's experiences of pregnancy were explored using Colaizzi's phenomenological approach (Bondas and Eriksson 2001). Colaizzi's approach involved a systematic analysis of peoples 'lived' experiences of a given phenomenon; in this case the phenomenon was pregnancy. Pregnancy is a particularly significant time emotionally for women, as they are said to gain higher scores on the Edinburgh Post Natal Depression Scale (EPNDS) in the antenatal period (Evans et al 2001). There are, though, many concerns with using this scale within clinical practice (Adams 2002). A systematic review of depression perinatally offers a

prevalence rate of major or minor depression of up to 12.9% (Gavin et al 2005). Despite this being lower than the rate at three months post-natally (19.2% Gavin et al 2005), it is still of significant concern.

Bondas and Eriksson (2001) found ten emerging themes in the women's experiences of pregnancy, which were clustered into three categories. The category of 'the perfect baby' included the themes of promoting the health of the unborn baby, health as no longer taken for granted and changing health behaviours. The category of 'an altered mode of being' included the themes: changing body, variations in mood, ill-health as part of being pregnant and worries. The third category was 'striving for family communion' which incorporated the themes of the evolving significance of the baby, dreams, expectations and planning and changing relationships.

The essence or invariant meaning emerged from within the cultural context of the women. The essential structure of the women's lived experience was one of "wishing for a perfect baby in an altered mode of being while striving for family communion" (Bondas & Eriksson 2001:835). On a superficial level these first two studies appear to have very different findings, but it is important to be aware that Bondas and Eriksson were only considering pregnancy, whereas Barclay et al were exploring pregnancy, birth and the early days post birth. Both indicate that this is a time of some anxiety for the women.

Using content analysis of focus groups and interviews, Cronin (2003) also explored motherhood. The key themes seem to have little relationship with those found by Bondas and Eriksson (2001). An exception to this, though, is their theme of 'altered mode of being' and, like Bondas and Eriksson (2001), she highlights the significance of family. The differences may be in part due to Cronin's study having a focus on need, whereas Bondas and Eriksson's study was more open.

There were four concepts in Cronin's study (2003); birth and hospitalisation, support, motherhood and psychological issues. Within each of these there were a number of key themes found. The major findings seem to be very similar to those of Barclay et al (1997), despite being undertaken on different sides of the world. Given that both Cronin and Barclay et al conducted their studies after the women had become mothers and been through the process of pregnancy, birth and the early days afterwards, it is less surprising that the findings are more similar to each other than with those of Bondas and Eriksson (2001). The women in Cronin's study

(2003) found that coping with the lifestyle changes was difficult, but that they gradually adapted to their new roles, as did those in Barclay et al's study (1997) and Miller's study (2007).

The study, undertaken by Miller (2007), used a longitudinal narrative approach through interview data. Three interviews were conducted with each participant: one prior to the birth (approximately 8 months pregnant), the second after the six-week postnatal check and the third when the baby was approximately eight months old.

This narrative approach led to a discursive paper exploring the experiences of the women (Miller 2007). In their transition to motherhood, the women, in the beginning, try to do the right thing and be responsible, which is similar to the women in Bondas and Eriksson's (2001) study. Initially, they appear to trust the official political discourses of motherhood that birth and mothering will come naturally to them and, if they should have problems, that medicine will address these. Although these discourses were not highlighted in the previous studies, Miller suggests these are social discourses of our society. The women held the belief that they would remain in control of their bodies and confidently know what they were doing. From this starting point the women's experiences of birth were not what they expected and they felt let down by both their own bodies and the professionals.

During the birth of their babies the women experienced loss of control and felt as though they were failures. Eventually, the women gained confidence in their ability to mother and developed relationships with their babies. These findings during and after the birth closely resemble those of Barclay et al's (1997) main findings and are similar to those of Cronin (2003), except they are couched in different terms, probably due to differing methodological approaches.

Cronin's study (2003) is much more pragmatic than the more interpretative study conducted by Miller (2007) or the descriptive study of Bondas and Eriksson (2001). Her focus was on the needs, perceptions and experiences of first-time mothers. As with Barclay et al (1997) and Miller (2007) she found that the new mothers experienced shock, but for Cronin (2003) and Miller (2007) this was primarily due to the birth experience, whereas for Barclay et al (1997) it was the realisation of what motherhood entailed.

Barclay et al (1997) and Miller's (2007) studies may appear to be a rather negative view of motherhood, in comparison to Bondas and Eriksson (2001). This is, perhaps, unsurprising since Bondas and Eriksson's participants were looking forward, with some anxiety, to the event, whereas the others were considering the event in retrospect. However, many of the struggles and concerns for the women are similar for all the studies considered above. Despite some of this negativity, they all suggest women eventually work things out and are able to mother their babies. Perhaps the most significant difference in the studies is that Bondas and Eriksson's study has family communion as a significant feature.

For all the women in the studies of Bondas and Eriksson, Barclay et al, Cronin and Miller, motherhood involved quite monumental changes in all areas of their lives. After an unspecified time they appeared to adjust to these and to strive to become what has been labelled 'good mothers'.

Given that motherhood can be accepted as both becoming and being a mother and the literature seems to suggest that women at this time strive to become a 'good mother' (Brown et al. 1997, Bondas and Eriksson 2001, Marchant 2004, Magill-Cuerden 2006, Miller 2007), it is important that this concept is explored and understood. The next section will, therefore, explore the literature to gain an understanding of what it means to be a good mother.

To be a 'Good Mother'

"the 'good mother' is required to be loving and caring, to have 'never ending' supplies of patience.....remain calm and relaxed at all times...good listener and communicator...sensitive to children's' needs"
(Brown et al 1997:5).

Popular online magazines, such as Parenting, inform us that to be a good mother the woman needs to be "adaptable, patient, loving, compassionate, empathetic, kind, strong and determined" (Suttie-Gunson 2007:1). Suttie-Gunson (2007) goes on to say that a good mother will sacrifice anything for her children, that she loves them unconditionally, and forgives them any pain they cause. This is followed up with the advice to 'follow your instincts and you will be a good mother'. This is in contrast to a number of studies that suggest it takes time for women to reach an intuitive responding to their babies (Barclay et al 1996, Cronin 2003, Wilkins 2006, Miller 2007).

There are many cultural images of motherhood and mothers like those above, from media images to early childhood fairy tales of romantic love and 'happy ever after' marriage and motherhood. "Society tells us that motherhood is natural and blissful. The beautiful Madonna adorns church frescos. Smiling, sun-kissed supermodels hold their babies in a modern mimicry of this ancient motif." (Stewart 2004:107).

Whilst most would recognise these as idealised images, feminists inform us that women have internalised these images and carry a vision of the perfect mother into their journey to motherhood (Stewart 2004). Whether the extreme view offered by feminists is accurate or not, conversations with those becoming mothers inform us that there is a sense of the 'good mother' that they are trying to achieve (Miller 2007).

Brown et al (1997) explored the concept of 'good mother', considering whether there were significant changes to this over the recent decades, given the social and cultural changes. They also explored if those women who became depressed during early motherhood did, indeed, have a more unrealistic view of motherhood than those who did not develop depression; a commonly held belief. To do this they initially conducted a survey of recent mothers, including an assessment using the Edinburgh Post Natal Depression Scale (EPNDS). They then did a follow up study, again sending out questionnaires including the EPNDS. Once these were completed, each respondent was interviewed using semi-structured interviewing.

They considered if, as had been suggested, there were two differing discourses of the 'good mother': the original 'good mother' being the stereotype prior to recent, but huge, societal changes and the new 'good mother' as the stereotype after these changes. The old or original 'good mother' was identified as being a woman who focused on love and security for her child and with other passive attributes, such as patience and reliability. The new 'good mother' was said to be interested in her own independence and individuality: she focused on providing stimulation for her child's development.

Despite the identified new stereotype of a 'good mother', all the women (Brown et al 1997) accepted a stereotype most like the traditional view of a 'good mother'. That is, they believed a mother should primarily be loving and caring, with never-ending patience. The mother should be calm and relaxed at all times, be a good communicator, and be

understanding and sensitive to the needs of the child. Instead of leaving this stereotype, to associate themselves with a new stereotype of modern mothers who were independent and stimulating, they seemed to have included the stimulation and guidance in the original stereotype.

Unlike predictions of a change of stereotype to correspond with societal change where more women are in professional and full-time paid employment, the women (Brown et al 1997) assimilated new ideas into an existing concept. Piaget (Barker 2007) might suggest the new stereotype was not distinct or different enough to cause cognitive dissonance or unbalance their equilibrium and lead to accommodation of a new schema or stereotype. The women had assimilated new thoughts into an old schema, in this case the stereotype of a 'good mother'.

Despite a generally accepted belief that women who suffer from postnatal depression after the birth of their baby have significantly more unrealistic expectations of motherhood, there was no difference between those with depression and those without. Both the women who scored highly on the EPNDS and the women who did not, held the same stereotype of a 'good mother' (Brown et al 1997).

This stereotype of the 'good mother' seems to be pervasive and enduring, with Campbell in a Christian text in 1984 saying that mother love is different to other sorts of love. He describes it as maternal tenderness, the mother as comforter, interpreter and as a warm presence in a frightening world. Marchant (2004), twenty years later in a recent midwifery text, offers a similar description of the 'good mother'. She states that mothering is altruistic caring, undemanding and selfless love.

This type of motherhood and the stereotype of 'good mother' is, though, culturally determined and influenced by the cultural hegemony. Prior to the eighteenth century children were seen mostly as economic resources and by some even despised as little animals. The industrial revolution and protestant evangelism have probably been the most influential factors in the current stereotype (Muniz 2008). Scientific motherhood in the nineteenth century, which can be viewed alongside the professional and paternalistic ideologies, probably gave rise to the current 'good mother' stereotype. The scientific motherhood only recognised those mothers who were able to devote their time fully to their babies and children as good mothers. Women who needed to do paid employment did not count as true mothers.

A 'good mother' is totally, loving, caring, patient, kind, selfless, sensitive, understanding and so much more, according to the stereotypes held by women, told in stories and text books and promoted in the media. To add to this, I would suggest, unachievable way of being, there is also the pressure of the baby or child being damaged without it; "Everything depends on the mother" (Russell cited Exley 2004).

Summary

This chapter has explored what motherhood is, the experiences of women becoming mothers and the expectations of mothers, including those expectations which they put on themselves (Brown et al 1997).

The transition to motherhood is the process of becoming a mother through pregnancy, birth and the early days after the birth, as it takes women a little time after the birth to adjust and become a mother (Barclay et al 1996, Cronin 2003, Wilkins 2006).

There is general agreement that, within the cultural hegemony, there are social expectations of mothers – those who experience motherhood (Marchant 2004, Magill-Cuerden 2006, Miller 2007). Motherhood is enacted within a social and political arena, which influences the dominant discourses on mothering (Littlewood and McHugh 1997, Rothman 2000, Magill-Cuerden 2006, Miller 2007). With monumental changes occurring for the women (Barclay et al 1996, Bondas and Eriksson 2001, Cronin 2003, Miller 2007) and cultural pressures influenced by the dominant discourses of medicine and nature (Miller 2007), women strive to be 'good mothers' (Brown et al 1997, Bondas and Eriksson 2001, Marchant 2004, Magill-Cuerden 2006, Miller 2007). The 'good mother' appears to be an unachievable, generally-held stereotype.

A mother is:

“she is their earth...
she is their food and their bed and the extra blanket
when it grows cold in the night; she is their warmth and their health and
their shelter”
(Hathaway cited Exley 2004)

CHAPTER TWO

WHO SUPPORTS WOMEN BECOMING MOTHERS?

Introduction

There are a number of sources from which women might seek and/ or receive support in becoming a mother. This chapter will briefly consider the support needs of women at this time, what support is and who might be able to provide support for them. This will include a consideration of the role of the baby's father, nurses, doulas (those people, usually women, who offer a social and emotional presence to women during the birth) and midwives.

Support

Morrison and Bennett (2006: 361) clearly state that “we all need support”. The National Service Framework (NSF) for children, young people and maternity services in England (DoH 2004) likewise states that women should be ‘supported’ during pregnancy, birth and in the care of themselves and their babies after birth. They also state that, as part of this support, women should be ‘encouraged’ to have as ‘normal’ a pregnancy and birth as possible. For both midwifery and obstetrics, care should be based on good outcomes, clinically and psychologically, whilst putting equal emphasis on preparation for parenthood (DoH 2004). Provision of care and preparation for parenthood could both be seen to be supportive activities. Support can also be seen to underlie the National Institute for Clinical Excellence antenatal (NICE 2003) and postnatal care (NICE 2006) guidelines, with their focus on women-centred care and informed decision making. If, as is suggested, we all need support and that a core concept within midwifery and obstetric care is support, there is a need to clarify what support is and why it is important, prior to exploring who supports women on their journey to motherhood.

Support v.t.n.

A dictionary definition of support is:

1. Carry, hold up, keep from falling or sinking
2. enable to last out, keep from failing, give strength to, encourage
3. endure, tolerate
4. supply with necessities, provide for
5. lend assistance or countenance to, back up, second, further
6. hear out, tend to substantiate or corroborate, bring facts to confirm
7. keep up or represent adequately (Sykes 1982:1072)

The dictionary definition, as demonstrated above, does not offer a precise understanding of support; it provides a number of options, not all of which are listed here. With other words it is clear which meaning is appropriate in a given context, for the word 'support' this is not the case. All of the above definitions could apply to the context of offering support to women on their journey to motherhood. It would, though, appear prudent at this point to distinguish between physical and social support. The support advocated by Morrison and Bennett (2006), that they suggest we all need, might be considered to be social support. Physical support, although having some blurred edges to its definition, can be seen to link more closely to the first dictionary definition of carry, hold up, keep from falling.

Social support appears a rather more flexible concept and can be defined as the resources provided by one person to enhance the well-being of the other (McCourt 2003) but this is so broad that it offers little understanding of the support needed and given to women in their transition to motherhood. It is also worth acknowledging that social support can include physical activities, although it is probably more helpful to label these mostly as practical activities in this situation. To develop a clearer understanding of social support, it may be useful to explore what it does and what it looks like.

Social support is said to have an enormous influence on health and well-being, which has led to a number of theories being developed to understand the phenomenon. Psychologists have developed theories, such as the direct effect and the stress buffer theory, where the social support provides a buffer against the impact of stress on health (Morrison and Bennett 2006). It is likely that these psychological theories underpin the sociological theories (McCourt 2003). Sociological theories, such as